WSR 09-14-004
EMERGENCY RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed June 19, 2009, 9:41 a.m., effective June 19, 2009, 9:41 a.m.]

Effective Date of Rule: Immediately.

Purpose: Revises WAC 181-78A-325 changing the number of hours of internship for preparation programs to provide to administrators to receive their certification.

Citation of Existing Rules Affected by this Order: Amending X [WAC 181-78A-325].

Statutory Authority for Adoption: RCW 28A.410.210, 28A.305.130, and 28A.410.010.

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Budget reductions require adjustments in certification internship requirements for administrators. The number of hours is reduced from seven hundred twenty to five hundred forty.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 1, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 1, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.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: June 19, 2009.

David Brenna
Legislative and
Policy Coordinator

AMENDATORY SECTION (Amending WSR 06-14-010, filed 6/22/06, effective 7/23/06)

WAC 181-78A-325 Program approval requirement—Field experience for all administrators. The internship shall take place in an education setting serving under the general supervision of a certificated practitioner who is performing in the role for which certification is sought. Components of the required internship shall include demonstration by the candidate that he or she has the appropriate, specific relevant skills pursuant to WAC 181-78A-270. An approved preparation program for administrators and, prior to August 31, 1998, for principals, shall require an internship of at least ((~~three hundred sixty hours: Provided, That an approved preparation program for principals shall require for those persons entering the program August 31, 1998, and after, an internship which requires practice as an intern during a full school year. A "full school year" shall mean seven hundred twenty hours of which at least one-half shall be during school hours, when students and/or staff are present and include the principal performance domains as stated in WAC 181-78A-270 (2)(a) or (b): Provided further, That~~)) five hundred forty hours. An approved preparation program for principals shall require for those individuals entering the program on or after September 1, 2004, an internship that shall include demonstration by the candidate that she or he has the appropriate, specific skills pursuant to the standards identified in WAC 181-78A-270 (2)(b) and meets, at minimum, the standards-based benchmarks approved by the professional educator standards board and published by the office of the superintendent of public instruction. The benchmarks may not be changed without prior professional educator standards board approval.

WSR 09-14-027
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 09-120—Filed June 23, 2009, 4:04 p.m., effective June 23, 2009, 4:04 p.m.]

Effective Date of Rule: Immediately.

Purpose: The purpose of this rule making is to allow nontreaty commercial fishing opportunity in the Columbia River while protecting fish listed as threatened or endangered under the Endangered Species Act. This rule making 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 policy guidance for Columbia River fisheries.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-33-01000F and 220-33-01000G; and amending WAC 220-33-010.

Statutory Authority for Adoption: RCW 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 2008-2017 *United States v. Oregon Management Agreement* (Aug. 12, 2008) (Doc. No. 2546); *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; and 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: Sets fishing periods for the summer season commercial fisheries for the mainstem Columbia River. Based on the preseason runsize, there are 4,000 upper Columbia summer chinook available for commercial harvest in the mainstem. 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, consistent with the compact action taken on May 13 and June 10, 2009. The department is in the process of filing permanent rules to define "properly stored" nets.

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 federal court order sets the current parameters for sharing between treaty Indians and others. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon Management Agreement* (Aug. 12, 2008) (Doc. No. 2546).

Some Columbia River Basin salmon and steelhead stocks are listed as threatened or endangered under the federal Endangered Species Act. On May 5, 2008, 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 treaty and nontreaty Columbia River fisheries governed by the 2008-2017 *U.S. v. Oregon Management Agreement*. 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, the Endangered Species Act, 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. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 0, Repealed 2; Federal Rules or Standards: New 1, Amended 0, Repealed 2; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at 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 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: June 23, 2009.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-33-01000G Columbia River seasons below Bonneville. Notwithstanding the provisions of WAC 220-33-010, WAC 220-33-020, and WAC 220-33-030, 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:

1. Mainstem Columbia River

a) Dates: 7:00 p.m. Wednesday June 24 to 5:00 a.m. Thursday June 25, 2009;

7:00 p.m. Tuesday June 30 to 5:00 a.m. Wednesday July 1, 2009

b) Area: SMCRA 1A, 1B, 1C, 1D and 1E (Zones 1-5)

c) Sanctuaries: Grays River, Elochoman-A, Cowlitz River, Kalama-A, Lewis-A, Washougal, and Sandy Rivers.

d) Gear: Drift gillnets only. 8-inch minimum mesh. Nets not lawful for use at that time and area may be onboard the boat if properly stored. A "properly stored" net is defined as a net on a drum that is fully covered by 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.

e) Allowable sales: Chinook, sockeye, coho, shad and white sturgeon (43-54 inch fork length). A maximum of five white sturgeon may be possessed or sold by each participating vessel during each calendar week (Sunday through Saturday) that the fishery is open. The weekly sturgeon sales limit applies to mainstem and Select Area fisheries

f) A 24-hour quick reporting rule is in effect for Washington buyers.

Reviser's note: The unnecessary underlining 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 section of the Washington Administrative code is repealed:

WAC 220-33-01000F	Columbia River seasons below Bonneville. (08-118)

The following section of the Washington Administrative Code is repealed effective July 2, 2009:

WAC 220-33-01000G	Columbia River seasons below Bonneville.

WSR 09-14-044

EMERGENCY RULES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(Aging and Disability Services Administration)

[Filed June 24, 2009, 1:59 p.m., effective June 24, 2009, 1:59 p.m.]

Effective Date of Rule: Immediately.

Purpose: The department is amending chapter 388-828 WAC, the DDD assessment, to add the children's intensive in-home behavioral support program (CIIBS) eligibility algorithm.

Citation of Existing Rules Affected by this Order: Amending WAC 388-828-1620.

Statutory Authority for Adoption: RCW 71A.12.30 [71A.12.030].

Other Authority: Section 205 (1)(i), chapter 329, Laws of 2008, 2008 ESHB 2687.

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: The 2008 supplemental budget, ESHB 2687, section (1)(i) directs the department to develop and implement a federal HCBS waiver to provide intensive behavior support services for up to one hundred children with developmental disabilities and their families. DDD is incorporating rules for the CIIBS eligibility algorithm into chapter 388-828 WAC.

An initial public notice was filed September 29, 2008, as WSR 08-20-087. This third emergency rule extends the emergency rule filed February 25, 2009, as WSR 09-06-049.

Centers for Medicare and Medicaid Services approved the waiver as of May 1, 2009, and stakeholder work is being completed. The rules are expected to be formally proposed by July 2009.

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 5, Amended 1, Repealed 0.

Number of Sections Adopted at 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 5, Amended 1, Repealed 0.

Date Adopted: June 19, 2009.

Stephanie E. Schiller

Rules Coordinator

AMENDATORY SECTION (Amending WSR 07-10-029, filed 4/23/07, effective 6/1/07)

WAC 388-828-1620 How does DDD determine which panels are mandatory in your DDD assessment? DDD determines which panels are mandatory in your DDD assessment by assigning you to a client group using the following table:

If you are approved by DDD to receive:	Your client group is:
(1) DDD ((~~DCBS~~)) HCBS waiver services per chapter 388-845 WAC; or (2) State-only residential services per chapter 388-825 WAC; or (3) ICF/MR services per 42 CFR 440 and 42 CFR 483.	Waiver and State-Only Residential
(4) Medicaid personal care (MPC) per chapter 388-106 WAC; or (5) DDD HCBS Basic, Basic Plus, CIIBS or Core waiver services per chapter 388-845 WAC and personal care services per chapter 388-106 WAC; or (6) Medically intensive health care program services per chapter 388-551 WAC; or (7) Adult day health services per chapter 388-106 WAC; or (8) Private duty nursing services per chapter 388-106 WAC; or (9) Community options program entry system (COPES) services per chapter 388-106 WAC; or (10) Medically needy residential waiver services per chapter 388-106 WAC; or (11) Medicaid nursing facility care services per chapter 388-106 WAC.	Other Medicaid Paid Services
(12) County employment services per chapter 388-850 WAC. (13) Other DDD paid services per chapter 388-825 WAC, such as: (a) Family support services; or (b) Professional services. (14) Nonwaiver voluntary placement program services per chapter 388-826 WAC; (15) SSP only per chapter 388-827 WAC;	State-Only Paid Services
(16) You are not approved to receive any DDD paid services.	No Paid Services

NEW SECTION

WAC 388-828-8500 What is the children's intensive in-home behavioral support (CIIBS) program algorithm? The children's intensive in-home behavioral support (CIIBS) program algorithm is a formula in the DDD assessment that calculates your out-of-home placement risk score to determine your eligibility for the CIIBS waiver per chapter 388-845 WAC.

NEW SECTION

WAC 388-828-8505 When does the DDD assessment run the CIIBS algorithm to determine your eligibility for the CIIBS waiver? The DDD assessment runs the CIIBS algorithm to determine your eligibility for the CIIBS waiver when your support assessment is moved to current and:

(1) You are the assessed age of eight or older and under age eighteen;

(2) Your behavior acuity level is high per WAC 388-828-5640;

(3) Your caregiver's risk score is medium, high or immediate per WAC 388-828-5300;

(4) Your ICF/MR score is eligible per WAC 388-828-4400; and

(5) You are not enrolled in the CIIBS waiver.

NEW SECTION

WAC 388-828-8510 What elements does the CIIBS algorithm use to calculate your out-of-home placement risk score? The CIIBS algorithm uses the following elements to determine your out-of-home placement risk score:

(1) The DDD protective supervision acuity scale (WAC 388-828-5000 to 388-828-5100);

(2) The DDD caregiver status acuity scale (WAC 388-828-5120 to 388-828-5360);

(3) The DDD behavioral acuity scale (WAC 388-828-5500 to 388-828-5640);

(4) The DDD activities of daily living (ADL) acuity scale (WAC 388-828-5380 to 388-828-5480);

(5) The DDD mobility acuity scale (WAC 388-828-5380 to 388-828-5480); and

(6) Eligible condition of "autism" as indicated in the DDD determination (WAC 388-823-0500).

NEW SECTION

WAC 388-828-8515 How does DDD determine your CIIBS out-of-home placement risk score? Your CIIBS out-of-home placement risk score is calculated using the following table:

Section and WAC reference	**If you meet the following criteria:**	**Then adjust your score by:**	**Score if you meet criteria**
	Clients meeting eligibility criteria in WAC 388-828-8505		**Beginning Score = 0**
DDD Determination WAC 388-823-0500	Eligible condition of autism in the DDD determination.	Adding 40 points	=
ADL Acuity Level WAC 388-828-5480	Your ADL support needs level = high, medium or low	Subtracting 54 points	=
Behavior Acuity Scale WAC 388-828-5500 through 388-828-5640	Your most prominent behavior = assault/injury and Severity of your most prominent behavior = "potentially dangerous" or "life threatening"	Adding 14 points	=
Protective Supervision Acuity Scale WAC 388-828-5060	Your answer to the following question: "What level of monitoring does the client typically require during awake hours?" = "Line of sight/earshot"	Adding 13 points	=
DDD Caregiver Status Acuity WAC 388-828-5300	Your caregiver risk level = high or immediate	Adding 136 points	=
Backup Caregiver Status WAC 388-828-5320	Your answer to the following question: "Under what conditions are other caregiver(s) available?" = "No other caregiver available"	Adding 33 points	=
Mobility Acuity Scale WAC 388-828-5900	Your mobility acuity level = high, medium or low	Subtracting 15 points	=

Section and WAC reference	If you meet the following criteria:	Then adjust your score by:	Score if you meet criteria
		Sum of all of scores above is your CIIBS out-of-home placement risk score	=

NEW SECTION

WAC 388-828-8520 How does DDD determine if I am eligible for the CIIBS waiver? DDD uses the following table to determine if you are eligible for the CIIBS waiver based on your CIIBS out-of-home placement risk score per WAC 388-828-8510:

If your CIIBS out-of-home placement risk score is:	Then your CIIBS eligibility is:
96 or greater	Yes - Severe
17 through 95	Yes - High
Less than 17	No - (not eligible)

WSR 09-14-045
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed June 24, 2009, 2:20 p.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: Amending and adopting new rules in chapter 388-71 WAC, Home and community services and programs, and sections in chapter 388-106 WAC, Long-term care services, to implement changes required due to federal requirements and the 2009-11 Washington state legislative budget.

Citation of Existing Rules Affected by this Order: Amending WAC 388-71-0724, 388-71-0726, 388-71-0728, 388-71-0734, and 388-106-0815.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

Other Authority: Washington state 2009-11 budget (ESHB 1244), section 206(10); and section 1915(i) of the Social Security Act.

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; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Federal funds for this program end June 30, 2009, due to a federal directive requiring adult day health (ADH) services to be removed from the rehabilitative services section of the medicaid state plan. In order to continue ADH services, aging and disability services administration (ADSA) will provide ADH services under Section 1915(i) of the Social Security Act. The 1915(i) option has different financial eligibility rules that require nonexcluded income to be at or below 150% of the federal poverty level (FPL).

The legislature in ESHB 1244, section 206(10), made significant service changes to ADH. Starting July 1, 2009, ADSA will no longer pay for ADH for people who live in adult family homes, licensed boarding homes, division of developmental disabilities (DDD) group homes, DDD companion homes or who receive DDD supported living services. Transportation to ADH currently provided by the medicaid transportation broker will be included as part of the rate for ADH. ADH providers will be required to coordinate or provide transportation as necessary to assure access to the service.

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 1, Amended 5, Repealed 0.

Number of Sections Adopted at 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 1, Amended 5, Repealed 0.

Date Adopted: June 23, 2009.

Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 03-06-024, filed 2/24/03, effective 7/1/03)

WAC 388-71-0724 Adult day services—Contracting and rates. (1) The department, or an area agency on aging (or other department designee) as authorized by the department, must determine that the adult day care or day health center meets the applicable adult day care or day health requirements and any additional requirements for contracting with the area agency on aging through a COPES contract or with the department through a medicaid provider contract. If a center is contracting for both day care and day health, requirements of both adult day services must be met.

(a) A prospective provider desiring to provide adult day services shall be provided an application form from the department or the area agency on aging.

(b) The prospective provider will provide the area agency on aging with evidence of compliance with, or admin-

istrative procedures to comply with, the adult day service rules under this chapter.

(c) The area agency on aging will conduct a site inspection of the adult day center and review of the requirements for contracting.

(d) Within thirty days of completing the site visit, the area agency on aging will advise the prospective provider in writing of any deficiencies in meeting contracting requirements.

(e) The area agency on aging will verify correction of any deficiencies within thirty days of receiving notice from the prospective provider that deficiencies have been corrected, before contracting can take place.

(f) The area agency on aging will provide the department with a written recommendation as to whether or not the center meets contracting requirements.

(2) Minimum application information required to apply for contract with the department, or an area agency on aging includes:

(a) Mission statement, articles of incorporation, and bylaws, as applicable;

(b) Names and addresses of the center's owners, officers, and directors as applicable;

(c) Organizational chart;

(d) Total program operating budget including all anticipated revenue sources and any fees generated;

(e) Program policies and operating procedure manual;

(f) Personnel policies and job descriptions of each paid staff position and volunteer position functioning as staff;

(g) Policies and procedures meeting the requirements of mandatory reporting procedures as described in chapter 74.34 RCW to adult protective services for vulnerable adults and local law enforcement for other participants;

(h) Audited financial statement;

(i) Floor plan of the facility;

(j) Local building inspection, fire department, and health department reports;

(k) Updated TB test for each staff member according to local public health requirements;

(l) Sample client case file including all forms that will be used; and

(m) Activities calendar for the month prior to application, or a sample calendar if the day service provider is new.

(3) The area agency on aging or other department designee monitors the adult day center at least annually to determine continued compliance with adult day care and/or adult day health requirements and the requirements for contracting with the department or the area agency on aging.

(a) The area agency on aging will send a written notice to the provider indicating either compliance with contacting requirements or any deficiencies based on the annual monitoring visit and request a corrective action plan. The area agency on aging will determine the date by which the corrective action must be completed

(b) The area agency on aging will notify the department of the adult day center's compliance with contracting requirements or corrected deficiencies and approval of the corrective action plan for continued contracting.

(4) Adult day care services

(a) Adult day care services are reimbursed on an hourly basis up to four hours per day. Service provided four or more hours per day will be reimbursed at the daily rate.

((~~(5) Payment rates are established on an hourly and daily basis for adult day care centers as may be adopted in rule.~~))

(b) Rate adjustments are determined by the state legislature. ((~~Providers seeking current reimbursement rates can refer to SSPS billing instructions~~)) Information on current reimbursement rates are available at http://www.adsa.wa.gov/professional under the "office of rates management" section.

(c) Transportation to and from the program site is not reimbursed under the adult day care rate. Transportation arrangements are made with locally available transportation providers or informal resources.

