WSR 09-20-030
EMERGENCY RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Economic Services Administration)
[Filed September 29, 2009, 2:39 p.m., effective October 1, 2009]

Effective Date of Rule: October 1, 2009.

Purpose: In the 2009 legislative session, the legislature adopted ESHB 1794 (chapter 84, Laws of 2009), which makes changes to chapter 26.19 RCW, the Washington state child support schedule, based on recommendations of the 2007 child support schedule workgroup which was convened under 2SHB 1009 (chapter 313, Laws of 2007) and SHB 1845 (chapter 476, Laws of 2009), regarding medical support obligations in child support orders. Both of these bills have an effective date of October 1, 2009.

The division of child support (DCS) must adopt rules to implement this legislation by October 1, 2009. DCS has begun the rule-making process by filing a CR-101, preproposal notice of inquiry, for each of the bills: The CR-101 for ESHB 1794 was filed as WSR 09-10-046, and the CR-101 for SHB 1845 was filed as WSR 09-14-075. As the rule development process progressed, DCS determined that, in order to make all the required changes under both ESHB 1794 and SHB 1845, it would be necessary to adopt one set of rules which covered both bills.

DCS will be unable to complete the regular adoption process by the effective date. DCS is adopting emergency rules at this time, but continues the regular rule-making process and will adopt final rules as soon as possible.

Citation of Existing Rules Affected by this Order: Amending WAC 388-14A-1020 What definitions apply to the rules regarding child support enforcement?, 388-14A-2035 Do I assign my rights to support when I receive public assistance?, 388-14A-2036 What does assigning my rights to support mean?, 388-14A-3140 What can happen at a hearing on a support establishment notice?, 388-14A-3205 How does DCS calculate my income?, 388-14A-3310 The division of child support serves a notice of support owed to establish a fixed dollar amount under an existing child support order, 388-14A-3312 The division of child support serves a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support to establish a fixed dollar amount owed under a child support order, 388-14A-3315 When DCS serves a notice of support debt ((~~or~~)), notice of support owed ((~~or~~)), notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support, we notify the other party to the child support order, 388-14A-3317 What is an annual review of a support order under RCW 26.23.110?, 388-14A-3318 What is an annual review of a notice of support owed under WAC 388-14A-3312?, 388-14A-3320 What happens at a hearing on a notice of support owed?, 388-14A-3400 Are there limitations on how much of my income is available for child support?, 388-14A-4100 How does the division of child support enforce my obligation to provide health insurance for my children?, 388-14A-4110 If my support order requires me to provide ((~~health insurance~~)) medical support for my children, what do I have to do?, 388-14A-4112 When does the division of child support enforce a custodial parent's obligation to provide ((~~health insurance coverage~~)) medical support?, 388-14A-4115 Can my support order reduce my support obligation if I pay for health insurance?, 388-14A-4120 DCS uses the National Medical Support Notice to enforce an obligation to provide health insurance coverage, 388-14A-4165 What happens when a noncustodial parent does not earn enough to pay child support plus the health insurance premium?, 388-14A-4175 ((~~Is an employer~~)) Who is required to notify the division of child support when insurance coverage for the children ends?, 388-14A-4180 When must the division of child support communicate with the DSHS health and recovery services administration?, 388-14A-5002 How does DCS distribute support collections in a nonassistance case?, 388-14A-5003 How does DCS distribute support collections in an assistance case?, 388-14A-5004 How does DCS distribute support collections in a former assistance case?, 388-14A-5005 How does DCS distribute federal tax refund offset collections?, 388-14A-5006 How does DCS distribute support collections when the paying parent has more than one case?, 388-14A-5007 If the paying parent has more than one case, can DCS apply support money to only one specific case?, 388-14A-6300 Duty of the administrative law judge in a hearing to determine the amount of a support obligation and 388-14A-8130 How does DCS complete the WSCSS worksheets when setting a joint child support obligation when the parents of a child in foster care are married and residing together?; and new section WAC 388-14A-4111 When may DCS decline a request to enforce a medical support obligation?

Statutory Authority for Adoption: Section 5 of ESHB 1794 (chapter 84, Laws of 2009) and RCW 34.05.020, 34.05.060; 34.05.220, 74.08.090, 74.20.040 and SHB 1845 (chapter 476, Laws of 2009), RCW 26.18.170(14), 26.23.-050(8), 26.23.110(13), 34.05.020, 34.05.220, 74.04.055, 74.04.057, 74.08.090, 74.20.040, 74.20A.310, 74.20A.-055(9), 74.20A.056(11).

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: ESHB 1794 (chapter 84, Laws of 2009) and SHB 1845 (chapter 476, Laws of 2009) both have an effective date of October 1, 2009. Although DCS has begun the regular rule-making process to adopt rules under this bill, we are unable to complete the adoption process by the effective date. DCS continues the regular rule-making process and will adopt final rules as soon as possible.

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 28, 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 Mak-

ing: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 28, Repealed 0.

Date Adopted: September 28, 2009.

Stephanie E. Vaughn
Rules Coordinator

AMENDATORY SECTION (Amending WSR 09-02-059, filed 1/5/09, effective 1/27/09)

WAC 388-14A-1020 What definitions apply to the rules regarding child support enforcement? For purposes of this chapter, the following definitions apply:

"Absence of a court order" means that there is no court order setting a support obligation for the noncustodial parent (NCP), or specifically relieving the NCP of a support obligation, for a particular child.

"Absent parent" is a term used for a noncustodial parent.

"Accessible coverage" means health insurance coverage which provides primary care services to the children with reasonable effort by the custodian.

"Accrued debt" means past-due child support which has not been paid.

"Administrative order" means a determination, finding, decree or order for support issued under RCW 74.20A.055, 74.20A.056, or 74.20A.059 or by another state's agency under an administrative process, establishing the existence of a support obligation (including medical support) and ordering the payment of a set or determinable amount of money for current support and/or a support debt. Administrative orders include:

(1) An order entered under chapter 34.05 RCW;

(2) An agreed settlement or consent order entered under WAC 388-14A-3600; and

(3) A support establishment notice which has become final by operation of law.

"Agency" means the Title IV-D provider of a state. In Washington, this is DCS.

"Agreed settlement" is an administrative order that reflects the agreement of the noncustodial parent, the custodial parent and the division of child support. An agreed settlement does not require the approval of an administrative law judge.

"Aid" or **"public assistance"** means cash assistance under the temporary assistance for needy families (TANF) program, the aid to families with dependent children (AFDC) program, federally funded or state-funded foster care, and includes day care benefits and medical benefits provided to families as an alternative or supplement to TANF.

"Alternate recipient" means a child of the employee or retiree named within a support order as being entitled to coverage under an employer's group health plan.