((~~(6) Rates as of July 1, 2002, are as follows:~~

~~Counties~~	~~COPES Adult Day Care~~	
	~~Daily Rate~~	~~Hourly Rate~~
~~King~~	~~$36.48~~	~~$9.10~~
~~Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, & Yakima~~	~~$32.45~~	~~$8.11~~
~~All other counties~~	~~$30.75~~	~~$7.69~~

~~(7)~~)) (5) Adult day health services

(a) Payment rates are established on a ((~~daily~~)) per day basis for adult day health centers ((~~as may be adopted in rule~~)). Rate adjustments are determined by the state legislature. ((~~Providers seeking~~)) Information on current reimbursement rates ((~~can refer to MAA billing instructions or http://maa.dshs.wa.gov~~)) is available at http://www.adsa.dshs.wa.gov/professional under the "office of rates management" section.

(8) ((~~Rates as of July 1, 2002, are as follows:~~

~~Counties~~	~~Day Health Daily~~
~~King~~	~~$47.48~~
~~Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, & Yakima~~	~~$43.06~~
~~All other counties~~	~~$40.68~~))

(b) A one-time only initial intake evaluation provided by an adult day health center, including development of a negotiated care plan, is reimbursed at an established rate ((~~as may be adopted in rule~~)). ((~~The rate as of July 1, 2002 is eighty-nine dollars and thirty-eight cents~~)) Information on current reimbursement rates is available at http://www.adsa.dshs.wa.gov/professional under the "office of rates management" section. Rate adjustments are determined by the state legislature. Separate reimbursement is not available for subsequent evaluations.

(9) ((~~Transportation to and from the program site is not reimbursed under the adult day care rate. Transportation arrangements are made with locally available transportation providers or informal resources.~~

((~~(10)~~)) Transportation to and from the program site is ((~~not reimbursed under the~~)) included in the adult day health service rate. ((~~Transportation arrangements for eligible medicaid clients are made with local medicaid transportation brokers, informal providers, or other available resources per chapter 388-546 WAC.~~))

Reviser's note: The typographical errors in the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION (Amending WSR 03-06-024, filed 2/24/03, effective 7/1/03)

WAC 388-71-0726 Adult day health transportation. ((~~The following rules apply if medicaid transportation services are requested:~~))

(1) ((~~The day health center must refer the client to a local medicaid transportation broker. The broker may consult with the client, the client's physician, family, case manager, or day health center as needed in making any transportation arrangements~~)) Adult day health providers must coordinate or provide transportation as necessary to assure client access to service.

(2) ((~~In referring the client to a day health center, the case manager may consider: The frailty and endurance of the client, the client's skilled nursing or rehabilitative therapy needs, and a reasonable round-trip travel time that may not exceed two hours, unless there is no closer center that can meet the client's skilled care needs. Documentation of language barriers may be considered on an exception to rule basis by the case manager.~~

~~(3) All brokered transportation under this subsection is subject to the requirements of chapter 388-546 WAC or its successors. In the case of any conflicts, the provisions of chapter 388-546 WAC take precedence~~)) ADH providers may provide transportation either directly or through an arrangement with a third party.

AMENDATORY SECTION (Amending WSR 03-06-024, filed 2/24/03, effective 7/1/03)

WAC 388-71-0728 Coordination of services. (1) ((~~A COPES eligible client~~)) An individual receiving COPES services in his or her home may receive adult day care services on some days and adult day health services on different days if the service plan documents which level of service is to be provided on which days. However, core services must be provided on all days that adult day health skilled services are provided, and reimbursement is limited to the day health rate on days that day health services are provided.

(2) Clients receiving residential services from the department in an adult family home, boarding home, or other licensed community residential facility may not receive ((~~COPES-funded~~)) state paid adult day care((~~, but may receive medicaid adult day health services when the skilled nursing or rehabilitative services are approved by the client's case manager as part of the client's service plan~~)).

(3) Clients receiving residential services from an adult family home, licensed boarding home, division of developmental disabilities (DDD) group home, DDD companion home or receive DDD supported living services may not receive state paid adult day health.

(4) A licensed boarding home providing department-approved day care under chapter 388-78A WAC is subject to any applicable provisions of that chapter and is also subject to the rules under this chapter if the facility contracts with an area agency on aging or the department to provide COPES or other medicaid-funded adult day services.

AMENDATORY SECTION (Amending WSR 05-02-064, filed 1/4/05, effective 2/4/05)

WAC 388-71-0734 Limiting expenditures. (1) In order to provide adult day services within the limits of available funding, the department may limit services when program expenditures exceed the budget appropriation or when limiting services is required to prevent expenditures from exceeding the appropriation.

(2) When adult day health program expenditures exceed available funding, the department may limit adult day health services based on the four care level system as determined through the established department assessment and described in chapter 388-105 WAC.

(a) Using the care level determined by the department assessment tool, the department will limit adult day services on a statewide basis to clients whose total scores exceed the assessed need level identified by the department as necessary to provide adult day health services to the extent of available funding.

(b) At least thirty days before implementing the limitation on services under this subsection, the department will notify the area agencies on aging, adult day health centers, and the affected adult day health clients that services are being limited and for what period of time the limitation is estimated to remain in effect.

(c) For purposes of RCW 74.08.080, the reduction in services shall be deemed an assistance adjustment for an entire class of recipients that is required by state laws prohibiting the department from expending funds in excess of appropriations.

(3) The department may adopt additional or alternative rules to control costs, such as, but not limited to, imposing a moratorium on contracting with new adult day centers, limiting services to clients based on level of care need, or reducing the numbers of days per week that clients may receive services or develop a wait list for ADH services.

AMENDATORY SECTION (Amending WSR 05-11-082, filed 5/17/05, effective 6/17/05)

WAC 388-106-0815 Am I eligible for adult day health? (1) You are eligible for adult day health services if you meet all of the following criteria. You are:

(a) Age eighteen years or older.

(b) Enrolled in one of the following medical assistance programs:

(i) Categorically needy (CNP);

(ii) Categorically needy qualified medicare beneficiaries (CNP-QMB);

(iii) General assistance—Expedited medicaid disability (GA-X); or

(iv) Alcohol and Drug Abuse Treatment and Support Act (ADATSA).

(c) Your nonexcluded income does not exceed one hundred fifty percent of the federal poverty level (FPL);

(d) Assessed as having an unmet need for skilled nursing under WAC 388-71-0712 or skilled rehabilitative therapy under WAC 388-71-0714; and

(i) There is a reasonable expectation that these services will improve, restore or maintain your health status, or in the case of a progressive disabling condition, will either restore or slow the decline of your health and functional status or ease related pain or suffering; and

(ii) You are at risk for deteriorating health, deteriorating functional ability, or institutionalization; and

(iii) You have a chronic or acute health condition that you are not able to safely manage due to a cognitive, physical, or other functional impairment.

(((~~d~~))) (e) Assessed as having needs for personal care or other core services, whether or not those needs are otherwise met.

(2) You are not eligible for adult day health if you:

(a) Can independently perform or obtain the services provided at an adult day health center;

(b) Have referred care needs that:

(i) Exceed the scope of authorized services that the adult day health center is able to provide;

(ii) Do not need to be provided or supervised by a licensed nurse or therapist;

(iii) Can be met in a less structured care setting; or

(iv) In the case of skilled care needs, are being met by paid or unpaid caregivers.

(c) Live in a nursing home or other institutional facility; ((~~or~~))

(d) Receive residential long-term care services from an adult family home, licensed boarding home, division of developmental disabilities (DDD) group home, DDD companion home or receive DDD supported living services;

(e) Are not capable of participating safely in a group care setting.

NEW SECTION

WAC 388-106-0820 Is there a wait list for adult day health? The department will create a waiting list in accordance with caseload limits determined by legislative funding. Wait listed clients will gain access in the following manner:

(1) Residents of nursing homes, ICFs/MR, or hospital patients requiring ADH services to safely discharge to an in-home setting will be ranked first on the wait list by date of application for services;

(2) For all other applicants, the client with the earlier application for services will have priority over later applications for services.

WSR 09-14-046
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed June 24, 2009, 2:22 p.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: Amending WAC 388-106-0125 How does CARE use criteria to place me in a classification group for in-home care?, the department is revising this rule to amend the in-home classifications to allow for the reduction of in-home base hours for each of the seventeen classification groups.

Citation of Existing Rules Affected by this Order: Amending WAC 388-106-0125.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

Other Authority: Washington state 2009-11 budget (ESHB 1244, section 206(5)).

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: The Washington state 2009-11 operating budget (ESHB 1244, section 206(5)) directs the department to reduce the number of in-home hours authorized. The hours awarded for in-home long-term care for each of the seventeen CARE classification groups are reduced by a certain percentage. As instructed by the legislature, classification groups with greater care needs receive a smaller percentage reduction than classification groups with lesser care needs.

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 1, Repealed 0.

Number of Sections Adopted at 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 1, Repealed 0.

Date Adopted: June 23, 2009.

Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 08-10-022, filed 4/25/08, effective 5/26/08)

WAC 388-106-0125 How does CARE use criteria to place me in a classification group for in-home care?

CARE uses the criteria of cognitive performance score as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behavior and behavior point score as determined under WAC 388-106-0100, ADLS as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110 to place you into one of the following seventeen in-home groups. CARE classification is determined first by meeting criteria to be placed into a group, then you are further classified based on ADL score or behavior point score into a classification sub-group following a classification path of highest possible base hours to lowest qualifying base hours.

(1) If you meet the criteria for exceptional care, then CARE will place you in **Group E.** CARE then further classifies you into:

(a) **Group E High** with ((~~420~~)) 416 base hours if you have an ADL score of 26-28; or

(b) **Group E Medium** with ((~~350~~)) 346 base hours if you have an ADL score of 22-25.

(2) If you meet the criteria for clinical complexity and have cognitive performance score of 4-6 or you have cognitive performance score of 5-6, then you are classified in **Group D** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group D High** with ((~~280~~)) 277 base hours if you have an ADL score of 25-28; or

(b) **Group D Medium-High** with ((~~240~~)) 234 base hours if you have an ADL score of 18-24; or

(c) **Group D Medium** with ((~~190~~)) 185 base hours if you have an ADL score of 13-17; or

(d) **Group D Low** with ((~~145~~)) 138 base hours if you have an ADL score of 2-12.

(3) If you meet the criteria for clinical complexity and have a CPS score of less than 4, then you are classified in **Group C** regardless of your mood and behavior qualification or behavior points. CARE then further classifies you into:

(a) **Group C High** with ((~~200~~)) 194 base hours if you have an ADL score of 25-28; or

(b) **Group C Medium-High** with ((~~180~~)) 174 base hours if you have an ADL score of 18-24; or

(c) **Group C Medium** with ((~~140~~)) 132 base hours if you have an ADL score of 9-17; or

(d) **Group C Low** with ((~~95~~)) 87 base hours if you have an ADL score of 2-8.

(4) If you meet the criteria for mood and behavior qualification and do not meet the classification for C, D, or E groups, then you are classified into **Group B.** CARE further classifies you into:

(a) **Group B High** with ((~~155~~)) 147 base hours if you have an ADL score of 15-28; or

(b) **Group B Medium** with ((~~90~~)) 82 base hours if you have an ADL score of 5-14; or

(c) **Group B Low** with ((~~52~~)) 47 base hours if you have an ADL score of 0-4; or

(5) If you meet the criteria for behavior points and have a CPS score of greater than 2 and your ADL score is greater than 1, and do not meet the classification for C, D, or E groups, then you are classified in **Group B.** CARE further classifies you into:

(a) **Group B High** with ((~~155~~)) 147 base hours if you have a behavior point score 12 or greater; or

(b) **Group B Medium-High** with ((~~110~~)) 101 base hours if you have a behavior point score greater than 6; or

(c) **Group B Medium** with ((~~90~~)) 82 base hours if you have a behavior point score greater than 4; or

(d) **Group B Low** with ((~~52~~)) 47 base hours if you have a behavior point score greater than 1.

(6) If you are not clinically complex and your CPS score is less than 5 and you do not qualify under either mood and behavior criteria, then you are classified in **Group A.** CARE further classifies you into:

(a) **Group A High** with ((~~78~~)) 71 base hours if you have an ADL score of 10-28; or

(b) **Group A Medium** with ((~~62~~)) 56 base hours if you have an ADL score of 5-9; or

(c) **Group A Low** with ((~~29~~)) 26 base hours if you have an ADL score of 0-4.

WSR 09-14-047
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 09-122—Filed June 24, 2009, 4:07 p.m., effective June 24, 2009, 4:07 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend personal use fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-25500S and 220-56-25500T; and amending WAC 220-56-255.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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 south coast (Westport) recreational halibut fishery is projected to have taken the Pacific halibut quota set aside for the primary season. This rule conforms to federal action taken by the Pacific Fisheries Management Council. 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 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 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 Mak-

ing: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: June 24, 2009.

Philip Anderson
Director

NEW SECTION

WAC 220-56-25500T Halibut—Seasons—Daily and possession limits. Notwithstanding the provisions of WAC 220-56-255, effective immediately until further notice, it is unlawful to fish for or possess halibut taken for personal use, except as provided in this section:

(1) Marine Area 1 - Closed.

(2) Marine Area 2 - Open 12:01 a.m. through 11:59 p.m. June 28 only, except for Northern Nearshore fishery (see below).

(i) Marine Area 2 (Northern Nearshore fishery): Those waters from 47º25.00'N. latitude (Queets River) south to 46º58.00'N latitude and east of 124º30.00'W longitude, open through September 30, 2009, Thursday through Sundays only.

(3) Marine Areas 3 and 4 - Closed.

(4) Marine Area 5 - Open through July 3, 2009, Thursdays through Mondays only.

(5) Marine Areas 6 through 11 and 13 - Closed.

(6) Daily limit one halibut, no minimum size limit. The possession limit is two daily limits of halibut in any form, except the possession limit aboard the fishing vessel is one daily limit.

(7) All other permanent rules remain in effect.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-56-25500S	Halibut—Seasons—Daily and possession limits. (09-99)

The following section of the Washington Administrative Code is repealed effective 12:01 a.m. October 1, 2009:

WAC 220-56-25500T	Halibut—Seasons—Daily and possession limits.

WSR 09-14-048
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 09-119—Filed June 24, 2009, 4:07 p.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: Amend personal use fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-25000J; and amending WAC 220-56-250.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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: Yelloweye rockfish are one of seven overfished species managed under rebuilding plans by the Pacific Fishery Management Council (PFMC). Yelloweye rockfish may be caught incidentally when anglers target lingcod in deeper waters. Management measures, including depth restrictions, have been effective at reducing the incidental catch of overfished species including yelloweye rockfish while anglers are targeting lingcod. This rule conforms to federal action taken by PFMC. 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 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: June 24, 2009.

Philip Anderson
Director

NEW SECTION

WAC 220-56-25000J Lingcod—Areas and seasons. Notwithstanding the provisions of WAC 220-56-250, effective July 1 through August 31, 2009, in waters of Marine Area 2, it is unlawful to fish for, retain or possess lingcod south of 46°58 N. Latitude and seaward of 30 fathoms on Fridays and Saturdays.

REPEALER

The following section of the Washington Administrative Code is repealed effective September 1, 2009:

WAC 220-56-25000J	Lingcod—Areas and seasons.

WSR 09-14-050
EMERGENCY RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed June 25, 2009, 11:39 a.m., effective June 25, 2009, 11:39 a.m.]

Effective Date of Rule: Immediately.

Purpose: To remove the specified threshold for the use of moneys in the transportation vehicle fund for the major repair.

Citation of Existing Rules Affected by this Order: Amending WAC 392-142-260.

Statutory Authority for Adoption: RCW 28A.156.130.

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: To allow enough time for repairs to a school bus prior to the start of the 2009-10 school year.

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 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 1, 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: June 25, 2009.

Randy I. Dorn
State Superintendent

AMENDATORY SECTION (Amending WSR 03-13-049, filed 6/12/03, effective 7/13/03)

WAC 392-142-260 Allowable uses of transportation vehicle fund. School districts shall use moneys in the transportation vehicle fund for the following purposes:

(1) The purchase of school buses;

(2) Performing major repairs of a school bus receiving prior approval by the superintendent of public instruction. ((~~Repairs costing less than twenty-five percent of the current state-determined purchase price for that type and category of vehicle shall not be considered a major repair.~~))

(3) The transfer of moneys from the transportation vehicle fund to the debt service fund exclusively for the payment of debt and interest incurred by the transportation vehicle fund shall not be considered to be a transfer of moneys from the transportation vehicle fund to any other fund within the meaning of RCW 28A.160.130.

WSR 09-14-051
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 09-123—Filed June 25, 2009, 3:33 p.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-24-04000Q; and amending WAC 220-24-040.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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: A harvestable quota of salmon is available for the troll fleet. These rules are adopted at the recommendation of the Pacific Fishery Management Council, in accordance with preseason fishing plans. 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 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: June 25, 2009.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 220-24-04000Q All-citizen commercial salmon troll. Notwithstanding the provisions of WAC 220-24-040, effective immediately until further notice, it is unlawful to fish for salmon with troll gear or to land salmon taken with troll gear into a Washington port except during the seasons provided for in this section:

(1) Salmon Management and Catch Reporting Areas 1, 2, 3, and that portion of Area 4 west of 125º05'00" W longitude and south of 48º23'00" N latitude, open:

July 1 through July 7, 2009;
July 11 through July 14, 2009;
July 18 through July 21, 2009;
July 25 through July 28, 2009;
August 1 through August 4, 2009;

August 8 through August 11, 2009;
August 15 through August 18, 2009;
August 22 through August 25, 2009;
August 29 through September 1, 2009;
September 5 through September 8, 2009;
September 12 through September 15, 2009;

(2) The Cape Flattery and Columbia River Control Zones are closed. Mandatory Yelloweye Rockfish Conservation Area is closed.

(3) Landing and possession limit of 40 Chinook and 200 Coho per boat per each entire open period for the entire catch areas 1, 2, 3 and 4 from July 1 through September 15

(4) Minimum size for Chinook salmon is 28 inches in length. Minimum size for Coho salmon is 16 inches in length. No minimum size for pink, sockeye or chum salmon. All retained coho must have a healed adipose fin clip. It is unlawful to retain chum salmon north of Cape Alava during August and September.

(5) Lawful troll gear is restricted to all legal troll gear with single point, single shank barbless hooks.

(6) Fishers must land and deliver their catch within 24 hours of any closure of a fishery provided for in this section, and vessels fishing or in possession of salmon while fishing north of Leadbetter Point must land and deliver their fish within the area and North of Leadbetter point. Vessels fishing or in possession of salmon while fishing south of Leadbetter Point must land and deliver their fish within the area and south of Leadbetter Point.

(7) The Cape Flattery Control Zone is defined as the area from Cape Flattery (48º23'00" N latitude) to the northern boundary of the U.S. Exclusive Economic Zone, and the area from Cape Flattery south to Cape Alava, 48º10'00" N latitude, and east of 125º05'00" W longitude.

(8) Columbia Control Zone - An area at the Columbia River mouth, bounded on the west by a line running northeast/southwest between the red lighted Buoy #4 (46º13'35" N. Lat., 124º06'50" W. long.) and the green lighted Buoy #7 (46º15'09' N. lat., 124º06'16" W. long.); on the east, by the Buoy #10 line which bears north/south at 357º true from the south jetty at 46º14'00" N. lat., 124º03'07" W. long, to its intersection with the north jetty; on the north, by a line running northeast/southwest between the green lighted Buoy #7 to the tip of the north jetty (46º14'48" N. lat., 124º05'20" W. long.), and then along the north jetty to the point of intersection with the Buoy #10 line; and, on the south, by a line running northeast/southwest between the red lighted Buoy #4 and tip of the south jetty (46º14'03" N. lat., 124º04'05" W. long.), and then along the south jetty to the point of intersection with the Buoy #10 line.

(9) Mandatory Yelloweye Rockfish Conservation Area - The area in Washington Marine Catch Area 3 from 48º00.00' N latitude; 125º14.00' W longitude to 48º02.00' N latitude; 125º14.00' W longitude to 48º02.00' N latitude; 125º16.50' W longitude to 48º00.00' N latitude; 125º16.50' W longitude and connecting back to 48º00.00' N latitude; 125º14.00' W longitude.

(10) It is unlawful to fish in Salmon Management and Catch Reporting Areas 1, 2, 3 or 4 with fish on board taken south of Cape Falcon, Oregon: and all fish taken from Salmon Management and Catch Reporting Areas 1, 2, 3, and 4 must be landed before fishing south of Cape Falcon, Oregon.

(11) This commercial troll fishery is designated as a "quick reporting required" fishery, and commercial purchasers and receivers must comply with the provisions of WAC 220-69-240(12).

Reviser's note: The typographical errors in the above section occurred in the copy filed by the agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

REPEALER

The following section of the Washington Administrative Code is repealed effective September 17, 2009:

WAC 220-24-04000Q	All-citizen commercial salmon troll.

WSR 09-14-056
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 09-126—Filed June 26, 2009, 11:33 a.m., effective June 30, 2009, 6:00 a.m.]

Effective Date of Rule: June 30, 2009, 6:00 a.m.

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. 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 Existing Rules Affected by this Order: Repealing WAC 220-32-05100P; and amending WAC 220-32-051.

Statutory Authority for Adoption: RCW 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 2008-2017 *United States v. Oregon Management Agreement* (Aug. 12, 2008) (Doc. No. 2546); *Puget Sound Gillnetters Ass'n v. Moos*, 92 Wn.2d 939, 603 P.2d 819 (1979); *State v. James*, 72 Wn.2d 746, 435 P.2d 521 (1967); 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; and 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: Sets a two and [one-]half day fishing period for summer season treaty gillnet fisheries. Based on preseason forecasts, chinook and sockeye are available for treaty Indian harvest. Continues to allow sales for treaty Indian fisheries, caught in platform and hook-and-line fisheries. Also continues to allow sales of these fish caught

in tributary fisheries and the area immediately below Bonneville Dam (see next paragraph) by enrolled Yakama Nation tribal members when the mainstem above Bonneville Dam is open for commercial sales. Impact limits to ESA-listed chinook remain available for treaty Indian fisheries. Harvest is expected to remain within the allocation and guidelines of the 2008-2017 management agreement. Rule is consistent with action of the Columbia River compact on May 26 and June 25, 2009. Conforms state rules with tribal rules. There is insufficient time to promulgate permanent regulations.

New regulations for 2009 include fisheries that are described in the MOA between Washington state and the Yakama Nation. Yakama Nation tribal members will be allowed to fish for subsistence purposes within a specific area of the Washington shoreline below Bonneville Dam when open for enrolled Yakama Nation members under lawfully enacted Yakama Nation tribal subsistence fisheries. Sales will be allowed when the open fishery is concurrent with either commercial gillnet openings or platform gear in Zone 6 (SMCRA 1F, 1G, 1H). Sales of fish caught in this fishery are consistent with mainstem Zone 6 (SMCRA 1F, 1G, 1H) allowable sales, with the exception of sturgeon (which may not be sold or kept for subsistence purposes).

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. Some salmon and steelhead stocks in the Columbia River are listed as threatened or endangered under the federal Endangered Species Act. Columbia River fisheries are monitored very closely to ensure consistency with court orders and Endangered Species Act 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. There is insufficient time to adopt permanent rules.

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 0, Amended 0, Repealed 0.

Number of Sections Adopted at 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: June 26, 2009.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-32-05100Q Columbia River salmon seasons above Bonneville Dam. Notwithstanding the provisions of WAC 220-32-050, WAC 220-32-051, WAC 220-32-052, and WAC 220-32-058: effective immediately until further notice: it is unlawful for a person to take or possess salmon, steelhead, walleye, shad, carp, yellow perch, catfish, bass or sturgeon for commercial purposes in Columbia River Salmon Management Catch Reporting Areas (SMCRA) 1E, 1F, 1G, and 1H, except as provided in the following subsections; and the same prohibitions apply in the Wind River, White Salmon River, and Klickitat River, except that individuals possessing treaty fishing rights under the Yakima, Warm Springs, Umatilla, and Nez Perce treaties may fish for salmon, steelhead, walleye, shad, carp, yellow perch, catfish, bass or sturgeon under the following provisions, pursuant to lawfully enacted tribal rules:

1. Mainstem Columbia River above Bonneville Dam

a) SEASON: 6:00 a.m. Tuesday, June 30 to 6:00 p.m. Thursday, July 2, 2009

b) AREA: Zone 6 (SMCRA 1F, 1G, 1H).

c) GEAR: No mesh restriction on gillnets.

2. Mainstem Columbia River above Bonneville Dam

a) SEASON: Immediately until further notice.

b) AREA: Zone 6 (SMCRA 1F, 1G, 1H).

c) GEAR: Hoop nets, dip bag nets, and rod and reel with hook-and-line.

3. Columbia River Tributaries above Bonneville Dam

a) SEASON: Immediately until further notice, and only during those days and hours when the tributaries listed below are open under lawfully enacted Yakama Nation tribal subsistence fishery regulations for enrolled Yakama Nation members, and have either commercial gillnet openings or allow platform gear in Zone 6 (SMCRA 1F, 1G, 1H).

b) AREA: White Salmon, and Klickitat and Wind rivers.

c) GEAR: Hoop nets, dip bag nets, and rod and reel with hook-and-line.

4. Mainstem Columbia River below Bonneville Dam

a) SEASON: Immediately until further notice, and only under the conditions in the Memo of Agreement (MOA) titled "2007 Memorandum of Agreement Between the Yakama Nation and Washington Department of Fish and Wildlife Regarding Tribal Fishing Below Bonneville Dam" and only for enrolled Yakama Nation members in areas that have either commercial gillnet openings or allow platform gear in Zone 6 (SMCRA 1F, 1G, 1H).

b) AREA: (SMCRA) 1E On the Washington shoreline from 600 feet below the fish ladder at the Bonneville Dam North shore powerhouse, downstream to Beacon Rock (bank fishing only).

c) GEAR: Hoop nets, dip bag nets, and rod and reel with hook-and-line, consistent with Yakama Nation regulations.

5. SANCTUARIES: Standard river mouth and dam sanctuaries applicable to these gear types, except the Spring Creek Hatchery sanctuary not in effect.

6. ALLOWABLE SALES: Chinook, coho, sockeye, steelhead, walleye, shad, carp, yellow perch, catfish and bass. Sturgeon may not be sold. Sturgeon between 43-54 inches in fork length in The Dalles and John Day pools (SMCRA 1G, 1H) may be retained for subsistence. Sturgeon between 38-54 inches in fork length in the Bonneville pool (SMCRA 1F) may also be retained for subsistence. Fish may NOT be sold on USACE Property below Bonneville Dam, but may be caught and transported off USACE Property for sale. Sturgeon below Bonneville Dam may **NOT** be retained and may **NOT** be sold.

7. ADDITIONAL REGULATIONS: 24-hour quick reporting required for Washington wholesale dealers, pursuant to WAC 220-69-240.

REPEALER

The following section of the Washington Administrative Code is repealed effective 6:00 a.m. June 30, 2009:

WAC 220-32-05100P	Columbia River salmon seasons above Bonneville Dam. (09-114)

WSR 09-14-060
EMERGENCY RULES
DEPARTMENT OF HEALTH
(Medical Quality Assurance Commission)

[Filed June 29, 2009, 4:53 p.m., effective June 29, 2009, 4:53 p.m.]

Effective Date of Rule: Immediately.

Purpose: New rules are needed to create a background check temporary practice permit for physicians and physician assistants applying for licensure with an out-of-state address, those who have recently lived out-of-state and for those with a criminal history in Washington. This temporary practice permit will be issued for any applicant who has met all other licensure requirements except the national criminal background check requirement. However, the temporary practice permit will not be issued unless an FBI fingerprint card for the applicant has been received by the department. The background check temporary practice permit will allow them to practice up to six months while the FBI fingerprint card is being processed.

Statutory Authority for Adoption: RCW 18.130.064 and 18.130.075.

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 fingerprinting process is a lengthy process. Delays in licensing of otherwise qualified applicants affects patient safety. Employers are affected by the licensure delays and are unable to fully staff hospitals and other medical facilities. Lack of staffing affects the patients and the facilities' ability to accept and safely care for patients. Underserved areas of the state are also affected. This rule qualifies for emergency rule making for the preservation of the public health, safety and general welfare of the citizens of Washington state.

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 2, Amended 0, Repealed 0.

Number of Sections Adopted at 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 2, Amended 0, Repealed 0.

Date Adopted: June 29, 2009.

Maryella E. Jansen
Executive Director
Medical Quality
Assurance Commission

NEW SECTION

WAC 246-918-075 Background check—Temporary practice permit. The medical quality assurance commission (MQAC) conducts background checks on applicants to assure safe patient care. Completion of a national criminal background check may require additional time. The MQAC may issue a temporary practice permit when the applicant has met all other licensure requirements, except the national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

(1) If there are no violations identified in the in-state background check, and the applicant meets all other licensure conditions, including receipt by the department of health of a completed Federal Bureau of Investigation (FBI) fingerprint card, the MQAC may issue a temporary practice permit allowing time to complete the national criminal background check requirements.

The MQAC will issue a temporary practice permit that is valid for three months. A one time extension of three months will be granted if the national background check report has not been received by the MQAC.

(2) The temporary practice permit allows the applicant to work in the state of Washington as a physician assistant during the time period specified on the permit. The temporary practice permit serves as a license to practice medicine as a physician assistant.

(3) The MQAC issues a full license after it receives the national background check report if the report is negative and the applicant otherwise meets the requirements for a license.

(4) The temporary practice permit is no longer valid after the license is issued or action is taken on the application because of the background check.

NEW SECTION

WAC 246-919-396 Background check—Temporary practice permit. The medical quality assurance commission (MQAC) conducts background checks on applicants to assure safe patient care. Completion of a national criminal background check may require additional time. The MQAC may issue a temporary practice permit when the applicant has met all other licensure requirements, except the national criminal background check requirement. The applicant must not be subject to denial of a license or issuance of a conditional license under this chapter.

(1) If there are no violations identified in the in-state background check, and the applicant meets all other licensure conditions, including receipt by the department of health of a completed Federal Bureau of Investigation (FBI) fingerprint card, the MQAC may issue a temporary practice permit allowing time to complete the national criminal background check requirements.

The MQAC will issue a temporary practice permit that is valid for three months. A one time extension of three months will be granted if the national background check report has not been received by the MQAC.

(2) The temporary practice permit allows the applicant to work in the state of Washington as a physician during the time period specified on the permit. The temporary practice permit serves as a license to practice medicine.

(3) The MQAC issues a full license after it receives the national background check report if the report is negative and the applicant otherwise meets the requirements for a license.

(4) The temporary practice permit is no longer valid after the license is issued or action is taken on the application because of the background check.

WSR 09-14-083
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed June 30, 2009, 7:38 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: These amendments are necessary to describe the payment methodology the department will use to meet the legislature's intent that the department continue to meet federal payment standards for durable medical equipment (DME) with a lower overall level of appropriation as required under sections 201 and 209 of the state operating budget for the 2009-2011 fiscal years.

Citation of Existing Rules Affected by this Order: Amending WAC 388-543-2900.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.057, 74.08.090.

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Emergency rule adoption is required in order for the department to fully meet the legislatively mandated appropriation reduction for the DME program for fiscal years 2010-2011.

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 1, Repealed 0.

Number of Sections Adopted at 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 1, Repealed 0.

Date Adopted: June 24, 2009.

Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 03-19-083, filed 9/12/03, effective 10/13/03)

WAC 388-543-2900 Medical supplies and nondurable medical equipment (MSE)—Reimbursement methodology. (1) ((~~MAA determines rates for each category of medical supplies and non-DME (MSE) using either the~~)) The department sets, evaluates and annually updates rates for each category of medical supplies and nonDME (MSE) using one or more of the following:

(a) ((~~Medicare fee schedule; or~~

~~(b) Manufacturers' catalogs and commercial data bases for price comparisons~~)) Medicare fee schedule, for those items that are included in the fee schedule for the medicare program, as established by the federal centers for medicare and medicaid services.

(b) For those items not included in the medicare fee schedule, the department uses manufacturers' catalogs and commercial data bases to identify brands to comprise the department's pricing cluster. When establishing the fee for products in a pricing cluster, the maximum allowable fee is the lesser of either:

(i) Eighty-five percent of the average manufacturer's list price; or

(ii) One hundred twenty-five percent of the average dealer cost.

(c) Input from stakeholders or other relevant sources that the department determines to be reliable and appropriate.

(2) ((~~MAA evaluates and updates the maximum allowable fees for MSE as follows~~)) All the brands for which the department obtains pricing information comprise the department's pricing cluster. However, the department may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients as determined by the department. The department considers all of the following:

(a) ((~~MAA sets the maximum allowable fees for new MSE using one of the following:~~

~~(i) Medicare's fee schedule; or~~

~~(ii) For those items without a medicare fee, commercial data bases to identify brands to make up MAA's pricing cluster. MAA establishes the fee for products in the pricing cluster by using the lesser of either:~~

~~(A) Eighty-five percent of the average manufacturer's list price; or~~

~~(B) One hundred twenty-five percent of the average dealer cost.~~

~~(b) All the brands for which MAA obtains pricing information make up MAA's pricing cluster. However, MAA may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients. MAA considers all of the following:~~

~~(i) A client's medical needs;~~

~~(ii) Product quality;~~

~~(iii) Cost; and~~

~~(iv) Available alternatives~~)) A client's medical needs;

(b) Product quality;

(c) Cost; and

(d) Available alternatives.

(3) ((~~MAA's~~)) The department's nursing facility per diem rate, established pursuant to chapter 74.46 RCW and chapter 388-96 WAC, includes any reusable and disposable medical supplies that may be required for a nursing facility client. ((~~MAA~~)) The department may reimburse the following medical supplies separately for a client in a nursing facility:

(a) Medical supplies or services that replace all or parts of the function of a permanently impaired or malfunctioning internal body organ. This includes, but is not limited to the following:

(i) Colostomy and other ostomy bags and necessary supplies; and

(ii) Urinary retention catheters, tubes, and bags, excluding irrigation supplies;

(b) Supplies for intermittent catheterization programs, for the following purposes:

(i) Long term treatment of atonic bladder with a large capacity; and

(ii) Short term management for temporary bladder atony; and

(c) Surgical dressings required as a result of a surgical procedure, for up to six weeks after surgery.