"Annual fee" means the twenty-five dollar annual fee charged between October 1 and September 30 each year, required by the federal deficit reduction act of 2005 and RCW 74.20.040.

"Applicant/custodian" means a person who applies for nonassistance support enforcement services on behalf of a child or children residing in their household.

"Applicant/recipient," "applicant," and **"recipient"** means a person who receives public assistance on behalf of a child or children residing in their household.

"Arrears" means the debt amount owed for a period of time before the current month.

"Assistance" means cash assistance under the state program funded under Title IV-A of the federal Social Security Act.

"Assistance unit" means a cash assistance unit as defined in WAC 388-408-0005. An assistance unit is the group of people who live together and whose income or resources the department counts to decide eligibility for benefits and the amount of benefits.

"Birth costs" means medical expenses incurred by the custodial parent or the state for the birth of a child.

"Cash medical support" is a term used in RCW 26.09.105 and certain federal regulations to refer to amounts paid by an obligated parent to the other parent or to the state in order to comply with the medical support obligation stated in a child support order.

"Conditionally assigned arrears" means those temporarily assigned arrears remaining on a case after the period of public assistance ends.

"Conference board" means a method used by the division of child support for resolving complaints regarding DCS cases and for granting exceptional or extraordinary relief from debt.

"Consent order" means a support order that reflects the agreement of the noncustodial parent, the custodial parent and the division of child support. A consent order requires the approval of an administrative law judge.

"Court order" means a judgment, decree or order of a Washington state superior court, another state's court of comparable jurisdiction, or a tribal court.

"Current support" or **"current and future support"** means the amount of child support which is owed for each month.

"Custodial parent or CP" means the person, whether a parent or not, with whom a dependent child resides the majority of the time period for which the division of child support seeks to establish or enforce a support obligation.

"Date the state assumes responsibility for the support of a dependent child on whose behalf support is sought" means the date that the TANF or AFDC program grant is effective. For purposes of this chapter, the state remains responsible for the support of a dependent child until public assistance terminates, or support enforcement services end, whichever occurs later.

"Delinquency" means failure to pay current child support when due.

"Department" means the Washington state department of social and health services (DSHS).

"Dependent child" means a person:

(1) Seventeen years of age or younger who is not self-supporting, married, or a member of the United States armed forces;

(2) Eighteen years of age or older for whom a court order requires support payments past age eighteen;

(3) Eighteen years of age or older, but under nineteen years of age, for whom an administrative support order exists

if the child is participating full-time in a secondary school program or the same level of vocational or technical training.

"Disbursement" means the amount of child support distributed to a case that is paid to the family, state, other child support enforcement agency in another state or foreign country, Indian tribe, or person or entity making the payment.

"Disposable earnings" means the amount of earnings remaining after the deduction of amounts required by law to be withheld.

"Distribution" means how a collection is allocated or split within a case or among multiple cases.

"Earnings" means compensation paid or payable for personal service. Earnings include:

(1) Wages or salary;

(2) Commissions and bonuses;

(3) Periodic payments under pension plans, retirement programs, and insurance policies of any type;

(4) Disability payments under Title 51 RCW;

(5) Unemployment compensation under RCW 50.40.-020, 50.40.050 and Title 74 RCW;

(6) Gains from capital, labor, or a combination of the two; and

(7) The fair value of nonmonetary compensation received in exchange for personal services.

"Employee" means a person to whom an employer is paying, owes, or anticipates paying earnings in exchange for services performed for the employer.

"Employer" means any person or organization having an employment relationship with any person. This includes:

(1) Partnerships and associations;

(2) Trusts and estates;

(3) Joint stock companies and insurance companies;

(4) Domestic and foreign corporations;

(5) The receiver or trustee in bankruptcy; and

(6) The trustee or legal representative of a deceased person.

"Employment" means personal services of whatever nature, including service in interstate commerce, performed for earnings or under any contract for personal services. Such a contract may be written or oral, express or implied.

"Family" means the person or persons on whose behalf support is sought, which may include a custodial parent and one or more children, or a child or children in foster care placement. The family is sometimes called the assistance unit.

"Family arrears" means the amount of past-due support owed to the family, which has not been conditionally, temporarily or permanently assigned to a state. Also called "nonassistance arrears."

"Family member" means the caretaker relative, the child(ren), and any other person whose needs are considered in determining eligibility for assistance.

"Foreign order" means a court or administrative order entered by a tribunal other than one in the state of Washington.

"Foster care case" means a case referred to the Title IV-D agency by the Title IV-E agency, which is the state division of child and family services (DCFS).

"Fraud," for the purposes of vacating an agreed settlement or consent order, means:

(1) The representation of the existence or the nonexistence of a fact;

(2) The representation's materiality;

(3) The representation's falsity;

(4) The speaker's knowledge that the representation is false;

(5) The speaker's intent that the representation should be acted on by the person to whom it is made;

(6) Ignorance of the falsity on the part of the person to whom it is made;

(7) The latter's:

(a) Reliance on the truth of the representation;

(b) Right to rely on it; and

(c) Subsequent damage.

"Full support enforcement services" means the entire range of services available in a Title IV-D case.

"Good cause" for the purposes of late hearing requests and petitions to vacate orders on default means a substantial reason or legal justification for delay, including but not limited to the grounds listed in civil rule 60. The time periods used in civil rule 60 apply to good cause determinations in this chapter.

"Head of household" means the parent or parents with whom the dependent child or children were residing at the time of placement in foster care.

"Health care costs" means medical expenses. Certain statutes in chapter 26.19 RCW refer to medical expenses as health care costs.

"Health insurance" means insurance coverage for all medical services related to an individual's general health and well being. These services include, but are not limited to: Medical/surgical (inpatient, outpatient, physician) care, medical equipment (crutches, wheel chairs, prosthesis, etc.), pharmacy products, optometric care, dental care, orthodontic care, preventive care, mental health care, and physical therapy.

"Health insurance coverage" does not include medical assistance provided under chapter 74.09 RCW.

"Hearing" means an adjudicative proceeding authorized by this chapter, or chapters 26.23, 74.20 and 74.20A RCW, conducted under chapter 388-02 WAC and chapter 34.05 RCW.

"I/me" means the person asking the question which appears as the title of a rule.

"Income" includes:

(1) All gains in real or personal property;

(2) Net proceeds from the sale or exchange of real or personal property;

(3) Earnings;

(4) Interest and dividends;

(5) Proceeds of insurance policies;

(6) Other periodic entitlement to money from any source; and

(7) Any other property subject to withholding for support under the laws of this state.