(4) ((~~MAA~~)) The department considers decubitus care products to be included in the nursing facility per diem rate and does not reimburse for these separately.

WSR 09-14-084
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed June 30, 2009, 7:44 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: The department is amending WAC 388-825-068 What medicaid state plan services can DDD authorize?, on an emergency basis to maintain consistency with changes being made to chapters 388-106 and 388-71 WAC as a result of 2009 legislation.

Citation of Existing Rules Affected by this Order: Amending WAC 388-825-068.

Statutory Authority for Adoption: RCW 71A.12.030, 71A.12.040, 71A.14.030.

Other Authority: Washington state 2009-11 budget (ESHB 1244), section 205 (1)(j); and section 1915(i) of the Social Security Act.

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; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: This emergency rule implements changes made to adult day health in the medicaid state plan as of June 30, 2009, and the services changes made by the legislature in ESHB 1244, section 205 (1)(j). An initial public notice was filed March 10, 2009, as WSR 09-04-092.

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 1, Repealed 0.

Number of Sections Adopted at 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 1, Repealed 0.

Date Adopted: June 24, 2009.

Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 08-11-072, filed 5/19/08, effective 6/19/08)

WAC 388-825-068 What medicaid state plan services can DDD authorize? DDD ((~~can~~)) may authorize the following medicaid state plan services:

(1) Medicaid personal care, per chapter 388-106 WAC;

(2) Private duty nursing for adults age eighteen and older; per chapter 388-106 WAC;

(3) Private duty nursing for children under the age of eighteen, per WAC 388-551-3000;

(4) Adult day health for adults, per chapter 388-106 WAC ((~~388-106-0810 and 388-106-0815~~)); and

(5) ICF/MR services, per chapters 388-835 and 388-837 WAC.

((~~Medicaid State Plan Services~~))	
((~~Adult day health~~ ~~ICF/MR services~~ ~~Medically intensive home care program for children~~ ~~Private duty nursing for adults~~))	((~~Medicaid personal care~~ ~~• In-home~~ ~~• Adult family home~~ ~~• Adult residential care~~))

WSR 09-14-085
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed June 30, 2009, 7:46 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: These amendments are necessary to describe the reimbursement methodology the department will use for rural health clinics (RHC), as authorized by 42 U.S.C. 1396a(bb) and to match the language in the department's state plan which ensures state receipt of federal funds.

Citation of Existing Rules Affected by this Order: Amending WAC 388-549-1100, 388-549-1400, and 388-549-1500.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.510, 74.09.522.

Other Authority: 42 U.S.C. § 1396a(bb), 42 C.F.R. § 405.2472, 42 C.F.R. § 491.

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: This emergency rule adoption is required in order to match the language in the department's state plan which ensures state receipt of federal funds.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 3, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at 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 3, Repealed 0.

Date Adopted: June 24, 2009.

Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 08-05-011, filed 2/7/08, effective 3/9/08)

WAC 388-549-1100 Rural health clinics—Definitions. This section contains definitions of words and phrases that apply to this chapter. Unless defined in this chapter or WAC 388-500-0005, the definitions found in the Webster's New World Dictionary apply.

"APM index"—The alternative payment methodology (APM) is used to update APM encounter payment rates on an annual basis. The APM index is a measure of input price changes experienced by Washington's FQHC and RHC providers. The index is derived from the federal medicare economic index (MEI) and Washington-specific variable measures.

"Base year"—The year that is used as the benchmark in measuring a clinic's total reasonable costs for establishing base encounter rates.

"Change in scope of service"—A change in the type, intensity, duration, or amount of service.

"Encounter"—A face-to-face visit between a client and a qualified rural health clinic (RHC) provider (e.g., a physician, physician's assistant, or advanced registered nurse practitioner) who exercises independent judgment when providing services that qualify for an encounter rate.

"Encounter rate"—A cost-based, facility-specific rate for covered RHC services, paid to a rural health clinic for each valid encounter it bills.

"Enhancements" (also called healthy options (HO) enhancement)—A monthly amount paid to RHCs for each client enrolled with a managed care organization (MCO). Plans may contract with RHCs to provide services under healthy options. RHCs receive enhancements from the department in addition to the negotiated payments they receive from the MCOs for services provided to enrollees.

"Fee-for-service"—A payment method the department uses to pay providers for covered medical services provided to medical assistance clients, except those services provided under the department's prepaid managed care organizations or those services that qualify for an encounter rate.

"Interim rate"—The rate established by the department to pay a rural health clinic for covered RHC services prior to the establishment of a ((~~prospective payment system (PPS)~~)) permanent rate for that facility.

"Medicare cost report"—The cost report is a statement of costs and provider utilization that occurred during the time period covered by the cost report. RHCs must complete and submit a report annually to medicare.

"Mobile unit"—The objects, equipment, and supplies necessary for provision of the services furnished directly by the RHC are housed in a mobile structure.

"Permanent unit"—The objects, equipment and supplies necessary for the provision of the services furnished directly by the clinic are housed in a permanent structure.

"Rural area"—An area that is not delineated as an urbanized area by the Bureau of the Consensus.

"Rural health clinic (RHC)"—A clinic, as defined in 42 CFR 405.2401(b), that is primarily engaged in providing RHC services and is:

• Located in a rural area designated as a shortage area as defined under 42 CFR 491.2;

• Certified by medicare as a RHC in accordance with applicable federal requirements; and

• Not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

"Rural health clinic (RHC) services"—Outpatient or ambulatory care of the nature typically provided in a physician's office or outpatient clinic and the like, including specified types of diagnostic examination, laboratory services, and emergency treatments. The specific list of services which must be made available by the clinic can be found under 42 CFR part 491.9.

AMENDATORY SECTION (Amending WSR 08-05-011, filed 2/7/08, effective 3/9/08)

WAC 388-549-1400 Rural health clinics—Reimbursement and limitations. (1) ((~~For rural health clinics (RHC) certified by medicare on and after January 1, 2001, the department pays RHCs an encounter rate per client, per day using a prospective payment system (PPS) as required by 42 USC 1396a(bb) for RHC services~~)) Effective January 1, 2001, the payment methodology for rural health clinics (RHC) conforms to 42 USC 1396a(bb). As set forth in 42 USC 1396a (bb)(2) and (3), all RHCs that provide services on January 1, 2001 through December 31, 2008 are reimbursed on a prospective payment system (PPS).

(2) Effective January 1, 2009, RHCs have the choice to continue being reimbursed under the PPS or to be reimbursed under an alternative payment methodology (APM), as authorized by 42 USC 1396a (bb)(6). As required by 42 USC 1396a(bb), payments made under the APM must be at least as much as PPS.

(a) The department calculates the RHC's PPS encounter rate for RHC core services as follows:

(i) Until the RHC's first audited medicare cost report is available, the department pays an average encounter rate of other similar RHCs (such as hospital-based or free-standing) within the state, otherwise known as an interim rate.

(ii) Upon availability of the RHC's audited medicare cost report, the department sets the clinic's encounter rate at one hundred percent of its costs as defined in the cost report. The RHC will receive this rate for the remainder of the calendar year during which the audited cost report became available. The encounter rate is then inflated each January 1 by the medicare economic index (MEI) for primary care services.

((~~(2)~~)) (3) For RHCs in existence during calendar years 1999 and 2000, the department sets the payment prospectively using a weighted average of one hundred percent of the clinic's total reasonable costs for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during the calendar year 2001 to establish a base encounter rate.

(a) The department adjusts a PPS base encounter rate to account for an increase or decrease in the scope of services provided during calendar year 2001 in accordance with WAC 388-549-1500.

(b) The PPS base encounter rates are determined using medicare's audited cost reports and each year's rate is weighted by the total reported encounters. The department does not apply a capped amount to these base encounter rates. The formula used to calculate the base encounter rate is as follows:

$$\text{Base Encounter Rate} = \frac{(1999\ \text{Rate} \times 1999\ \text{Encounters}) + (2000\ \text{Rate} \times 2000\ \text{Encounters})}{(1999\ \text{Encounters} + 2000\ \text{Encounters})}$$

(c) Beginning in calendar year 2002 and any year thereafter, the encounter rate is increased by the MEI and adjusted for any increase or decrease in the clinic's scope of services.

((~~(3)~~)) (4) The department calculates the RHC's APM encounter rate as follows:

(a) For the period beginning January 1, 2009, the APM utilizes RHC base encounter rates as described in WAC 388-549-1400 (3)(b). The base rates are inflated by each annual percentage, from years 2002 through 2009, of the APM index. The result is the year 2009 APM rate for each RHC that chooses to be reimbursed under the APM.

(b) To ensure that the APM pays an amount that is at least equal to the PPS, the annual inflator used to increase the APM rates is the greater of the APM index or the MEI.

(c) The department will periodically rebase the APM rates. The department will not rebase rates determined under the PPS.

(5) The department pays for one encounter, per client, per day except in the following circumstances:

(a) The visits occur with different doctors with different specialties; or

(b) There are separate visits with unrelated diagnoses.

((~~(4)~~)) (6) RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

((~~(5)~~)) (7) Services other than RHC services that are provided in an RHC are not included in the RHC encounter rate. Payments for non-RHC services provided in an RHC are made on a fee-for-service basis using the department's published fee schedules. Non-RHC services are subject to the coverage guidelines and limitations listed in chapters 388-500 through 388-557 WAC.

((~~(6)~~)) (8) For clients enrolled with a managed care organization, covered RHC services are paid for by that plan.

((~~(7)~~)) (9) The department does not pay the encounter rate or the enhancements for clients in state-only programs. Services provided to clients in state-only programs are considered fee-for-service, regardless of the type of service performed.

(10) For clients enrolled with a managed care organization (MCO), the department pays each RHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payment, called enhancements, are paid in

amounts necessary to ensure compliance with 42 USC 1396a (bb)(5)(A).

(a) The RHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO.

(b) To ensure that the appropriate amounts are paid to each RHC, the department performs an annual reconciliation of the enhancement payments.

AMENDATORY SECTION (Amending WSR 08-05-011, filed 2/7/08, effective 3/9/08)

WAC 388-549-1500 Rural health clinics—Change in scope of service. (1) The department considers a rural health clinic's (RHC) change in scope of service to be a change in the type, intensity, duration, and/or amount of services provided by the RHC. Changes in scope of service apply only to covered medicaid services.

(2) When the department determines that a change in scope of service has occurred after the base year, the department will adjust the RHC's ((~~perspective payment system (PPS)~~)) encounter rate to reflect the change.

(3) RHCs must:

(a) Notify the department's RHC program manager in writing, at the address published in the department's rural health clinic billing instructions, of any changes in scope of service no later than sixty days after the effective date of the change; and

(b) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.

(4) The department adjusts the ((~~PPS~~)) encounter rate to reflect the change in scope of service using one or more of the following:

(a) A medicaid comprehensive desk review of the RHC's cost report;

(b) Review of a medicare audit of the RHC's cost report; or

(c) Other documentation relevant to the change in scope of service.

(5) The adjusted encounter rate will be effective on the date the change of scope of service is effective.

WSR 09-14-086
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed June 30, 2009, 7:48 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: These rules are necessary to describe the reimbursement methodology the department will use, as authorized by 42 U.S.C. 1396a(bb), to meet the legislature's intent that the department continue to meet federal payment standards for federally qualified health centers (FQHCs) with a lower overall level of appropriation as required under sections 201 and 209 of the 2009-2011 final legislative budget.

Statutory Authority for Adoption: RCW 74.08.090.

Other Authority: 42 U.S.C. 1396a(bb).

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: This emergency rule adoption is required in order for the department to fully meet the legislatively-mandated appropriation reduction in ESHB 1244 for FQHCs for fiscal years 2010-2011.

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 6, Amended 0, Repealed 0.

Number of Sections Adopted at 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 6, Amended 0, Repealed 0.

Date Adopted: June 24, 2009.

Stephanie E. Schiller
Rules Coordinator

Chapter 388-548 WAC

Federally Qualified Health Centers

NEW SECTION

WAC 388-548-1000 Federally qualified health centers—Purpose. This chapter establishes the department's:

(1) Requirements for enrollment as a federally qualified health center (FQHC) provider; and

(2) Reimbursement methodology for services provided by FQHCs to clients of medical assistance.

NEW SECTION

WAC 388-548-1100 Federally qualified health centers—Definitions. This section contains definitions of words or phrases that apply to this chapter. Unless defined in this chapter or WAC 388-500-0005, the definitions found in the Webster's New World Dictionary apply.

APM index - The alternative payment methodology (APM) is used to update APM encounter payment rates on an annual basis. The APM index is a measure of input price changes experienced by Washington's FQHC and RHC providers. The index is derived from the federal medicare economic index (MEI) and Washington-specific variable measures.

Base year - The year that is used as the benchmark in measuring a clinic's total reasonable costs for establishing base encounter rates.

Change in scope of service - A change in the type, intensity, duration, or amount of service.

Cost report - A statement of costs and provider utilization that occurred during the time period covered by the cost report. FQHCs must complete a cost report when there is a change in scope, rebasing of the encounter rate, or when the department sets a base rate.

Encounter - A face-to-face visit between a client and a qualified federally qualified health center (FQHC) provider (e.g., a physician, physician's assistant, or advanced registered nurse practitioner) who exercises independent judgment when providing services that qualify for an encounter rate.

Encounter rate - A cost-based, facility-specific rate for covered FQHC services, paid to a federally qualified health center for each valid encounter it bills.

Enhancements (also called healthy options (HO) enhancement) - A monthly amount paid by the department to FQHCs for each client enrolled with a managed care organization (MCO). Plans may contract with FQHCs to provide services under healthy options. FQHCs receive enhancements from the department in addition to the negotiated payments they receive from the MCOs for services provided to enrollees.

Federally qualified health center (FQHC) - An entity that has entered into an agreement with the centers for medicare and medicaid services (CMS) to meet medicare program requirements under 42 CFR 405.2434 and:

(1) Is receiving a grant under section 329, 330, or 340 of the public health service (PHS) act, or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to recieve a grant under section 330 of the public health service act;

(2) Based on the recommendation of the PHS, is determined by CMS to meet the requirements for receiving such as grant;

(3) Was treated by CMS, for purposes of part B, as a comprehensive federally funded health center (FFHC) as of January 1, 1990; or

(4) Is an outpatient health program or facility operated by a tribe or tribal organizations under the Indian Self-Determination Act or by an Urban Indian organization receiving funding under Title V of the Indian Health Care Improvement Act.

Fee-for-service - A payment method the department uses to pay providers for covered medical services provided to medical assistance clients, except those services provided under the department's prepaid managed care organizations or those services that qualify for an encounter rate.

Interim rate - The rate established by the department to pay a federally qualified health center for covered FQHC services prior to the establishment of a permanent rate for that facility.

Reviser's note: The spelling 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 388-548-1200 Federally qualified health centers—Enrollment. (1) To enroll as a medical assistance provider and receive payment for services, a federally qualified health center (FQHC) must:

(a) Receive FQHC certification for participation in the Title XVIII (medicare) program according to 42 CFR 491;

(b) Sign a core provider agreement; and

(c) Operate in accordance with applicable federal, state, and local laws.

(2) The department uses one of two timeliness standards for determining the effective date of a medicaid-certified FQHC.

(a) The department uses medicare's effective date if the FQHC returns a properly completed core provider agreement and FQHC enrollment packet within sixty calendar days from the date of medicare's letter notifying the clinic of the medicare certification.

(b) The department uses the date the signed core provider agreement is received if the FQHC returns the properly completed core provider agreement and FQHC enrollment packet sixty-one or more calendar days after the date of medicare's letter notifying the clinic of the medicare certification.

NEW SECTION

WAC 388-548-1300 Federally qualified health centers—Services. (1) The following outpatient services qualify for FQHC reimbursement:

(a) Physician services specified in 42 CFR 405.2412.

(b) Nurse practitioner or physician assistant services specified in 42 CFR 405.2414.

(c) Clinical psychologist and clinical social worker services specified in 42 CFR 405.2450.

(d) Visiting nurse services specified in 42 CFR 405.2416.

(e) Nurse-midwife services specified in 42 CFR 405.2401.

(f) Preventive primary services specified in 42 CFR 405.2448.

(2) The department pays for FQHC services when they are:

(a) Within the scope of an eligible client's medical assistance program. Refer to WAC 388-501-0060; and

(b) Medically necessary as defined WAC 388-500-0005.

(3) FQHC services may be provided by any of the following individuals in accordance with 42 CFR 405.2446:

(a) Physicians;

(b) Physician assistants (PA);

(c) Nurse practitioners (NP);

(d) Nurse midwives or other specialized nurse practitioners;

(e) Certified nurse midwives;

(f) Registered nurses or licensed practical nurses; and

(g) Psychologists or clinical social workers.

NEW SECTION

WAC 388-548-1400 Federally qualified health centers—Reimbursement and limitations. (1) Effective Janu-

ary 1, 2001, the payment methodology for federally qualified health centers (FQHC) conforms to 42 U.S.C. 1396a(bb). As set forth in 42 U.S.C. 1396a (bb)(2) and (3), all FQHCs that provide services on January 1, 2001, and through December 31, 2008, are reimbursed on a prospective payment system (PPS).

(2) Effective January 1, 2009, FQHCs have the choice to continue being reimbursed under the PPS or to be reimbursed under an alternative payment methodology (APM), as authorized by 42 U.S.C. 1396a (bb)(6). As required by 42 U.S.C. 1396a(bb), payments made under the APM must be at least as much as PPS.

(3) The department calculates the FQHC's PPS encounter rate as follows:

(a) Until the FQHC's first audited department cost report is available, the department pays an average encounter rate of other similar FQHCs within the state, otherwise known as an interim rate;

(b) Upon availability of the FQHC's audited cost report, the department sets the clinic's encounter rate at one hundred percent of its costs as defined in the cost report. The FQHC will receive this rate for the remainder of the calendar year during which the audited cost report became available. Thereafter, the encounter rate is then inflated each January 1 by the medicare economic index (MEI) for primary care services.

(4) For FQHCs in existence during calendar years 1999 and 2000, the department sets the payment prospectively using a weighted average of one hundred percent of the clinic's total reasonable costs for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during the calendar year 2001 to establish a base encounter rate.

(a) The department adjusts a PPS base encounter rate to account for an increase or decrease in the scope of services provided during calendar year 2001 in accordance with WAC 388-548-1500.

(b) The PPS base encounter rates are determined using audited cost reports and each year's rate is weighted by the total reported encounters. The department does not apply a capped amount to these base encounter rates. The formula used to calculate the base encounter rate is as follows:

Base Encounter Rate=	(1999 Rate x 1999 Encounters)+ (2000 Rate x 2000 Encounters)
	(1999 Encounters+ 2000 Encounters)

(c) Beginning in calendar year 2002 and any year thereafter, the encounter rate is increased by the MEI for primary care services, and adjusted for any increase or decrease within the clinic's scope of services.

(5) The department calculates the FQHC's APM encounter rate as follows:

(a) For the period beginning January 1, 2009, the APM utilizes the FQHC base encounter rates, as described in WAC 388-548-1400 (4)(b).

(i) The base rates are adjusted to reflect any approved changes in scope of service between years 2002 and 2009.

(ii) The adjusted base rates are then inflated by each annual percentage, from years 2002 through 2009, of the APM index. The result is the year 2009 APM rate for each FQHC that chooses to be reimbursed under the APM.

(b) To ensure that the APM pays an amount that is at least equal to the PPS, the annual inflator used to increase the APM rates is the greater of the APM index or the MEI.

(c) The department will periodically rebase the APM rates. The department will not rebase rates determined under the PPS.

(6) The department limits encounters to one per client, per day except in the following circumstances:

(a) The visits occur with different doctors with different specialties; or

(b) There are separate visits with unrelated diagnoses.

(7) FQHC services and supplies incidental to the provider's services are included in the encounter rate payment.

(8) Services other than FQHC services that are provided in an FQHC are not included in the FQHC encounter rate. Payments for nonFQHC services provided in an FQHC are made on a fee-for-service basis using the department's published fee schedules. NonFQHC services are subject to the coverage guidelines and limitations listed in chapters 388-500 through 557 WAC.

(9) For clients enrolled with a managed care organization, covered FQHC services are paid for by that plan.

(10) Only clients enrolled in Title XIX (medicaid) or Title XXI (CHIP) are eligible for encounter or enhancement payments. The department does not pay the encounter rate or the enhancement rate for clients in state-only medical programs. Services provided to clients in state-only medical programs are considered fee-for-service regardless of the type of service performed.

(11) For clients enrolled with a managed care organization (MCO), the department pays each FQHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).

(a) The FQHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO.

(b) To ensure that the appropriate amounts are paid to each FQHC, the department performs an annual reconciliation of the enhancement payments.

NEW SECTION

WAC 388-548-1500 Federally qualified health centers—Change in scope of service. (1) The department considers a federally qualified health center (FQHC) change in scope of service to be a change in the type, intensity, duration, and/or amount of services provided by the FQHC. Changes in scope of service apply only to covered medicaid services.

(2) When the department determines that a change in scope of service has occurred after the base year, the department adjusts the FQHC's encounter rate to reflect the change.

(3) FQHCs must:

(a) Notify the department's FQHC program manager in writing, at the address published in the department's federally qualified health centers billing instructions, of any changes in scope of service no later than sixty calendar days after the effective date of the change; and

(b) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.

(4) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:

(a) A medicaid comprehensive desk review of the FQHC's cost report;

(b) Review of a medicare audit of the FQHC's cost report; or

(c) Other documentation relevant to the change in scope of service.

(5) The adjusted encounter rate will be effective on the date the change of scope of service is effective.

WSR 09-14-087
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed June 30, 2009, 7:50 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: The department is amending this section because it will no longer cover modifications to privately owned vehicles. This amendment is required to implement cost saving initiatives effective July 1, 2009, and to be in compliance with the department's federal state plan assurances.

Citation of Existing Rules Affected by this Order: Amending WAC 388-546-5500.

Statutory Authority for Adoption: RCW 74.08.090.

Other Authority: 42 C.F.R. Part 440.

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: This emergency rule adoption is required in order to implement cost saving initiatives for July 1, 2009, by implementing section 6083 of the Deficit Reduction Act of 2005 which allows states to receive federal medical assistance percentage matching rates. The department's current rule is not in compliance with the department's federal state plan assurances to receive the matching rates.

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

Number of Sections Adopted at 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 1, Repealed 0.

Date Adopted: June 17, 2009.

Stephanie E. Schiller

Rules Coordinator

AMENDATORY SECTION (Amending WSR 01-06-029, filed 3/2/01, effective 4/2/01)

WAC 388-546-5500 Modifications of privately owned vehicles—Noncovered. (1) ((~~MAA may cover and reimburse the purchase of vehicle driving controls, a vehicle wheelchair lift conversion, or the purchase or repair of a vehicle wheelchair lift, when:~~

~~(a) The requested item is necessary for the client's transportation to medically necessary MAA-covered services; and~~

~~(b) The client owns a vehicle that MAA determines is suitable for modification; and~~

~~(c) Medical transportation provided under WAC 388-546-5000 through 388-546-5400 cannot meet the client's need for transportation to and from medically necessary covered services at a lower total cost to the department (including anticipated costs); and~~

~~(d) Prior approval from MAA is obtained~~)) The department does not cover the purchase or repair of equipment for privately owned vehicles or modifications of privately owned vehicles under the nonemergency transportation program.

(2) ((~~Any vehicle driving controls, vehicle wheelchair lift conversion or vehicle wheelchair lift purchased by MAA under this section becomes the property of the client on whose behalf the purchase is made. MAA assumes no continuing liability associated with the ownership or use of the device.~~

~~(3) MAA limits the purchase of vehicle driving control(s), vehicle wheelchair lift conversion or vehicle wheelchair lift to one purchase per client. If a device purchased under this section becomes inoperable due to wear or breakage and the cost of repair is more than the cost of replacement, MAA will consider an additional purchase under this section as long as the criteria in subsection (1) of this section are met.~~

~~(4) MAA must remain the payer of last resort under this section.~~

~~(5) MAA does not cover the purchase of any new or used vehicle under this section or under this chapter~~)) The purchase or repair of equipment for privately owned vehicles or modifications of privately owned vehicles are not considered a healthcare service. Exception to rule (ETR) as described in WAC 388-501-0160 is not available for this noncovered determination.

WSR 09-14-088
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed June 30, 2009, 7:52 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: In accordance with sections 201 and 209 of the operating budget for fiscal years 2010 and 2011, the department is amending language in sections in chapter 388-550 WAC that pertain to the disproportionate share hospital (DSH) programs in order to meet the legislature's targeted budget expenditure levels. These changes include the elimination of the small rural, small rural indigent, and nonrural indigent DSH programs, and reducing the certified public expenditure payment program hold harmless payments.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-550-5200, 388-550-5210 and 388-550-5220; and amending WAC 388-550-4670, 388-550-4900, and 388-550-5150.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500.

Other Authority: 2009-11 omnibus operating budget (ESHB 1244).

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Emergency rule adoption is required in order for the department to comply with sections 201 and 209 of the operating budget for fiscal years 2010 and 2011 with respect to the determination of payment rates for inpatient and outpatient hospital services. A CR-101 for the permanent rules was filed as WSR 09-04-072 on February 2, 2009.

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 3.

Number of Sections Adopted at 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 3, Repealed 3.

Date Adopted: June 17, 2009.

Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 08-20-032, filed 9/22/08, effective 10/23/08)

WAC 388-550-4670 CPE payment program—"Hold harmless" provision. To meet legislative requirements, the department includes a "hold harmless" provision for hospital providers eligible for the certified public expenditure (CPE) payment program. Under the provision and subject to legislative directives and appropriations, hospitals eligible for payments under the CPE payment program will receive no less in combined state and federal payments than they would have received under the methodologies otherwise in effect as described in this section. All hospital submissions pertaining to the CPE payment program, including but not limited to cost report schedules, are subject to audit at any time by the department or its designee.

(1) The department:

(a) Uses historical cost and payment data trended forward to calculate prospective hold harmless grant payment amounts for the current state fiscal year (SFY); and

(b) Reconciles these hold harmless grant payment amounts when the actual claims data ((~~is~~)) are available for the current fiscal year.

(2) For ((~~each state fiscal year~~)) SFYs 2006 through 2009, the department calculates what the hospital would have been paid under the methodologies otherwise in effect for the ((~~state fiscal year (~~))SFY((~~)~~)) as the sum of:

(a) The total payments for inpatient claims for patients admitted during the fiscal year, calculated by repricing the claims using:

(i) For SFYs 2006 and 2007, the inpatient payment method in effect during SFY 2005; or

(ii) For SFYs 2008 and ((~~beyond~~)) 2009, the payment method that would otherwise be in effect during the CPE payment program year if the CPE payment program had not been enacted.

(b) The total net disproportionate share hospital and state grant payments paid for SFY 2005.

(3) For SFY 2010 and beyond, the department calculates what the hospital would have been paid under the methodologies otherwise in effect for the SFY as the sum of:

(a) The total of the inpatient claim payment amounts that would have been paid during the SFY had the hospital not been in the CPE program;

(b) One-half of the indigent assistance disproportionate share hospital payment amounts paid to and retained by each hospital during SFY 2005; and

(c) All of the other disproportionate share hospital payment amounts paid to and retained by each hospital during SFY 2005 to the extent the same disproportionate share hospital programs exist in the 2009-2011 biennium.

(4) For each SFY, the department determines total state and federal payments made under the program, including:

(a) Inpatient claim payments;

(b) Disproportionate share hospital (DSH) payments; and

(c) Supplemental upper payment limit payments ((~~made for SFY 2006 and 2007~~)), as applicable.

(((~~(4) The amount determined in subsection (3) of this section is subtracted from the amount calculated in subsection (2) of this section to determine the gross state grant~~

~~amount necessary to hold the hospital harmless. If the resulting number is positive, the hospital is entitled to a grant in that amount, subject to legislative directives and appropriations.~~

~~(a)~~)) (5) A hospital may receive a hold harmless grant, subject to legislative directives and appropriations, when the following calculation results in a positive number:

(a) For SFY 2006 through SFY 2009, the amount derived in subsection (4) of this section is subtracted from the amount derived in subsection (2) of this section; or

(b) For SFY 2010 and beyond, the amount derived in subsection (4) of this section is subtracted from the amount derived in subsection (3) of this section.

(6) The department calculates interim hold harmless and final hold harmless grant amount as follows:

(a) An interim hold harmless grant amount is calculated approximately ten months after the SFY to include the paid claims for the same SFY admissions. Claims are subject to utilization review prior to the interim hold harmless calculation. Prospective grant payments made under subsection (1) of this section are deducted from the calculated interim hold harmless grant amount to determine the net grant payment amount due to or due from the hospital.

(b) The ((~~department calculates the~~)) final hold harmless grant amount is calculated at such time as the final allowable federal portions of program payments are determined. The procedure is the same as the interim grant calculation but it includes all additional claims that have been paid or adjusted since the interim hold harmless calculation. Claims are subject to utilization review and audit prior to the final calculation of the hold harmless amount. Interim grant payments determined under (a) of this subsection are deducted from this final calculation to determine the net final hold harmless amount due to or due from the hospital.

AMENDATORY SECTION (Amending WSR 07-14-090, filed 6/29/07, effective 8/1/07)

WAC 388-550-4900 Disproportionate share hospital (DSH) payments—General provisions. (1) As required by section 1902 (a)(13)(A) of the Social Security Act (42 USC 1396 (a)(13)(A)) and RCW 74.09.730, the department makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income clients with special needs. These adjustments are also known as disproportionate share hospital (DSH) payments.

(2) No hospital has a legal entitlement to any DSH payment. A hospital may receive DSH payments only if:

(a) It satisfies the requirements of 42 USC 1396r-4;

(b) It satisfies all the requirements of department rules and policies; and

(c) The legislature appropriates sufficient funds.

(3) For purposes of eligibility for DSH payments, the following definitions apply:

(a) "Base year" means ((~~the hospital fiscal year or~~)) the twelve-month medicare cost report year that ended during the calendar year immediately preceding the year in which the state fiscal year (SFY) for which the DSH application is being made begins.

(b) "Case mix index (CMI)" means the average of diagnosis related group (DRG) weights for all of an individual hospital's DRG-paid medicaid claims during the state fiscal year (SFY) two years prior to the SFY for which the DSH application is being made.

(c) "Charity care" means necessary hospital care rendered to persons unable to pay for the hospital services or unable to pay the deductibles or coinsurance amounts required by a third-party payer. The charity care amount is determined in accordance with the hospital's published charity care policy.

(d) ((~~"Disproportionate share hospital (DSH) cap" means the maximum amount per state fiscal year that the state can distribute in DSH payments to hospitals (statewide DSH cap), or the maximum amount of DSH payments a hospital may receive during a state fiscal year (hospital-specific DSH cap).~~

~~(e)~~)) "DSH reporting data file (DRDF)" means the information submitted by hospitals to the department which the department uses to verify medicaid ((~~patient~~)) client eligibility and ((~~patient~~)) applicable inpatient days.

(((~~f~~))) (e) "Hospital-specific DSH cap" means the maximum amount of DSH payments a hospital may receive from the department during a state fiscal year. ((~~For a critical access hospital (CAH), the DSH cap is based strictly on the net cost to the hospital of providing services to uninsured patients~~)) If a hospital does not qualify for DSH, the department will not calculate the hospital-specific DSH cap and the hospital will not receive DSH payments.

(((~~g~~))) (f) "Inpatient medicaid days" means inpatient days attributed to clients eligible for Title XIX medicaid programs. Excluded from this count are inpatient days attributed to clients eligible for state administered programs, medicare Part A, Title XXI, the refugee program and the take charge program.

(g) "Low income utilization rate (LIUR)" ((~~means~~)) the sum of ((~~these~~)) two percentages: (((~~1~~)))

(i) The ratio of payments received by the hospital for patient services provided to clients under medicaid (including managed care) ((~~and state-administered programs~~)), plus cash subsidies received by the hospital from state and local governments for patient services, divided by total payments received by the hospital from all patient categories; plus (((~~2~~)))

(ii) The ratio of inpatient charity care charges (((~~excluding contractual allowances~~))) less inpatient cash subsidies received by the hospital from state and local governments, less contractual allowances and discounts, divided by total ((~~billed~~)) charges for inpatient services. ((~~The department uses LIUR as one criterion to determine a hospital's eligibility for the low income disproportionate share hospital (LIDSH) program. To qualify for LIDSH, a hospital's LIUR must be greater than twenty-five percent.~~))

(h) "Medicaid inpatient utilization rate (MIPUR)" ((~~means the number of inpatient days of service provided by a hospital to medicaid clients during its hospital fiscal year or medicare cost report year, divided by the number of inpatient days of service provided by that hospital to all patients during the same period~~)) is calculated as a fraction (expressed as a percentage), the numerator of which is the hospital's number

of inpatient days attributable to clients who (for such days) were eligible for medical assistance during the base year (regardless of whether such clients received medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. "Inpatient days" include each day in which a person (including a newborn) is an inpatient in the hospital, whether or not the person is in a specialized ward and whether or not the person remains in the hospital for lack of suitable placement elsewhere.

(i) "Medicare cost report year" means the twelve-month period included in the annual cost report a medicare-certified hospital or institutional provider is required by law to submit to its fiscal intermediary.

(j) ((~~"Nonrural hospital" means a hospital that is not a peer group E hospital or a small rural hospital and is located inside the state of Washington or in a designated bordering city. For DSH purposes, the department considers as nonrural any hospital located in a designated bordering city.~~

~~(k)~~)) "Obstetric services" means routine, nonemergency obstetric services and the delivery of babies.