"Income withholding action" includes all withholding actions which DCS is authorized to take, and includes but is not limited to the following actions:

(1) Asserting liens under RCW 74.20A.060;

(2) Serving and enforcing liens under chapter 74.20A RCW;

(3) Issuing orders to withhold and deliver under chapter 74.20A RCW;

(4) Issuing notices of payroll deduction under chapter 26.23 RCW; and

(5) Obtaining wage assignment orders under RCW 26.18.080.

"Locate" can mean efforts to obtain service of a support establishment notice in the manner prescribed by WAC 388-14A-3105.

"Medical assistance" means medical benefits under Title XIX of the federal Social Security Act provided to families as an alternative or supplement to TANF.

"Medical expenses" for the purpose of establishing support obligations under RCW 26.09.105, 74.20A.055 and 74.20A.056, or for the purpose of enforcement action under chapters 26.23, 74.20 and 74.20A RCW, including the notice of support debt and the notice of support owed, means((:

•)) medical costs incurred on behalf of a child, which include:

• Medical services related to an individual's general health and well-being, including but not limited to, medical/surgical care, preventive care, mental health care and physical therapy; and

• Prescribed medical equipment and prescribed pharmacy products;

• Health care coverage, such as coverage under a health insurance plan, including the cost of premiums for coverage of a child;

• Dental and optometrical costs incurred on behalf of a child; and

• Copayments and/or deductibles incurred on behalf of a child.

Medical expenses are sometimes also called health care costs or medical costs.

"Medical support" means ((~~either or both~~)) any combination of the following:

(1) ((~~Medical expenses; and~~

~~(2)~~)) Health insurance coverage for a dependent child;

(2) Amounts owed by one parent to the other parent as a monthly payment toward the premium paid by the other parent for health insurance coverage for a dependent child;

(3) Amounts owed by a noncustodial parent to the state as a monthly payment toward the cost of managed care coverage for the child by the state, if the child receives state-financed medical coverage through the department under chapter 74.09 RCW for which there is an assignment; and

(4) Amounts owed by one parent to the other parent as his or her proportionate share of uninsured medical expenses for a dependent child.

"Monthly payment toward the premium" means a parent's contribution toward:

• Premiums paid by the other parent for insurance coverage for the child; or

• Amounts paid for managed care coverage for the child by the state, if the child receives state-financed medical coverage through the department under chapter 74.09 RCW for which there is an assignment.

This contribution is based on the obligated parent's proportionate share of the premium paid, but may not exceed twenty-five percent of the obligated parent's basic support obligation.

"National Medical Support Notice" or **"NMSN"** is a federally mandated form that DCS uses to enforce a health insurance support obligation; the NMSN is a notice of enrollment as described in RCW 26.18.170.

"Noncustodial parent or NCP" means the natural parent, adoptive parent, responsible stepparent or person who signed and filed an affidavit acknowledging paternity, from whom the state seeks support for a dependent child. A parent is considered to be an NCP when for the majority of the time during the period for which support is sought, the dependent child resided somewhere other than with that parent.

"Obligated parent" means a parent who is required under a child support order to provide health insurance coverage or to reimburse the other parent for his or her share of medical expenses for a dependent child. The obligated parent could be either the NCP or the CP.

"Other ordinary expense" means an expense incurred by a parent which:

(1) Directly benefits the dependent child; and

(2) Relates to the parent's residential time or visitation with the child.

"Participant" means an employee or retiree who is eligible for coverage under an employer group health plan.

"Pass-through" means the portion of a support collection distributed to assigned support that the state pays to a family currently receiving TANF.

"Past support" means support arrears.

"Paternity testing" means blood testing or genetic tests of blood, tissue or bodily fluids. This is also called genetic testing.

"Payment services only" or **"PSO"** means a case on which the division of child support's activities are limited to recording and distributing child support payments, and maintaining case records. A PSO case is not a IV-D case.

"Permanently assigned arrears" means those arrears which the state may collect and retain up to the amount of unreimbursed assistance.

"Physical custodian" means custodial parent (CP).

"Plan administrator" means the person or entity which performs those duties specified under 29 USC 1002 (16)(A) for a health plan. If no plan administrator is specifically so designated by the plan's organizational documents, the plan's sponsor is the administrator of the plan. Sometimes an employer acts as its own plan administrator.

"Proportionate share" means an amount equal to a parent's percentage share of the combined monthly net income of both parents as computed on the worksheets when determining a parent's child support obligation under chapter 26.19 RCW.

"Putative father" includes all men who may possibly be the father of the child or children on whose behalf the application for assistance or support enforcement services is made.

"Reasonable efforts to locate" means any of the following actions performed by the division of child support:

(1) Mailing a support establishment notice to the noncustodial parent in the manner described in WAC 388-14A-3105;

(2) Referral to a sheriff or other server of process, or to a locate service or department employee for locate activities;

(3) Tracing activity such as:

(a) Checking local telephone directories and attempts by telephone or mail to contact the custodial parent, relatives of the noncustodial parent, past or present employers, or the post office;

(b) Contacting state agencies, unions, financial institutions or fraternal organizations;

(c) Searching periodically for identification information recorded by other state agencies, federal agencies, credit bureaus, or other record-keeping agencies or entities; or

(d) Maintaining a case in the division of child support's automated locate program, which is a continuous search process.

(4) Referral to the state or federal parent locator service;

(5) Referral to the attorney general, prosecuting attorney, the IV-D agency of another state, or the Department of the Treasury for specific legal or collection action;

(6) Attempting to confirm the existence of and to obtain a copy of a paternity acknowledgment; or

(7) Conducting other actions reasonably calculated to produce information regarding the NCP's whereabouts.

"Required support obligation for the current month" means the amount set by a superior court order, tribal court order, or administrative order for support which is due in the month in question.

"Resident" means a person physically present in the state of Washington who intends to make their home in this state. A temporary absence from the state does not destroy residency once it is established.

"Residential care" means foster care, either state or federally funded.

"Residential parent" means the custodial parent (CP), or the person with whom the child resides that majority of the time.

"Responsible parent" is a term sometimes used for a noncustodial parent.

"Responsible stepparent" means a stepparent who has established an in loco parentis relationship with the dependent child.

"Retained support" means a debt owed to the division of child support by anyone other than a noncustodial parent.

"Satisfaction of judgment" means payment in full of a court-ordered support obligation, or a determination that such an obligation is no longer enforceable.

"Secretary" means the secretary of the department of social and health services or the secretary's designee.

"State" means a state or political subdivision, territory, or possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico, a federally recognized Indian tribe or a foreign country.

"Superior court order" means a judgment, decree or order of a Washington state superior court, or of another state's court of comparable jurisdiction.

"Support debt" means support which was due under a support order but has not been paid. This includes:

(1) Delinquent support;

(2) A debt for the payment of expenses for the reasonable or necessary care, support and maintenance including medical expenses, birth costs, child care costs, and special child rearing expenses of a dependent child or other person;

(3) A debt under RCW 74.20A.100 or 74.20A.270; or

(4) Accrued interest, fees, or penalties charged on a support debt, and attorney's fees and other litigation costs awarded in an action under Title IV-D to establish or enforce a support obligation.

"Support enforcement services" means all actions the Title IV-D agency is required to perform under Title IV-D of the Social Security Act and state law.

"Support establishment notice" means a notice and finding of financial responsibility under WAC 388-14A-3115, a notice and finding of parental responsibility under WAC 388-14A-3120, or a notice and finding of medical responsibility under WAC 388-14A-3125.

"Support money" means money paid to satisfy a support obligation, whether it is called child support, spousal support, alimony, maintenance, enforcement of medical expenses, health insurance, or birth costs.

"Support obligation" means the obligation to provide for the necessary care, support and maintenance of a dependent child or other person as required by law, including health insurance coverage, medical expenses, birth costs, and child care or special child rearing expenses.

"Temporarily assigned arrears" means those arrears which accrue prior to the family receiving assistance, for assistance applications dated on or after October 1, 1997, but before October 1, 2008. After the family terminates assistance, temporarily assigned arrears become conditionally assigned arrears.

"Temporary assistance for needy families," or "TANF" means cash assistance under the temporary assistance for needy families (TANF) program under Title IV-A of the Social Security Act.

"Title IV-A" means Title IV-A of the Social Security Act established under Title XX of the Social Security amendments and as incorporated in Title 42 USC.

"Title IV-A agency" means the part of the department of social and health services which carries out the state's responsibilities under the temporary assistance for needy families (TANF) program (and the aid for dependent children (AFDC) program when it existed).

"Title IV-D" means Title IV-D of the Social Security Act established under Title XX of the Social Security amendments and as incorporated in Title 42 USC.

"Title IV-D agency" or **"IV-D agency"** means the division of child support, which is the agency responsible for carrying out the Title IV-D plan in the state of Washington. Also refers to the Washington state support registry (WSSR).

"Title IV-D case" is a case in which the division of child support provides services which qualifies for funding under the Title IV-D plan.

"Title IV-D plan" means the plan established under the conditions of Title IV-D and approved by the secretary, Department of Health and Human Services.

"Title IV-E" means Title IV-E of the Social Security Act established under Title XX of the Social Security amendments and as incorporated in Title 42 U.S.C.

"Title IV-E case" means a foster care case.

"Tribal TANF" means a temporary assistance for needy families (TANF) program run by a tribe.

"Tribunal" means a state court, tribal court, administrative agency, or quasi-judicial entity authorized to establish, enforce or modify support orders or to determine parentage.

"Uninsured medical expenses":

(((~~(1)~~))) For the purpose of establishing or enforcing support obligations ((~~under RCW 26.23.110,~~)) means:

(((~~(a)~~))) (1) Medical expenses not paid by insurance for medical, dental, prescription and optometrical costs incurred on behalf of a child; and

(((~~(b)~~))) (2) Premiums, copayments, or deductibles incurred on behalf of a child((~~; and~~

~~(2) Includes health insurance premiums that represent the only health insurance covering a dependent child when either:~~

~~(a) Health insurance for the child is not required by a support order or cannot be enforced by the division of child support (DCS); or~~

~~(b) The premium for covering the child exceeds the maximum limit provided in the support order~~)).

"Unreimbursed assistance" means the cumulative amount of assistance which was paid to the family and which has not been reimbursed by assigned support collections.

"Unreimbursed medical expenses" means any amounts paid by one parent for uninsured medical expenses, which that parent claims the obligated parent owes under a child support order, which percentage share is stated in the child support order itself, not just in the worksheets.

"We" means the division of child support, part of the department of social and health services of the state of Washington.

"WSSR" is the Washington state support registry.

"You" means the reader of the rules, a member of the public, or a recipient of support enforcement services.

AMENDATORY SECTION (Amending WSR 06-03-120, filed 1/17/06, effective 2/17/06)

WAC 388-14A-2035 Do I assign my rights to support when I receive public assistance? (1) When you receive public assistance you assign your rights to support to the state. This section applies to all applicants and recipients of cash assistance under the state program funded under Title IV-A of the federal Social Security Act.

(2) As a condition of eligibility for assistance, a family member must assign to the state the right to collect and keep, subject to the limitation in subsection (3), any support owing to the family member or to any other person for whom the family member has applied for or is receiving assistance.

(3) Amounts assigned under this section may not exceed the lesser of the total amount of assistance paid to the family or the total amount of the assigned support obligation.

(4) When you receive medicaid or medical benefits, you assign your rights to medical support to the state. This applies to all recipients of medical assistance under the state program funded under Title XIX of the federal Social Security Act:

(a) If your children receive medicaid or other state-financed medical coverage through the department under chapter 74.09 RCW for which there is an assignment and if your order provides for the payment of a monthly payment toward the premium when the obligated parent does not provide coverage, the division of child support (DCS) may serve a notice of support owed to establish the amount owed by the noncustodial parent as a monthly payment toward the premium paid for coverage by the state, as provided in WAC 388-14A-3312.

(b) Any amounts established under WAC 388-14A-3312 for periods while your children receive medicaid or other state-financed medical coverage are assigned to the state and are distributed as provided in WAC 388-14A-5011.

(c) Amounts assigned under this section may not exceed the lesser of the total amount of premiums paid by the state for your children or the total amount of the assigned monthly payment toward the premium.

(5) In addition to the assignment described in this section, there is an assignment of support rights under Title IV-E of the social security act when a child receives foster care services.

(a) The state provides foster care programs which may be federally-funded or state funded, or may place a child with a relative.

(b) As part of its state plan under Title IV-D of the social security act and 45 CFR 302.52, DCS provides child support enforcement services for foster care cases as required by 45 CFR 302.33, RCW 74.20.330 and 74.20A.030.

AMENDATORY SECTION (Amending WSR 09-02-059, filed 1/5/09, effective 1/27/09)

WAC 388-14A-2036 What does assigning my rights to support mean? (1) As a condition of eligibility for assistance, a family member must assign to the state the right to collect and keep, subject to the limitation in WAC 388-14A-2035(3):

(a) Any support owing to the family member or to any other person for whom the family member has applied for or is receiving assistance if the family applied for cash public assistance before October 1, 2008.

(b) Support owing to the family member, or to any other person for whom the family member has applied for or is receiving cash public assistance, for any month during which the family receives assistance.