(((~~(l)~~)) (k) "Service year" means the one year period used to measure the costs and associated charges for hospital services. The service year may refer to a hospital's fiscal year or medicare cost report year, or to a state fiscal year.

(l) "Statewide disproportionate share hospital (DSH) cap" is the maximum amount per state fiscal year (SFY) that the state can distribute in DSH payments to all qualifying hospitals during a SFY.

(m) ((~~"Small rural hospital" means a hospital that is not a peer group E hospital, has fewer than seventy-five acute licensed beds, is located inside the state of Washington, and is located in a city or town with a nonstudent population of no more than seventeen thousand one hundred fifteen in calendar year 2006 as determined by the Washington State office of financial management estimate. The nonstudent population ceiling increases cumulatively by two percent each succeeding state fiscal year.~~

~~(n)~~)) "Uninsured patient" ((~~means an individual who does not have health insurance that would apply to the hospital service the individual sought and received. An individual who did have health insurance that applied to the hospital service the individual sought and received, is considered an insured individual for DSH program purposes, even if the insurer did not pay the full charges for the services. When determining the cost of a hospital service provided to an uninsured patient, the department uses as a guide whether the service would have been covered under medicaid~~)) is a person without health insurance coverage for the service that the person sought and received. (An "insured patient," for DSH program purposes, is a person with health insurance coverage for the service that the person sought and received, even if the insurer did not pay the full charges for the service.) To determine whether a service provided to an uninsured patient may be included for DSH application and calculation purposes, the department considers only services that would have been covered and paid through the department's fee-for-service process.

(4) To be considered for a DSH payment for each SFY, a hospital ((~~located in the state of Washington or in a designated bordering city~~)) must ((~~submit to the department a completed and final DSH application by the due date. The due date will be posted on the department's web site~~)) meet the criteria in this section:

(a) DSH application requirement.

(i) Only a hospital located in the state of Washington or in a designated bordering city is eligible to apply for and receive DSH payments. An institution for mental disease (IMD) owned and operated by the state of Washington is exempt from the DSH application requirement.

(ii) A hospital that meets DSH program criteria is eligible for DSH payments in any SFY only if the department receives the hospital's DSH application by the deadline posted on the department's website.

(b) DSH application review and correction period.

(i) This subsection applies only to DSH applications that meet the requirements under (a) of this subsection.

(ii) The department reviews and may verify any information provided by the hospital on a DSH application. However, each hospital has the responsibility for ensuring its DSH application is complete and accurate.

(iii) If the department finds that a hospital's application is incomplete or contains incorrect information, the department will notify the hospital. The hospital must resubmit a new, corrected application. The department must receive the new DSH application from the hospital by the deadline for corrected DSH applications posted on the department's website.

(iv) If a hospital finds that its application is incomplete or contains incorrect information, it may choose to submit changes and/or corrections to the DSH application. The department must receive the corrected, complete, and signed DSH application from the hospital by the deadline for corrected DSH applications posted on the department's website.

(c) Official DSH application.

(i) The department considers as official the last signed DSH application submitted by the hospital as of the deadline for corrected DSH applications. A hospital cannot change its official DSH application. Only those hospitals with an official DSH application are eligible for DSH payments.

(ii) If the department finds that a hospital's official DSH application is incomplete or contains inaccurate information that affects the hospital's LIDSH payment(s), the hospital does not qualify for, will not receive, and cannot retain, LIDSH payment(s). Refer to WAC 388-550-5000.

(5) A hospital is a disproportionate share hospital for a specific SFY if the hospital ((~~submits a completed DSH application for that specific year, if it~~)) satisfies the ((~~utilization rate~~)) MIPUR requirement (discussed in (a) of this subsection), and the obstetric services requirement (discussed in (b) of this subsection).

(a) The hospital must have a ((~~medicaid inpatient utilization rate (~~))MIPUR((~~)~~)) greater than one percent; and

(b) Unless one of the exceptions described in (i)(A) or (B) of this subsection applies, the hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals.

(i) The obstetric services requirement does not apply to a hospital that:

(A) Provides inpatient services predominantly to individuals younger than age eighteen; or

(B) Did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(ii) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(6) ((~~To determine a hospital's eligibility for any DSH program, the department uses the criteria in this section and the information obtained from the DSH application submitted by the hospital, subject to the following:~~

~~(a) Charity care. If the hospital's DSH application and audited financial statements for the relevant fiscal year do not agree on the amount for charity care, the department uses the lower amount listed. For purposes of calculating a hospital's LIUR, the department allows a hospital to claim charity care amounts related to inpatient services only. A hospital must submit a copy of its charity care policy for the relevant fiscal year as part of the hospital's DSH application.~~

~~(b) Total inpatient hospital days. If the hospital's DSH application and its medicare cost report do not agree on the number of total inpatient hospital days, the department uses the higher number listed to determine the hospital's MIPUR. Labor and delivery days count towards total inpatient hospital days. Nursing facility and swing bed days do not count towards total inpatient hospital days~~)) To determine a hospital's MIPUR, the department uses inpatient days.

(a) The total inpatient days on the official DSH application if this number is greater than the total inpatient hospital days on the medicare cost report; and

(b) The MMIS medicaid days as determined by the DRDF process if the Washington state medicaid days on the official DSH application do not match the eligible days on the final DRDF. If the hospital did not submit a DRDF, the department uses paid medicaid days from MMIS.

(7) The department administers the following DSH programs (depending on legislative budget appropriations):

(a) Low income disproportionate share hospital (LIDSH);

(b) Institution for mental diseases disproportionate share hospital (IMDDSH):

(c) General assistance-unemployable disproportionate share hospital (GAUDSH);

(d) ((~~Small rural disproportionate share hospital (SRDSH);~~

~~(e) Small rural indigent assistance disproportionate share hospital (SRIADSH);~~

~~(f) Nonrural indigent assistance disproportionate share hospital (NRIADSH);~~

~~(g)~~)) Public hospital disproportionate share hospital (PHDSH); and

(((~~h~~))) (e) Psychiatric indigent inpatient disproportionate share hospital (PIIDSH).

(8) Except for IMDDSH, the department allows a hospital to receive any one or all of the DSH payment ((~~adjustments~~)) it qualifies for, up to the individual hospital's DSH cap (see subsection (10) of this section) and provided that total DSH payments do not exceed the statewide DSH cap. See WAC 388-550-5130 regarding IMDDSH. To be eligible for payment under multiple DSH programs, a hospital must meet:

(a) The basic requirements in subsection (5) of this section; and

(b) The eligibility requirements for the particular DSH payment, as discussed in the applicable DSH program WAC.

(9) For each SFY, the department calculates DSH payments ((~~due an~~)) for each DSH program for eligible hospitals using data from ((~~the~~)) each hospital's base year. The department does not use base year data for GAUDSH and PIIDSH payments, which are calculated based on specific claims data.

(10) The department's total DSH payments to a hospital for any given SFY cannot exceed the ((~~individual hospital's annual DSH limit (also known as the~~)) hospital-specific DSH cap((~~,~~)) for that SFY. Except for critical access hospitals (CAHs), the department determines a hospital's DSH cap as follows. The department:

(a) ((~~The cost to the hospital of providing services to medicaid clients, including clients served under medicaid managed care organization (MCO) plans~~)) Uses the overall ratio of costs-to-charges (RCC) to determine costs for:

(i) Medicaid services, including medicaid services provided under managed care organization (MCO) plans; and

(ii) Uninsured charges; then

(b) ((~~Less the amount paid by the state under the non-DSH payment provision of the medicaid state plan~~)) Subtracts all payments related to the costs derived in (a) of this subsection; then

(c) ((~~Plus the cost to the hospital of providing services to uninsured patients;~~

~~(d) Less any cash payments made by or on behalf of uninsured patients; and~~

~~(e) Plus~~)) Makes any adjustments required and/or authorized by federal statute or regulation.

(11) A CAH's DSH cap is based strictly on the cost to the hospital of providing services to ((~~uninsured patients. In calculating a CAH's DSH cap, the department deducts payments received by the hospital from and on behalf of the uninsured patients from the hospital's costs of services for the uninsured patients~~)) medicaid clients, including those medicaid clients served under MCO plans, and uninsured patients. To determine a CAH's DSH cap amount, the department:

(a) Uses the overall RCC to determine costs for:

(i) Medicaid services provided under MCO plans; and

(ii) Uninsured charges; then

(b) Subtracts the total payments made by, or on behalf of, the medicaid clients serviced under MCO plans, and uninsured patients.

(12) In any given federal fiscal year, the total of the department's DSH payments cannot exceed the statewide DSH cap as published in the federal register.

(13) If the department's DSH payments for any given federal fiscal year exceed the statewide DSH cap, the department will adjust DSH payments to each hospital to account for the amount overpaid. The department makes adjustments in the following program order:

(a) PHDSH;

(b) ((~~SRIADSH;~~

~~(c) SRDSH;~~

~~(d) NRIADSH;~~

~~(e)~~)) GAUDSH;

(((~~f~~))) (c) PIIDSH;

(((~~g~~))) (d) IMDDSH; and

(((~~h~~))) (e) LIDSH.

(14) If the statewide DSH cap is exceeded, the department will recoup DSH payments made under the various DSH programs, in the order of precedence described in subsection (13) of this section, starting with PHDSH, until the amount exceeding the statewide DSH cap is reduced to zero. See specific program WACs for description of how amounts to be recouped are determined.

(15) The total amount the department may distribute annually under a particular DSH program is capped by legislative appropriation, except for PHDSH, GAUDSH, and PIIDSH, which are not fixed ((~~pools~~)) amounts. Any changes in payment amount to a hospital in a particular DSH ((~~pool~~)) program means a redistribution of payments within that DSH ((~~pool~~)) program. When necessary, the department will recoup from hospitals to make additional payments to other hospitals within that DSH ((~~pool~~)) program.

(16) If funds in a specific DSH program need to be redistributed because of legislative, administrative, or other state action, only those hospitals eligible for that DSH program will be involved in the redistribution.

(a) If an individual hospital has been overpaid by a specified amount, the department will recoup that overpayment amount from the hospital and redistribute it among the other eligible hospitals in the DSH ((~~pool~~)) program. The additional DSH payment to be given to each of the other hospitals from the recouped amount is proportional to each hospital's share of the particular DSH ((~~pool~~)) program.

(b) If an individual hospital has been underpaid by a specified amount, the department will pay that hospital the additional amount owed by recouping from the other hospitals in the DSH ((~~pool~~)) program. The amount to be recouped from each of the other hospitals is proportional to each hospital's share of the particular DSH ((~~pool~~)) program.

(17) All information ((~~submitted by a hospital~~)) related to ((~~its~~)) a hospital's DSH application is subject to audit by the department or its designee. ((~~The department may audit any, none, or all DSH applications for a given state fiscal year.~~)) The department determines the extent and timing of the audits. For example, the department or its designee may choose to do a desk review ((~~upon receipt~~)) of an individual hospital's DSH application and/or supporting documentation, or audit all hospitals that qualified for a particular DSH program after payments have been distributed under that program.

(18) If a hospital's submission of incorrect information or failure to submit correct information results in DSH overpayment to that hospital, the department will recoup the overpayment amount, in accordance with the provisions of RCW 74.09.220 and 43.20B.695.

(19) DSH calculations use fiscal year data, and DSH payments are distributed based on funding for a specific state fiscal year. Therefore, unless otherwise specified, changes and clarifications to DSH program rules apply for the full state fiscal year in which the rules are adopted.

AMENDATORY SECTION (Amending WSR 07-14-090, filed 6/29/07, effective 8/1/07)

WAC 388-550-5150 Payment method—General assistance-unemployable disproportionate share hospital (GAUDSH). (1) A hospital is eligible for the general assistance-unemployable disproportionate share hospital (GAUDSH) payment if the hospital:

(a) Meets the criteria in WAC 388-550-4900;

(b) Is an in-state or designated bordering city hospital;

(c) Provides services to clients eligible under the medical care services program; and

(d) Has a medicaid inpatient utilization rate (MIPUR) of one percent or more.

(2) The department determines the GAUDSH payment for each eligible hospital in accordance with:

(a) WAC 388-550-4800 for inpatient hospital claims submitted for general assistance unemployable (GAU) clients; and

(b) WAC 388-550-5800 through 388-550-6450 and WAC 388-550-7000 through 388-550-7600 for outpatient hospital claims submitted for GAU clients.

(3) The department makes GAUDSH payments to a hospital on a claim-specific basis.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-550-5200	Payment method—Small rural disproportionate share hospital (SRDSH).
WAC 388-550-5210	Payment method—Small rural indigent assistance disproportionate share hospital (SRIADSH) program.
WAC 388-550-5220	Payment method—Nonrural indigent assistance disproportionate share hospital (NRIADSH).

WSR 09-14-089
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed June 30, 2009, 7:54 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: The department is amending WAC 388-850-045 on an emergency basis to revise the county funding formula to comply with state budget appropriations.

Citation of Existing Rules Affected by this Order: Amending WAC 388-850-045.

Statutory Authority for Adoption: RCW 71A.12.030, 71A.12.040, 71A.14.030.

Other Authority: Section 205 (1)(n), chapter 564, Laws of 2009 PV 61st legislature; chapter 34.05 RCW.

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: This emergency rule implements changes made to the county funding formula as a result of changes in the state budget appropriation for county programs. An initial public notice was filed December 22, 2008, as WSR 09-01-132. Stakeholder work is continuing.

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 1, Repealed 0.

Number of Sections Adopted at 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 1, Repealed 0.

Date Adopted: June 11, 2009.

Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 05-11-015, filed 5/9/05, effective 6/9/05)

WAC 388-850-045 ((~~Funding formula—Developmental disabilities.~~)) What is the formula for distribution of funding to the counties? (1) For the purposes of this section, "county" shall mean the legal subdivision of the state, regardless of any agreement with another county to provide developmental disabilities services jointly.

(2) The allocation of funds to counties shall be based on the following criteria:

(a) ((~~Each county shall receive a base amount of funds. The amount shall be based on the prior biennial allocation, including any funds from budget provisos from the prior biennium, and subject to the availability of state and federal funds;~~

~~(b)~~)) The distribution of ((~~any additional~~)) funds provided by the legislature or other sources shall be based on a distribution formula which best meets the needs of the population to be served((~~as follows:~~

~~(i) On a basis which~~)).

(b) The distribution formula takes into consideration ((~~minimum grant amounts,~~)) requirements of clients residing in an ICF/MR or clients on one of the division's Title XIX home and community-based waivers, ((~~and the general population of the county, and~~))eligible birth to three, special education enrollment and the general population of the county as well as the population ((~~eligible for~~)) receiving county-funded developmental disabilities services((~~;~~)).

(((~~(ii) On a basis that takes into consideration the population numbers of minority groups residing within the county;~~

~~(iii) A biennial adjustment shall be made after these factors are considered; and~~

~~(iv) Counties not receiving any portion of additional funds pursuant to this formula shall not have their base allocation reduced due to application of this formula.~~

~~(c) Funding appropriated through legislative proviso, including vendor rate increases, shall be distributed to the population directed by the legislature utilizing a formula as directed by the legislature or using a formula specific to that population or distributed to identified people;~~

~~(d)~~)) (c) The ability of the community to provide funds for the developmental disability program provided in chapter 71A.14 RCW may be considered with any or all of the above.

(3) A county may utilize seven or less percent of the county's allocated funds for county administrative expenses. A county may utilize more than seven percent for county administration with approval of the division director. ((~~A county electing to provide all services directly, in addition to county administration, is exempt from this requirement.~~))

(((~~(4) The department may withhold five or less percent of allocated funds for new programs, for statewide priority programs, and for emergency needs.~~))

WSR 09-14-090
EMERGENCY RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed June 30, 2009, 7:56 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: These amendments are required to meet the 2009-2011 final legislative budget reductions in section 1109, chapter 564, Laws of 2009 (ESHB 1244). Specifically, the department will no longer cover orally administered enteral nutrition products for clients twenty-one years of age and older.

Citation of Existing Rules Affected by this Order: Amending WAC 388-554-100, 388-554-200, 388-554-300, 388-554-400, 388-554-500, 388-554-600, 388-554-700, and 388-554-800.

Statutory Authority for Adoption: RCW 74.04.050, 74.08.090.

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Emergency rule adoption is required in order for the department to fully meet the legislatively mandated appropriation reduction in section 1109, chapter 564, Laws of 2009 (ESHB 1244) for the durable medical equipment (DME) for fiscal years 2010-2011.

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 1, Amended 8, Repealed 0.

Number of Sections Adopted at 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 1, Amended 8, Repealed 0.

Date Adopted: June 10, 2009.

Stephanie E. Schiller
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 09-15 issue of the Register.

WSR 09-14-091
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed June 30, 2009, 7:57 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: Under sections 201 and 209 of the operating budget for fiscal years 2010 and 2011, funding for maternity support services (First Steps program) is reduced by 20% from current levels. The department is amending language in sections in chapter 388-533 WAC, in order to meet these targeted budget expenditure levels. The changes include redefining the eligibility criteria for maternity support services and reducing the number of pregnant women and their infants who qualify for enhanced MSS services. The maximum number of units eligible clients may receive has been reduced.