(2) While your family receives assistance, support is distributed and disbursed in accordance with WAC 388-14A-5000 through 388-14A-5015.

(3) After your family terminates from assistance, certain accrued arrears remain assigned to the state in accordance with the following rules:

(a) For assistance applications dated prior to October 1, 1997, you permanently assigned to the state all rights to support which accrued before the application date until the date your family terminated from assistance.

(b) For assistance applications dated on or after October 1, 1997, and before October 1, 2000:

(i) You permanently assigned to the state all rights to support which accrued while your family receives assistance; and

(ii) You temporarily assigned to the state all rights to support which accrued before the application date, until October 1, 2000, or when your family terminated from assistance, whichever date is later.

(c) For assistance applications dated on or after October 1, 2000, and before October 1, 2008:

(i) You permanently assigned to the state all rights to support which accrued while the family received assistance; and

(ii) You temporarily assigned to the state all rights to support which accrued before the application date, until the date your family terminated from assistance.

(d) For assistance applications dated on or after October 1, 2008, you permanently assign to the state all rights to support which accrue while the family receives assistance.

(4) When you assign your medical support rights to the state, you authorize the state on behalf of yourself and the children in your care to enforce the noncustodial parent's full duty to provide medical support.

(a) When you begin receiving medicaid or medical assistance, you do not assign to the state any accrued medical support arrears that may be owed to you by the noncustodial parent (NCP).

(b) If your support order provides for the payment of a monthly payment toward the premium when the obligated parent does not provide coverage, the division of child support (DCS) may serve a notice of support owed to establish the amount owed by the NCP as a monthly payment toward the premium paid for coverage by the state, as provided in WAC 388-14A-3312.

(c) After you terminate medicaid or medical assistance, any assigned medical arrears remain assigned to the state.

AMENDATORY SECTION (Amending WSR 06-09-015, filed 4/10/06, effective 5/11/06)

WAC 388-14A-3140 What can happen at a hearing on a support establishment notice? (1) When a parent requests a hearing on a notice and finding of financial responsibility (NFFR), notice and finding of parental responsibility (NFPR), or notice and finding of medical responsibility (NFMR), the hearing is limited to resolving the ((~~NCP's~~)) current and future support obligation and the accrued support debt of the noncustodial parent (NCP), and to establishing the medical support obligations of both the NCP and the custodial parent (CP), if the CP is the legal or biological parent of the child(ren). The hearing is not for the purpose of setting a payment schedule on the support debt.

(2) The ((~~noncustodial parent (NCP) has~~)) NCP and the CP each have the burden of proving any defenses to their own liability. See WAC 388-14A-3370.

(3) ((~~Both~~)) The NCP and/or the custodial parent (CP) must show cause why the terms in the NFFR, NFPR, or NFMR are incorrect.

(4) The administrative law judge (ALJ) has authority to enter a support obligation that may be higher or lower than the amounts set forth in the NFFR, NFPR, or NFMR, including the support debt, current support, and the future support obligation.

(a) The ALJ may enter an order that differs from the terms stated in the notice, including different debt periods, if the obligation is supported by credible evidence presented by any party at the hearing, without further notice to any nonappearing party, if the ALJ finds that due process requirements have been met.

(b) Any support order entered by the ALJ must comply with the requirements of WAC 388-14A-6300.

(5) The ALJ has no authority to determine custody or visitation issues, or to set a payment schedule for the arrears debt.

(6) When a party has advised the ALJ that they will participate by telephone, the ALJ attempts to contact that party on the record before beginning the proceeding or rules on a motion. The ALJ may not disclose to the other parties the telephone number of the location of the party appearing by phone.

(7) In most support establishment hearings, the NCP and CP may participate in the hearing. However, in certain cases, there is no "custodial parent" because the child or children are in foster care.

(a) If both the NCP ((~~fails~~)) and CP fail to appear for hearing, see WAC 388-14A-3131.

(b) If only one of the parties appears for the hearing, see WAC 388-14A-3132.

(c) If both the NCP ((~~appears~~)) and CP appear for hearing, see WAC 388-14A-3133.

(8) In ((~~certain~~)) some cases, there can be two NCPs, called "joint NCPs." This happens when DCS serves a joint support establishment notice on the marital community made up of a husband and wife ((~~are jointly served a support establishment notice~~)) who reside together, seeking to establish a support obligation for a ((~~common~~)) child in common who is not residing in their home.

(a) If both joint NCPs fail to appear for hearing, see WAC 388-14A-3131;

(b) If both joint NCPs appear for hearing, see WAC 388-14A-3133; or

(c) One joint NCP may appear and represent the other joint NCP.

(9) When the CP ((~~asserts~~)) is granted good cause level B (see WAC 388-422-0020), DCS notifies the CP that ((~~they~~)) the CP will ((~~continue to~~)) receive documents, notices and orders. The CP may choose to participate at any time. Failure to appear at hearing results in a default order but does not result in a sanction for noncooperation under WAC 388-14A-2041.

(10) If any party appears for the hearing and elects to proceed, ((~~absent the granting of a continuance~~)) the ALJ hears the matter and enters an initial decision and order based on the evidence presented, unless the ALJ grants a continuance. The ALJ includes a party's failure to appear in the initial decision and order as an order of default against that party. The direct appeal rights of the party who failed to appear ((~~shall be~~)) are limited to an appeal on the record made at the hearing.

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-3205 How does DCS calculate my income? (1) The division of child support (DCS) calculates a parent's income using the best available information((~~,~~)). In the absence of records of a parent's actual earnings, DCS and/or the administrative law judge (ALJ) may impute a parent's income under RCW 26.19.071(6) in the following order of priority:

(a) ((~~Actual income~~)) Full-time earnings at the current rate of pay;

(b) ((~~Estimated income, if DCS has:~~

~~(i) Incomplete information;~~

~~(ii) Information based on the prevailing wage in the parent's trade or profession; or~~

~~(iii) Information that is not current.~~

~~(c) Imputed income under RCW 26.19.071(6)~~)) Full-time earnings at the historical rate of pay based on reliable information, such as employment security department data;

(c) Full-time earnings at a past rate of pay where information is incomplete or sporadic;

(d) Full-time earnings at minimum wage in the jurisdiction where the parent resides if the parent has a recent history of minimum wage earnings, is recently coming off public assistance, general assistance-unemployable, supplemental security income, or disability, has recently been released from incarceration, or is a high school student; or

(e) Median net monthly income of year-round full-time workers as derived from the United States bureau of census, current population reports.

(2) As an exception to the imputation process described in subsection (1) of this section, DCS and/or the ALJ imputes full time earnings at the minimum wage to a TANF recipient in the absence of actual income information((~~, DCS imputes full-time earnings at the minimum wage to a TANF recipient~~)). You may rebut the imputation of income if you are excused from being required to work while receiving TANF, because:

(a) You are either engaged in other qualifying WorkFirst activities which do not generate income, such as job search; or

(b) You are excused or exempt from being required to work in order to receive TANF, because of other barriers such as family violence or mental health issues.

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-3310 The division of child support serves a notice of support owed to establish a fixed dollar amount under an existing child support order. (1) The division of child support (DCS) may serve a notice of support owed under RCW 26.23.110 on either parent whenever it is necessary to establish a fixed dollar amount owed under a child support order. Situations when DCS may serve a notice of support owed include, but are not limited to:

(a) When the support obligation is not a fixed dollar amount;

(b) When DCS is implementing an adjustment or escalation provision of a court order; or

(c) When DCS is establishing the obligation of either the noncustodial parent (NCP) or custodial parent (CP) to contribute his or her proportionate share of medical support or medical expenses for the child(ren).

(2) DCS may serve a notice of support owed under RCW 26.23.110 on a noncustodial parent (NCP) ((~~under RCW 26.23.110~~)) to establish a fixed dollar amount of monthly support and accrued support debt, including day care costs:

(a) If the support obligation under an order is not a fixed dollar amount; or

(b) To implement an adjustment or escalation provision of a court order.

(((~~2~~))) (3) The notice of support owed may include day care costs and medical support if the court order provides for such costs.

(4) DCS may serve a notice of support owed under RCW 26.23.110 on either of the parties to a support order, whether the party being served is the noncustodial parent (NCP) or the custodial parent (CP), in order to establish that parent's share of medical expenses and/or medical support owed for the child or children covered by a support order. WAC 388-14A-3312 describes the use of a notice of support owed for this purpose.

(a) DCS may use the notice of support owed to collect unreimbursed medical expenses from either of the parties to a support order when the support order provides that a parent is responsible for his or her proportionate share of uninsured medical expenses, no matter which one has custody of the child(ren).

(((~~3~~))) (b) DCS may serve a notice of support owed to establish a parent's share of a health insurance premium paid by the other parent or DSHS for coverage for the child(ren), as provided in RCW 26.09.105 (1)(c). If the child support order provides that either or both parents are obligated to pay a monthly payment in the form of a proportionate share of the health insurance premium for the child(ren), and the obligated parent does not have health insurance available through his or her union or employer, DCS may serve a notice of support owed under RCW 26.23.110. DCS may serve the notice on:

(i) The NCP to establish and enforce the NCP's monthly payment toward the premium paid for coverage by the CP or by the state; or

(ii) The CP to establish and enforce the CP's monthly payment toward the premium paid for coverage by the NCP.

(5) DCS serves a notice of support owed under this section on ((~~an~~)) the NCP or the CP, as appropriate, like a summons in a civil action or by certified mail, return receipt requested.

(((~~4~~))) (6) Following service of a notice of support owed under this section, DCS mails notice to the other party to the support order.

(a) After service on the NCP, DCS mails a notice to payee under WAC 388-14A-3315.

(b) After service on the CP, DCS mails the NCP a copy of the notice which was served on the NCP.

(((~~5~~))) (7) In a notice of support owed, DCS includes the information required by RCW 26.23.110, and:

(a) The factors stated in the order to calculate monthly support or the amounts claimed for medical support;

(b) Any other information not contained in the order that was used to calculate monthly support or medical support and ((~~the~~)) any support debt; and

(c) Notice of the right to request an annual review of the order or a review on the date, if any, given in the order for an annual review.

(((~~(6)~~))) (8) The NCP, or the CP as appropriate, must make all support payments after service of a notice of support owed to the Washington state support registry. DCS does not credit payments made to any other party after service of a notice of support owed except as provided in WAC 388-14A-3375.

(((~~(7)~~))) (9) A notice of support owed becomes final and subject to immediate income withholding and enforcement without further notice under chapters 26.18, 26.23, and 74.20A RCW unless the NCP (or CP as appropriate), within twenty days of service of the notice in Washington:

(a) Contacts DCS, and signs an agreed settlement;

(i) Files a request with DCS for a hearing under this section; or

(ii) Obtains a stay from the superior court.

(b) A notice of support owed served in another state becomes final according to WAC 388-14A-7200.

(((~~(8)~~))) (10) DCS may enforce at any time:

(a) A fixed or minimum dollar amount for monthly support stated in the court order or by prior administrative order entered under this section;

(b) Any part of a support debt that has been reduced to a fixed dollar amount by a court or administrative order; and

(c) Any part of a support debt that neither party claims is incorrect.

(((~~(9)~~))) (11) For the rules on a hearing on a notice of support owed, see WAC 388-14A-3320.

(((~~(10)~~))) (12) A notice of support owed or a final administrative order issued under WAC 388-14A-3320 must inform the parties of the right to request an annual review of the order.

(((~~(11)~~))) (13) If ((~~an~~)) either the NCP or ((~~custodial parent (CP)~~)) CP requests a late hearing, ((~~the party~~)) he or she must show good cause for filing the late hearing request if it is filed more than one year after service of the notice of support owed.

(((~~(12)~~))) (14) A notice of support owed fully and fairly informs the ((~~NCP~~)) parties of the rights and responsibilities in this section.

(((~~(13)~~))) (15) For the purposes of this section, WAC 388-14A-3312, 388-14A-3315 and 388-14A-3320, the term "payee" includes "physical custodian," "custodial parent," or "party seeking reimbursement."

(16) DCS serves a notice of support owed under this section only when the party on whose behalf the notice is served has:

(a) An open IV-D case; and

(b) A Washington child support order.

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-3312 The division of child support serves a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support to establish a fixed dollar amount owed under a child support order. (1) Depending on the specific requirements of the child support order, the division of child support (DCS) may serve a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support under RCW 26.23.110 on either the noncustodial parent (NCP) or the custodial parent (CP), as appropriate, in order to:

(a) Establish as a sum certain and collect the obligated parent's proportionate share of uninsured medical expenses owed to the party seeking reimbursement;

(b) Establish as a sum certain and collect the obligated parent's monthly payment toward the premium paid by the other parent for insurance coverage for the child;

(c) Establish as a sum certain and collect the NCP's monthly payment toward the premium amounts paid for managed care coverage for the child by the state, if the child receives state-financed medical coverage through the department under chapter 74.09 RCW for which there is an assignment; or

(d) Establish and collect amounts owed under both subsections (a) and (b) of this section.

(2) Either the NCP or the CP (if the CP is both a parent and a party to the support order) may ask DCS to serve a notice of support owed ((~~for~~)) on the other party to the support order in order to establish the obligated parent's proportionate share of unreimbursed medical expenses ((~~on the other party to the support order, if that party is an obligated party under~~)) if the support order establishes such an obligation.