Citation of Existing Rules Affected by this Order: Amending WAC 388-533-0315, 388-533-0320, and 388-533-0345.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.760 through 74.09.910.

Other Authority: 2009-11 omnibus operating budget (ESHB 1244).

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Emergency rule adoption is required in order for the department to comply with sections 201 and 209 of the operating budget for fiscal years 2010 and 2011 with respect to maternity support services. A CR-101 for the permanent rule was filed as WSR 09-04-069 on February 2, 2009.

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 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 3, Repealed 0.

Date Adopted: June 19, 2009.

Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 04-13-049, filed 6/10/04, effective 7/11/04)

WAC 388-533-0315 Maternity support services—Definitions. The following definitions and those found in WAC 388-500-0005 apply to the maternity support services (MSS) program.

"Advocacy"—For the purposes of the MSS program, means actions taken to support the parent(s) in accessing needed services or goods and helping the parent(s) to develop skills to access services.

"Assurances document"—A signed agreement documenting that the provider understands and agrees to maintain certain required program elements; and to work toward integrating other specifically recommended practices. Also referred to as the MSS/ICM assurances document.

"Basic health messages"—For the purposes of the MSS program, means the preventative health education messages designed to promote healthy pregnancies, healthy newborns and healthy parenting during the first year of life.

"Case management"—For the purposes of the MSS program, means services to assist individuals who are eligible under the medicaid state plan, to gain access to needed medical, social, educational, and other services.

"Childbirth education classes (CBE)"—A series of educational sessions offered in a group setting and led by an approved instructor to prepare a pregnant woman and her support person for an upcoming childbirth.

((~~**"Childcare"**~~))

"DASA (division of alcohol and substance abuse)"—Childcare for women attending DASA-funded outpatient

alcohol or drug treatment services that may be provided through the treatment facility.

((**"First Steps"—** Childcare funded through the First Steps Program for the care of children of pregnant or postpregnant women who are attending appointments for medicaid-covered services, pregnant women on physician ordered bed rest, and for visits to the neonatal intensive care unit (NICU) after delivery.))

"Community and family health (CFH)"—Refers to the division within the state department of health whose mission is to improve the health and well-being of Washington residents with a special focus on infants, children, youth, pregnant woman, and prospective parents.

"Consultation"—For the purposes of the MSS program, means the practice of conferring with other professionals to share knowledge and problem solve with the intent of providing the best possible care to clients.

"Core services"—For the purposes of the MSS program, means the services that provide the framework for interdisciplinary, client-centered maternity support services and infant case management. These services include: Client screening, basic health messages, basic linkages, and ((~~minimum~~)) appropriate interventions.

"Department of health (DOH)"—The agency whose mission is to protect and improve the health of people in Washington state.

"Department of social and health services (DSHS)"—The state agency that administers social and health services programs for the state of Washington.

"First Steps"—The 1989 Maternity Care Access Act, known as First Steps. This program provides enhanced maternity care for pregnant and postpregnant women, and health care for infants. The program is managed collaboratively by DSHS and DOH. First Steps maternity care consists of obstetrical care, maternity support services, childbirth education classes, and infant case management.

((**"First Steps Childcare"—** See childcare.))

"Home visit"—For the purposes of the MSS program, means services delivered in the client's place of residence or other setting as described in the medical assistance administration's published MSS/ICM billing instructions.

"Infant case management (ICM)"—A program that provides case management services to eligible high-risk infants and their families. Eligibility for ICM may be established at the end of the maternity cycle and up to the infant's first birthday.

"Interagency agreement"—A written letter of agreement between two agencies for the exchange of referrals or service provision (e.g., a written agreement in letter format that agrees to an exchange of referrals or services for MSS/ICM clients).

"Interdisciplinary team"—Members from different professions and occupations that work closely together and communicate frequently to optimize care for the client (pregnant woman and infant). Each team member contributes specialized knowledge, skills and experience to support and augment the contributions of the other team members.

"Linkages"—Networking and/or collaboration between agencies in order to assure proper referral of clients and avoid duplication of services.

"Maternal and infant health (MIH)"—A section within the state department of health. MIH works collaboratively with DSHS to provide clinical consultation, oversight and monitoring of the MSS/ICM programs.

"Maternity cycle"—An eligibility period for maternity support services that begins during pregnancy and continues to the end of the month in which the sixtieth-day postpregnancy occurs.

"Maternity support services (MSS)"—Preventive health services for pregnant/postpregnant women including: Professional observation, assessment, education, intervention and counseling. MSS services are provided by an interdisciplinary team consisting of at minimum, a community health nurse, a nutritionist, and a behavioral health specialist. Additional MSS services may be provided by community health workers.

"Medical assistance administration (MAA)"—The administration within DSHS authorized to administer medical assistance programs.

((**"Minimum interventions"—** Defined levels of client assessment, education, intervention and outcome evaluation for specific risk factors found in client screening for MSS/ICM services, or identified during ongoing services.))

"Performance measure"—An indicator used to measure the results of a focused intervention or initiative.

"Risk factors"—The biopsychosocial factors that could lead to ((~~negative pregnancy or parenting~~)) poor birth outcomes. ((~~The MSS/ICM program design identifies specific risk factors and corresponding minimum interventions.~~))

"Service plan"—The written plan of care that must be developed and maintained throughout the eligibility period for each client in the MSS/ICM programs.

"Staff"—For the purposes of the MSS program, means the personnel employed by providers.

((**"Unit of service"—** Fifteen minutes of one-to-one service delivered face-to-face.))

AMENDATORY SECTION (Amending WSR 04-13-049, filed 6/10/04, effective 7/11/04)

WAC 388-533-0320 Maternity support services—Client eligibility. (1) To be eligible for maternity support services (MSS), a client must ((~~be~~)):

(a) Be covered under one of the following medical assistance ((~~administration~~)) programs:

(i) Categorically needy program (CNP);

(ii) ((~~Categorically needy program~~)) CNP—Children's health insurance program; (((~~CNP-Children's health insurance program); or~~))

(iii) ((~~Categorically needy program~~)) CNP—Emergency medical only (((~~CNP-Emergency medical only); and~~)); or

(iv) Medically needy program (MNP).

(b) ((~~Pregnant or still within the maternity cycle~~)) Be within the eligibility period of a maternity cycle as defined in WAC 388-533-0315; and

(c) Meet any other eligibility criteria as determined by the department and published in the department's current billing instructions and/or numbered memoranda.

(2) Clients meeting the eligibility criteria in ((~~WAC 388-533-0320(1)~~)) this section who are enrolled in ((~~an MAA~~)) a department-contracted managed care plan, are eligible for MSS ((~~services~~)) outside their plan. ((~~MSS services delivered outside the managed care plan are reimbursed on a fee-for-service basis and subject to the same program rules as apply to nonmanaged care clients.~~))

(3) Clients receiving MSS before July 1, 2009, are subject to the transition plan as determined and published by the department in numbered memoranda.

AMENDATORY SECTION (Amending WSR 04-13-049, filed 6/10/04, effective 7/11/04)

WAC 388-533-0345 Maternity support services—((~~Reimbursement~~)) Payment. ((~~Services provided under~~)) The department pays for the covered maternity support services (MSS) ((~~program are reimbursed~~)) described in this chapter on a fee-for-service basis subject to the following ((~~limitations~~)):

(1) ((~~MAA reimburses under this program only for services billed using approved procedure codes and modifiers as identified in MAA's published MSS/ICM billing instructions;~~)) MSS must be:

(a) Provided to a client who meets the eligibility requirements in WAC 388-533-0320;

(b) Provided by a qualified staff person who meets the criteria established in WAC 388-533-0325;

(c) Provided according to the department's current published maternity support services/infant case management (MSS/ICM) billing instructions and/or numbered memoranda;

(d) Billed using:

(i) The appropriate procedure codes and modifiers identified in the department's current published MSS/ICM billing instructions; and

(ii) The department-assigned MSS provider number.

(2) ((~~MAA reimburses~~)) The department:

(a) Pays for MSS ((~~services~~)) in units of time with one unit being equal to fifteen minutes of one-to-one service delivered face-to-face;

(b) Determines the maximum number of units allowed to comply with the legislature's targeted budget expenditure levels for payment of MSS; and

(c) Publishes the maximum number of units allowed in the MSS/ICM billing instructions and/or numbered memoranda.

(((~~(3) MAA reimburses a maximum of:~~

~~(a) Six units per client, per day for any combination of office or home visits;~~

~~(b) Sixty total units per client, from all disciplines, over the maternity cycle;~~

~~(c) A one-time-only fee per client for the family planning performance measure; and~~

~~(d) A one-time-only fee per client per pregnancy for the tobacco cessation performance measure.~~))

WSR 09-14-092

EMERGENCY RULES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(Health and Recovery Services Administration)

[Filed June 30, 2009, 7:59 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: Under sections 201 and 209 of the operating budget for fiscal years 2010 and 2011, funding for maternity support services (First Steps program) is reduced by 20% from current levels. The department is amending language in sections in chapter 388-533 WAC, in order to meet these targeted budget expenditure levels. The changes include redefining the eligibility criteria for infant case management services and reducing the number of infants who qualify for enhanced infant case management services under maternity support services. The maximum number of units eligible clients may receive has been reduced.

Citation of Existing Rules Affected by this Order: Amending WAC 388-533-0365, 388-533-0370, and 388-533-0386.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.760 through 74.09.910.

Other Authority: 2009-11 omnibus operating budget (ESHB 1244).

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Emergency rule adoption is required in order for the department to comply with sections 201 and 209 of the operating budget for fiscal years 2010 and 2011 with respect to maternity support services. A CR-101 for the permanent rule was filed as WSR 09-04-069 on February 2, 2009.

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 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 3, Repealed 0.

Date Adopted: June 19, 2009.

Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 04-13-049, filed 6/10/04, effective 7/11/04)

WAC 388-533-0365 Infant case management—Definitions. The following definitions and those found in WAC 388-500-0005, Medical definitions and 388-533-0315, Maternity support services definitions apply to this section:

"Infant case management (ICM)"—The program that provides case management services to eligible high-risk infants and their families. Eligibility for ICM may be established at the end of the maternity cycle up to the end of the month of the baby's first birthday.

"Parent(s)"—means a person who resides with an infant and provides the infant's day-to-day care, and is:

(1) The infant's natural or adoptive parent(s);

(2) A person other than a foster parent who has been granted legal custody of the infant; or

(3) A person who is legally obligated to support the infant.

AMENDATORY SECTION (Amending WSR 04-13-049, filed 6/10/04, effective 7/11/04)

WAC 388-533-0370 Infant case management—Eligibility. (1) To be eligible for infant case management (ICM), the infant must:

(a) ((~~The infant must~~)) Be covered under one of the medical assistance programs listed in WAC 388-533-0320 (1)(a) ((~~of this chapter~~));

(b) ((~~The parent(s) must need assistance in accessing or providing care for the infant~~)) Meet the age requirement for ICM which is the day after the maternity cycle (defined in WAC 388-533-0315) ends, through the last day of the month of the infant's first birthday; ((~~and~~))

(c) ((~~At least one or more of the following criteria exists:~~

~~(i) The parent(s) are unable to care for infant specifically due to at least one of the following:~~

~~(A) Incarceration of the mother within the last year;~~

~~(B) Low functioning ability (e.g., needs repeated instructions, not attuned to infant cues, leaves infant with inappropriate caregivers, parent has the equivalent of less than an eighth grade education);~~

~~(C) Unstable mental health issue (regardless of whether the mental health issue is being treated or not);~~

~~(D) Physical impairment;~~

~~(E) Infant's mother is experiencing postpregnancy depression or mood disorder or has a history of depression/mood disorder;~~

~~(F) Infant's parent(s) are unable to access resources due to age (nineteen years of age or younger);~~

~~(G) Social isolation (e.g., family is new to the community, parent(s) do not have a support system, family moves frequently, lack of supportive living environment);~~

~~(H) Inability to access resources due to language or cultural barrier.~~

~~(ii) The infant's safety is a concern specifically due to at least one of the following:~~

~~(A) Domestic or family violence in present or past relationship that keeps the parent(s) feeling unsafe;~~

~~(B) Substance abuse by the infant's mother and/or father that is impacting ability to parent;~~

~~(C) Secondhand smoke exposure to the infant;~~

~~(D) Child protective service involvement within the last year or mother/father had parental rights terminated in the past;~~

~~(E) Unstable living situation (e.g., homelessness, couch surfing, unsafe conditions, no cooking facilities, heat, or water).~~

~~(iii) The infant's health is a concern specifically due to at least one of the following:~~

~~(A) Low birth weight - less than five and one half pounds;~~

~~(B) Premature birth - less than thirty-seven weeks gestation;~~

~~(C) Failure to thrive (e.g., baby is not gaining weight, significant feeding difficulty, no eye contact, or baby is listless);~~

~~(D) Multiple births (twins, triplets. etc.);~~

~~(E) Excessive fussiness or infant has irregular sleeping patterns (e.g., parent(s)' sleep deprivation, exhaustion and/or need for respite childcare);~~

~~(F) Infant has an identified medical problem or disability~~)) Reside with at least one parent (see WAC 388-533-0365 for definition of parent);

(d) Have a parent(s) who needs assistance in accessing medical, social, educational and/or other services to meet the infant's basic health and safety needs;

(e) Not be receiving any case management services funded through Title XIX medicaid that duplicate ICM services; and

(f) Currently need case management services due to at least one of the following:

(i) Low birth weight (less than five and one-half pounds);

(ii) Premature birth (less than thirty-seven weeks gestation); or

(iii) The infant has met other qualifying criteria for case management services listed in the department's current published MSS/ICM billing instructions and/or numbered memoranda.

(2) Clients meeting the eligibility criteria in ((~~WAC 388-533-0370(1)~~)) subsection (1) of this section who are enrolled in ((~~an MAA~~)) a department-contracted managed care plan are eligible for ICM services outside their plan. ((~~ICM services delivered outside the managed care plan are reimbursed on a fee-for-service basis and subject to the same program rules as apply to nonmanaged care clients.~~))

(3) Clients receiving ICM before July 1, 2009, are subject to the transition plan as determined and published by the department in numbered memoranda

AMENDATORY SECTION (Amending WSR 04-13-049, filed 6/10/04, effective 7/11/04)

WAC 388-533-0386 Infant case management services—((~~Reimbursement~~)) Payment. The ((~~medical assistance administration (MAA) reimburses~~)) department pays for the covered infant case management (ICM) services described in WAC 388-533-0380 on a fee-for-service basis subject to the following ((~~terms and limitations~~)):

(1) ((~~ICM is reimbursed in units of service with one unit being equal to fifteen minutes of service;~~

~~(2) MAA reimburses:~~

~~(a) No more than six ICM units per month, per client; and~~

~~(b) No more than forty ICM units total per client through the end of the month of the baby's first birthday; and~~

~~(c) Only for services billed using the approved ICM procedure code and modifier identified in MAA's published MSS/ICM billing instructions~~)) The ICM services must be:

(a) Provided to clients who meet the eligibility requirements in WAC 388-533-0370;

(b) Provided by a qualified staff person who meets the criteria established in WAC 388-533-0375

(c) Provided according to the department's current maternity support services/infant case management (MSS/ICM) published billing instructions and/or numbered memoranda; and

(d) Billed using:

(i) The eligible infant's department-assigned client identification number;

(ii) The appropriate procedure codes and modifiers identified in the department's current MSS/ICM published billing instructions and/or numbered memoranda; and

(iii) The department-assigned MSS/ICM provider number.

(2) The department:

(a) Pays ICM services in units of time with one unit being equal to fifteen minutes of one-to-one service delivered face-to-face;

(b) Determines the maximum number of units allowed per client based on the legislature's targeted budget expenditure levels for payment of maternity support services; and

(c) Publishes the maximum number of units allowed per client in the MSS/ICM billing instructions and/or numbered memoranda.

WSR 09-14-093
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed June 30, 2009, 8:01 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: Under sections 201 and 209 of the operating budget for fiscal years 2010 and 2011, funding for dental services is reduced from current levels. The department is amending language in sections in chapter 388-535 WAC in order to meet these targeted budget expenditure levels. The changes include, for clients through age twenty, reducing coverage of restorative services (crowns) and reducing coverage for repairs to partial dentures; for clients age twenty-one and older, reducing coverage for endodontic treatment and oral and maxillofacial surgery; and for all clients, reducing coverage for partial dentures.

Citation of Existing Rules Affected by this Order: Amending WAC 388-535-1084, 388-535-1090, 388-535-1100, 388-535-1261, 388-535-1266, 388-535-1267, 388-535-1269, and 388-535-1271.

Statutory Authority for Adoption: RCW 74.08.090 and 74.09.800.

Other Authority: 2009-11 omnibus operating budget (ESHB 1244).

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Emergency rule adoption is required in order for the department to comply with sections 201 and 209 of the operating budget for fiscal years 2010 and 2011 with respect to dental services. A CR-101 for the permanent rule was filed as WSR 09-04-070 on February 2, 2009.

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 8, Repealed 0.