(a) If the CP is not both a parent and a party to the support order, DCS can not assist the CP in making a claim for unreimbursed medical expenses, but the CP may seek to recover such expenses by filing an action in court.

(b) DCS serves the notice if the party seeking reimbursement provides proof of payment of at least five hundred dollars in uninsured medical expenses.

(3) Either the NCP or the CP may ask DCS to serve a notice of support owed on the other parent when the support order provides that if health insurance is not available through the obligated parent's employer or union at a cost not to exceed twenty-five percent of the basic support obligation, the obligated parent must pay a monthly payment toward the premium paid for coverage which represents the obligated parent's proportionate share of the health insurance premium paid by the other parent or the state.

(a) DCS serves the notice to establish a monthly payment toward the premium paid by the other parent only if the obligated parent is not already providing coverage for the children.

(b) If the CP is not both a parent and a party to the support order DCS cannot assist the CP in making a claim for a monthly contribution toward any insurance coverage provided by the CP.

(4) Each parent's proportionate share of income and basic support obligation is found on the Washington state child support schedule worksheet that was completed as part of the support order.

(5) If the support order provides for the payment of a monthly amount as part of the parent's medical support obligation under RCW 26.09.105 (1)(c) but does not set that obli-

gation as a sum certain, the division of child support (DCS) may serve a notice of support owed under RCW 26.23.110 to establish the amount owed by the obligated parent as a monthly payment toward the premium paid for coverage by the other parent or the state, when appropriate.

(6) When either parent asks DCS to serve a notice of support owed to establish the other parent's proportionate share of unreimbursed medical expenses and the expenses include premiums for health insurance for the child(ren) covered by the order, DCS reviews the order to determine whether it provides for a monthly payment toward the premium when the obligated parent does not have insurance available through his or her employer or union.

(a) If the order does not have such a requirement, DCS includes the health insurance premiums in the claim for reimbursement of uninsured medical expenses.

(b) If the order does have such a requirement, DCS serves a notice of support owed which:

(i) Includes the health insurance premiums in the claim for reimbursement of uninsured medical expenses; and

(ii) If appropriate, includes the provisions necessary to establish a monthly contribution which represents the obligated parent's proportionate share of the premium paid by the other parent (not to exceed twenty-five percent of the obligated parent's basic support obligation), if the obligated parent is not already providing health insurance coverage for the child(ren).

(7) Once DCS serves a notice of support owed under this section that establishes a monthly payment toward the premium, which represents the obligated parent's proportionate share of the premium paid by the other parent or the state, the obligated parent is not required to reimburse the other parent or the state for any amounts of the obligated parent's proportionate share of the premium which are not paid because those amounts exceed twenty-five percent of the obligated parent's basic support obligation. The obligation to contribute a proportionate share of other uninsured medical expenses is not affected by the establishment of a monthly payment toward the premium under this section.

(8) If the child(ren) receive medicaid or other state-financed medical coverage through the department under chapter 74.09 RCW for which there is an assignment, DCS may serve a notice of support owed under RCW 26.23.110 to establish the amount owed by the noncustodial parent as a monthly payment toward the premium paid for coverage by the state, which represents the obligated parent's proportionate share of the premium paid by the state (not to exceed twenty-five percent of the obligated parent's basic support obligation), if the obligated parent is not already providing health insurance coverage for the child(ren).

(9) A parent's request that DCS serve a notice of support owed to establish the other parent's obligation for ((~~unreimbursed~~)) medical ((~~expenses~~)) support:

(a) May be for a period of up to twenty-four consecutive months.

(b) May include only medical services provided after July 21, 2007.

(c) May include only health insurance coverage provided after September 30, 2009.

(d) May not include months which were included in a prior notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support or a prior judgment.

(((~~d~~))) (e) Need not be for the twenty-four month period immediately following the period included in the prior notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support.

(((~~4~~))) (10) The party seeking reimbursement must ask DCS to serve a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support within two years of the date that the expense ((~~being~~)) or premium was incurred.

(a) The fact that a ((~~claim for unreimbursed~~)) request that DCS serve a notice of support owed for medical ((~~expenses~~)) support is ((~~rejected by DCS~~)) denied, either in whole or in part, does not mean that the parent cannot pursue reimbursement of those expenses by proceeding in court.

(b) If a parent obtains a judgment for ((~~unreimbursed~~)) reimbursement of medical ((~~expenses~~)) support, DCS enforces the judgment.

(((~~5~~))) (11) DCS does not serve a notice of support owed ((~~for unreimbursed medical expenses~~)) under RCW 26.23.110 unless the party seeking reimbursement for medical support declares under penalty of perjury that he or she has asked the obligated party to pay his or her share of the medical expenses and/or medical support, or provides good cause for not asking the obligated party to pay.

(a) If the medical expenses have been incurred within the last twelve months, this requirement is waived.

(b) If the obligated party denies having received notice that the other party was seeking reimbursement for medical expenses or support, the service of the notice of support owed ((~~for unreimbursed medical expenses~~)) constitutes the required notice.

(((~~6~~))) (12) The NCP must apply for full child support enforcement services before the NCP may ask DCS to enforce the CP's medical support obligation.

(a) DCS opens a separate case to enforce a CP's medical support obligation.

(b) The case where DCS is enforcing the support order and collecting from the NCP is called the main case.

(c) The case where DCS is acting on NCP's request to enforce CP's medical support obligation is called the medical support case.

(((~~7~~))) (d) WAC 388-14A-4112 describes the circumstances under which DCS enforces a CP's obligation to provide medical support.

(13) DCS serves a notice of support owed for medical support on the obligated parent like a summons in a civil action or by certified mail, return receipt requested.

(((~~8~~))) (14) Following service on the obligated parent, DCS mails a notice to the party seeking reimbursement under WAC 388-14A-3315.

(((~~9~~))) (15) In a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support, DCS includes the information required by RCW 26.23.110, and:

(a) The factors stated in the order regarding medical support;

(b) A statement of uninsured medical expenses and a declaration by the parent seeking reimbursement; and

(c) Notice of the right to request an annual review of the order, as provided in WAC 388-14A-3318.

(((~~10~~))) (16) A notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support becomes final and subject to immediate income withholding and enforcement without further notice under chapters 26.18, 26.23, and 74.20A RCW unless ((~~the obligated~~)) either parent, within twenty days of service of the notice in Washington:

(a) Contacts DCS, and signs an agreed settlement;

(b) Files a request with DCS for a hearing under this section; or

(c) Obtains a stay from the superior court.

(((~~11~~))) (17) A notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support served in another state becomes final according to WAC 388-14A-7200.