Number of Sections Adopted at 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 8, Repealed 0.

Date Adopted: June 22, 2009.

Stephanie E. Schiller
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 09-15 issue of the Register.

WSR 09-14-094
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed June 30, 2009, 8:03 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: To reduce by approximately 4% the rates of all levels of the seventeen level medicaid payment system for adult family homes (AFH) and licensed boarding homes with contracts to provide assisted living (AL), adult residential care (ARC), and enhanced adult residential care (EARC) services.

Citation of Existing Rules Affected by this Order: Amending WAC 388-105-0005.

Statutory Authority for Adoption: RCW 74.39A.030 (3)(a).

Other Authority: Section 206(4), chapter 564, Laws of 2009.

Under RCW 34.05.350 the agency for good cause finds that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, or 2011, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: Section 1812, chapter 564, Laws of 2009. This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect immediately. On May 19, 2009, the department began the permanent rule-making process by filing a CR-101 filed as WSR 09-11-100.

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 1, Repealed 0.

Number of Sections Adopted at 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 1, Repealed 0.

Date Adopted: June 19, 2009.

Stephanie E. Schiller
Rules Coordinator

AMENDATORY SECTION (Amending WSR 09-11-053, filed 5/13/09, effective 6/13/09)

WAC 388-105-0005 The daily medicaid payment rates for clients assessed using the comprehensive assessment reporting evaluation (CARE) tool and that reside in adult family homes (AFH) and boarding homes contracted to provide assisted living (AL), adult residential care (ARC), and enhanced adult residential care (EARC) services. For contracted AFH and boarding homes contracted to provide AL, ARC, and EARC services, the department pays the following daily rates for care of a medicaid resident:

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE
KING COUNTY

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$((~~69.22~~)) 66.45	$((~~74.64~~)) 71.87	$((~~48.95~~)) 46.99	$((~~48.95~~)) 46.99	$((~~48.32~~)) 46.39
A Med	$((~~74.95~~)) 71.95	$((~~80.37~~)) 77.37	$((~~55.54~~)) 53.32	$((~~55.54~~)) 53.32	$((~~54.83~~)) 52.64
A High	$((~~84.10~~)) 80.74	$((~~89.52~~)) 86.16	$((~~61.00~~)) 58.56	$((~~61.00~~)) 58.56	$((~~61.35~~)) 58.90
B Low	$((~~69.22~~)) 66.45	$((~~74.64~~)) 71.87	$((~~48.95~~)) 46.99	$((~~48.95~~)) 46.99	$((~~48.56~~)) 46.62
B Med	$((~~77.24~~)) 74.15	$((~~82.66~~)) 79.57	$((~~62.14~~)) 59.65	$((~~62.14~~)) 59.65	$((~~61.66~~)) 59.19
B Med-High	$((~~87.48~~)) 83.98	$((~~92.90~~)) 89.40	$((~~66.07~~)) 63.43	$((~~66.07~~)) 63.43	$((~~66.06~~)) 63.42
B High	$((~~92.09~~)) 88.41	$((~~97.51~~)) 93.83	$((~~75.53~~)) 72.51	$((~~75.53~~)) 72.51	$((~~75.53~~)) 72.51
C Low	$((~~74.95~~)) 71.95	$((~~80.37~~)) 77.37	$((~~55.54~~)) 53.32	$((~~55.54~~)) 53.32	$((~~54.83~~)) 52.64
C Med	$((~~84.10~~)) 80.74	$((~~89.52~~)) 86.16	$((~~69.72~~)) 66.93	$((~~69.72~~)) 66.93	$((~~70.02~~)) 67.22
C Med-High	$((~~104.70~~)) 100.51	$((~~110.12~~)) 105.93	$((~~92.94~~)) 89.22	$((~~92.94~~)) 89.22	$((~~91.73~~)) 88.06
C High	$((~~105.74~~)) 101.51	$((~~111.16~~)) 106.93	$((~~93.82~~)) 90.07	$((~~93.82~~)) 90.07	$((~~93.01~~)) 89.29

D Low	$((~~77.24~~)) 74.15	$((~~82.66~~)) 79.57	$((~~75.07~~)) 72.07	$((~~75.07~~)) 72.07	$((~~71.38~~)) 68.52
D Med	$((~~85.82~~)) 82.39	$((~~91.24~~)) 87.81	$((~~86.98~~)) 83.50	$((~~86.98~~)) 83.50	$((~~87.36~~)) 83.87
D Med-High	$((~~110.98~~)) 106.54	$((~~116.40~~)) 111.96	$((~~110.61~~)) 106.19	$((~~110.61~~)) 106.19	$((~~105.12~~)) 100.92
D High	$((~~119.59~~)) 114.81	$((~~125.01~~)) 120.23	$((~~119.59~~)) 114.81	$((~~119.59~~)) 114.81	$((~~119.69~~)) 114.90
E Med	$((~~144.53~~)) 138.75	$((~~149.95~~)) 144.17	$((~~144.53~~)) 138.75	$((~~144.53~~)) 138.75	$((~~144.63~~)) 138.84
E High	$((~~169.47~~)) 162.69	$((~~174.89~~)) 168.11	$((~~169.47~~)) 162.69	$((~~169.47~~)) 162.69	$((~~169.57~~)) 162.79

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE

METROPOLITAN COUNTIES*

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$((~~63.49~~)) 60.95	$((~~68.41~~)) 65.87	$((~~48.95~~)) 46.99	$((~~48.95~~)) 46.99	$((~~48.32~~)) 46.39
A Med	$((~~66.94~~)) 64.26	$((~~71.86~~)) 69.18	$((~~53.34~~)) 51.21	$((~~53.34~~)) 51.21	$((~~52.66~~)) 50.55
A High	$((~~81.81~~)) 78.54	$((~~86.73~~)) 83.46	$((~~58.17~~)) 55.84	$((~~58.17~~)) 55.84	$((~~58.08~~)) 55.76
B Low	$((~~63.49~~)) 60.95	$((~~68.41~~)) 65.87	$((~~48.95~~)) 46.99	$((~~48.95~~)) 46.99	$((~~48.56~~)) 46.62
B Med	$((~~72.65~~)) 69.74	$((~~77.57~~)) 74.66	$((~~58.84~~)) 56.49	$((~~58.84~~)) 56.49	$((~~58.37~~)) 56.04
B Med-High	$((~~82.29~~)) 79.00	$((~~87.21~~)) 83.92	$((~~62.57~~)) 60.07	$((~~62.57~~)) 60.07	$((~~62.60~~)) 60.10
B High	$((~~89.81~~)) 86.22	$((~~94.73~~)) 91.14	$((~~73.40~~)) 70.46	$((~~73.40~~)) 70.46	$((~~73.40~~)) 70.46
C Low	$((~~66.94~~)) 64.26	$((~~71.86~~)) 69.18	$((~~53.56~~)) 51.42	$((~~53.56~~)) 51.42	$((~~53.05~~)) 50.93
C Med	$((~~81.81~~)) 78.54	$((~~86.73~~)) 83.46	$((~~68.82~~)) 66.07	$((~~68.82~~)) 66.07	$((~~68.31~~)) 65.58
C Med-High	$((~~101.25~~)) 97.20	$((~~106.17~~)) 102.12	$((~~86.34~~)) 82.89	$((~~86.34~~)) 82.89	$((~~85.23~~)) 81.82
C High	$((~~102.26~~)) 98.17	$((~~107.18~~)) 103.09	$((~~91.84~~)) 88.17	$((~~91.84~~)) 88.17	$((~~90.43~~)) 86.81
D Low	$((~~72.65~~)) 69.74	$((~~77.57~~)) 74.66	$((~~74.04~~)) 71.08	$((~~74.04~~)) 71.08	$((~~69.80~~)) 67.01
D Med	$((~~83.48~~)) 80.14	$((~~88.40~~)) 85.06	$((~~85.24~~)) 81.83	$((~~85.24~~)) 81.83	$((~~85.01~~)) 81.61
D Med-High	$((~~107.33~~)) 103.04	$((~~112.25~~)) 107.96	$((~~107.87~~)) 103.56	$((~~107.87~~)) 103.56	$((~~101.92~~)) 97.84
D High	$((~~116.30~~)) 111.65	$((~~121.22~~)) 116.57	$((~~116.30~~)) 111.65	$((~~116.30~~)) 111.65	$((~~115.79~~)) 111.16

E Med	$((~~140.04~~)) 134.44	$((~~144.96~~)) 139.36	$((~~140.04~~)) 134.44	$((~~140.04~~)) 134.44	$((~~139.53~~)) 133.95
E High	$((~~163.78~~)) 157.23	$((~~168.70~~)) 162.15	$((~~163.78~~)) 157.23	$((~~163.78~~)) 157.23	$((~~163.27~~)) 156.74

*Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima counties.

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE
NONMETROPOLITAN COUNTIES**

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$((~~62.36~~)) 59.87	$((~~67.60~~)) 65.11	$((~~48.95~~)) 46.99	$((~~48.95~~)) 46.99	$((~~48.32~~)) 46.39
A Med	$((~~66.94~~)) 64.26	$((~~72.18~~)) 69.50	$((~~52.25~~)) 50.16	$((~~52.25~~)) 50.16	$((~~51.58~~)) 49.52
A High	$((~~81.81~~)) 78.54	$((~~87.05~~)) 83.78	$((~~57.23~~)) 54.94	$((~~57.23~~)) 54.94	$((~~57.01~~)) 54.73
B Low	$((~~62.36~~)) 59.87	$((~~67.60~~)) 65.11	$((~~48.95~~)) 46.99	$((~~48.95~~)) 46.99	$((~~48.56~~)) 46.62
B Med	$((~~72.65~~)) 69.74	$((~~77.89~~)) 74.98	$((~~57.75~~)) 55.44	$((~~57.75~~)) 55.44	$((~~57.29~~)) 55.00
B Med-High	$((~~82.29~~)) 79.00	$((~~87.53~~)) 84.24	$((~~61.40~~)) 58.94	$((~~61.40~~)) 58.94	$((~~61.38~~)) 58.92
B High	$((~~89.81~~)) 86.22	$((~~95.05~~)) 91.46	$((~~69.42~~)) 66.64	$((~~69.42~~)) 66.64	$((~~69.42~~)) 66.64
C Low	$((~~66.94~~)) 64.26	$((~~72.18~~)) 69.50	$((~~52.25~~)) 50.16	$((~~52.25~~)) 50.16	$((~~51.58~~)) 49.52
C Med	$((~~81.81~~)) 78.54	$((~~87.05~~)) 83.78	$((~~65.05~~)) 62.45	$((~~65.05~~)) 62.45	$((~~65.70~~)) 63.07
C Med-High	$((~~101.25~~)) 97.20	$((~~106.49~~)) 102.44	$((~~83.04~~)) 79.72	$((~~83.04~~)) 79.72	$((~~81.98~~)) 78.70
C High	$((~~102.26~~)) 98.17	$((~~107.50~~)) 103.41	$((~~86.81~~)) 83.34	$((~~86.81~~)) 83.34	$((~~85.52~~)) 82.10
D Low	$((~~72.65~~)) 69.74	$((~~77.89~~)) 74.98	$((~~69.99~~)) 67.19	$((~~69.99~~)) 67.19	$((~~66.01~~)) 63.37
D Med	$((~~83.48~~)) 80.14	$((~~88.72~~)) 85.38	$((~~80.57~~)) 77.35	$((~~80.57~~)) 77.35	$((~~80.39~~)) 77.17
D Med-High	$((~~107.33~~)) 103.04	$((~~112.57~~)) 108.28	$((~~101.96~~)) 97.88	$((~~101.96~~)) 97.88	$((~~96.37~~)) 92.52
D High	$((~~109.93~~)) 105.53	$((~~115.17~~)) 110.77	$((~~109.93~~)) 105.53	$((~~109.93~~)) 105.53	$((~~109.48~~)) 105.10
E Med	$((~~132.36~~)) 127.07	$((~~137.60~~)) 132.31	$((~~132.36~~)) 127.07	$((~~132.36~~)) 127.07	$((~~131.92~~)) 126.64
E High	$((~~154.80~~)) 148.61	$((~~160.04~~)) 153.85	$((~~154.80~~)) 148.61	$((~~154.80~~)) 148.61	$((~~154.36~~)) 148.19

** Nonmetropolitan counties: Adams, Asotin, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Garfield, Grant, Grays Harbor, Jefferson, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Orielle, San Juan, Skagit, Skamania, Stevens, Wahkiakum, Walla Walla and Whitman.

WSR 09-14-098
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 09-125—Filed June 30, 2009, 10:22 a.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: Amend personal use fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 232-28-61900E; and amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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 upper Columbia River summer chinook return at Wells Dam is adequate to provide necessary escapement goals, along with a harvest fishery. The stock is stable and not listed under the Endangered Species Act (ESA). Sockeye salmon returns are predicted to be in excess of needs for wild fish escapement. The stock is not listed under [the] ESA. 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 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: June 30, 2009.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 232-28-61900E Exceptions to statewide rules—Okanogan and Similkameen rivers. Notwithstanding the provisions of WAC 232-28-619, effective immediately until further notice, it is unlawful to violate the following provisions, provided that unless otherwise amended, all permanent rules remain in effect:

(1) Okanogan River (Okanogan Co.)

(a) Effective July 1 through September 15, 2009, a person may fish for salmon in those waters from the Highway 97 Bridge near the mouth to the Highway 97 Bridge at Oroville. Daily limit of six salmon, only four of which may be adults, and up to two of the adult salmon may be Chinook. Coho salmon and steelhead must be released. Anti-snagging rule and night closure are in effect for all species.

(b) Effective July 1 through October 15, 2009, a person may fish for salmon in those waters from the mouth to the Highway 97 Bridge. Daily limit of six salmon, up to four of which may be adults, and up to two of the adult salmon may be Chinook. Coho salmon and steelhead must be released. Anti-snagging rule and night closure are in effect for all species.

(c) Effective September 1 through September 15, 2009, in those waters upstream of the Highway 97 bridge in Malott, statewide gamefish rules are in effect, except release all trout. Anti-snagging rule and night closure are in effect for all species.

(2) Similkameen River (Okanogan Co.) Effective July 1 through September 15, 2009, a person may fish in those waters from the mouth upstream to the Highway 7 Bridge at Oroville. Daily limit of six salmon, only four of which may be adults, and up to two of the adult salmon may be Chinook. Coho salmon and steelhead must be released. Anti-snagging rule and night closure are in effect for all species.

REPEALER

The following section of the Washington Administrative Code is repealed effective October 16, 2009:

WAC 232-28-61900E	Exceptions to statewide rules—Okanogan and Similkameen rivers.

WSR 09-14-115
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 09-124—Filed June 30, 2009, 4:42 p.m., effective July 1, 2009]

Effective Date of Rule: July 1, 2009.

Purpose: The purpose of this rule making is to allow nontreaty recreational fishing opportunity in the Columbia River while protecting fish 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, federal law governing Washington's relationship with Oregon, and Washington fish and wildlife commission policy guidance for Columbia River fisheries.

Citation of Existing Rules Affected by this Order: Repealing WAC 232-28-61900C; and amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 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 2008-2017 *United States v. Oregon Management Agreement* (Aug. 12, 2008) (Doc. No. 2546); *Northwest Gillnetters Ass'n v. Sandison,* 95 Wn.2d 638, 628 P.2d 800 (1981); Washington fish and wildlife com-

mission 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; and 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: Sockeye salmon returns to the upper Columbia River are predicted to be in excess of needs for wild fish escapement to the spawning grounds. The population is not listed under the ESA. There is insufficient time to adopt permanent rules.

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 0, Amended 0, Repealed 0.

Number of Sections Adopted at 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: June 30, 2009.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 232-28-61900C Exceptions to statewide rules—Columbia River. Notwithstanding the provisions of WAC 232-28-619:

(1) Effective July 1 through August 15, 2009 - Columbia River from the Highway 395 Bridge at Pasco to Priest Rapids Dam, daily limit six salmon, only four of which may be adults, and up to two of the adult salmon may be Chinook. Steelhead must be released.

(2) Effective July 1 through October 15, 2009 - Columbia River from Priest Rapids Dam to Wells Dam, daily limit six salmon, only four of which may be adults, and up to two of the adult salmon may be Chinook. Coho salmon and steelhead must be released.

(3) Effective July 16 through August 31, 2009 - Columbia River from Wells Dam to Highway 173 Bridge in Brewster, daily limit six salmon, only four of which may be adults, and up to two of the adult salmon may be Chinook. Coho salmon and steelhead must be released. Release any Chinook with an anchor (floy) tag attached.

(4) Effective July 1 through October 15, 2009 - Columbia river from Highway 173 in Brewster to Highway 17 in Bridgeport, daily limit six salmon, only four of which may be adults, and up to two of the adult salmon may be Chinook. Coho salmon and steelhead must be released. Release any Chinook with an anchor (floy) tag attached.

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 section of the Washington Administrative Code is repealed effective October 16, 2009:

WAC 232-28-61900C	Exceptions to statewide rules—Columbia and Okanogan rivers.