(((~~12~~))) (18) For the rules on a hearing on a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support, see WAC 388-14A-3320.

(((~~13~~))) (19) A notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support or a final administrative order issued under WAC 388-14A-3320 must inform the parties of the right to request an annual review of the order.

(((~~14~~))) (20) If the obligated parent is the NCP, any amounts owing determined by the final administrative order are added to the debt on the main case.

(a) Amounts owed to the CP are added to the CP debt on the main case.

(b) Amounts owed to reimburse the state for medicaid or other state-financed medical coverage through the department under chapter 74.09 RCW for which there is an assignment are added to the main case as permanently assigned arrears.

(((~~15~~))) (21) If the obligated parent is the CP, any amounts owing determined by the final administrative order are paid in the following order:

(a) Any amount owed by the CP to the NCP is applied as an offset to any nonassistance child support arrears owed by the NCP on the main case only; or

(b) If there is no debt owed to the CP on the main case, payment of the amount owed by the CP is in the form of a credit against the NCP's future child support obligation:

(i) Spread equally over a twelve-month period starting the month after the administrative order becomes final, but not to exceed ten percent of the current support amount; or

(ii) When the future support obligation will end under the terms of the order in less than twelve months, spread equally over the life of the order, but not to exceed ten percent of the current support amount.

(c) If the amount owed by the CP exceeds the amount that can be paid off using the methods specified in subsections (a) and (b) of this section, DCS uses the medical support case to collect the remaining amounts owed using the remedies available to DCS for collecting child support debts.

(((~~16~~))) (22) If either the obligated parent or the parent seeking reimbursement or payment toward the premium requests a late hearing, that party must show good cause for filing the late hearing request if it is filed more than one year after service of the notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support.

(((~~17~~))) (23) A notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support fully and fairly informs the obligated parent of the rights and responsibilities in this section.

(((~~18~~))) (24) A notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support under this section is subject to annual review as provided in WAC 388-14A-3318.

(((~~19~~))) (25) If both CP and NCP request that DCS serve a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support on the other party, those notices remain separate and may not be combined.

(a) The office of administrative hearings (OAH) may schedule consecutive hearings but may not combine the matters under the same docket number.

(b) The administrative law judge (ALJ) must issue two separate administrative orders, one for each obligated parent.

(((~~20~~))) (26) DCS does not serve a second or subsequent notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support on an obligated parent until the party seeking reimbursement meets the conditions set forth in WAC 388-14A-3318.

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-3315 When DCS serves a notice of support debt ((~~or~~)), notice of support owed ((~~or~~)), notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support, we notify the other party to the child support order. (1) The division of child support (DCS) sends a notice to the payee/obligee under a Washington child support order or a foreign child support order when DCS receives proof of service on the ((~~noncustodial~~)) obligated parent (((~~NCP~~))) of:

(a) A notice of support owed under WAC 388-14A-3310; ((~~or~~))

(b) A notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support under WAC 388-14A-3312; or

(c) A notice of support debt under WAC 388-14A-3304.

(2) DCS sends the notice to payee by first class mail to the last known address of the payee and encloses a copy of the notice served on the ((~~NCP~~)) obligated parent.

(3) In a notice to payee, DCS informs the payee of the right to file a request with DCS for a hearing on a notice of support owed under WAC 388-14A-3310, a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support under WAC 388-14A-3312, or a notice of support debt under WAC 388-14A-3304 within twenty days of the date of a notice to payee that was mailed to a Washington address.

(4) If the notice to payee was mailed to an out-of-state address, the payee may request a hearing within sixty days of the date of the notice to payee.

(5) The notice of support owed under WAC 388-14A-3312 informs both the CP and the NCP of the right to file a request for hearing on the notice within twenty days of the date of a notice to payee that was mailed to a Washington address, or within sixty days if the NCP copy is mailed to an out-of-state address.

(6) The effective date of a hearing request is the date DCS receives the request.

(((~~(6) When DCS serves a notice of support owed for unreimbursed medical expenses under WAC 388-14A-3312, DCS mails the notice to payee to the parent seeking reimbursement.~~)))

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-3317 What is an annual review of a support order under RCW 26.23.110? (1) RCW 26.23.110 provides for an annual review of the ((~~support~~)) final administrative order which ((~~was previously the subject of~~)) resulted from a notice of support owed ((~~under that statute~~)), but only if ((~~the division of child support (DCS), the noncustodial parent (NCP), or the custodial parent (CP)~~)) one of the parties to that administrative order requests a review.

(a) This ((~~type of annual review concerns~~)) section describes the annual review that ((~~takes place after service of~~)) occurs for a final administrative order that resulted from a notice of support owed that was served under WAC 388-14A-3310.

(b) ((~~For the definition of an annual review of a support order under RCW 26.23.110 that takes place after service of~~)) WAC 388-14A-3318 describes the annual review that for a final administrative order that results from a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support that was served under WAC 388-14A-3312((~~, see WAC 388-14A-3318~~)).

(2) For purposes of chapter 388-14A WAC, an "annual review of a support order" is defined as:

(a) The collection by DCS of necessary information from CP and NCP;

(b) The service of a notice of support owed under WAC 388-14A-3310; and

(c) The determination of arrears and current support amount with an effective date which is at least twelve months after the date the last notice of support owed, or the last administrative order or decision based on a notice of support owed, became a final administrative order.

(3) A notice of support owed may be prepared and served sooner than twelve months after the date the last notice of support owed, or the last administrative order or decision based on a notice of support owed, became a final administrative order, but the amounts determined under the notice of support owed may not be effective sooner than twelve months after that date.

(4) Either CP or NCP may request an annual review of the support order, even though ((~~the statute~~)) RCW 26.23.110 mentions only the NCP.

(5) DCS may ((~~request~~)) commence an annual review of the support order on its own initiative, but has no duty to ((~~do so~~)) commence an annual review unless either the CP or NCP requests a review.

(6) For the purpose of this section, the terms "payee" and "CP" are interchangeable, and can mean either the payee under the order or the person with whom the child resides the majority of the time.

(7) The twelve-month requirement for an annual review under this section runs separately from the twelve-month requirement for an annual review under WAC 388-14A-3318.

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-3318 What is an annual review of a notice of support owed under WAC 388-14A-3312? (1) RCW 26.23.110 provides for an annual review of the support order which was previously the subject of a notice of support owed under that statute if the noncustodial parent (NCP) or the custodial parent (CP) requests a review.

(2) For purposes of chapter 388-14A WAC, the following rules apply to an "annual review of a support order" for a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support served under WAC 388-14A-3312:

(a) Either the CP or the NCP may be the party seeking reimbursement.

(b) The party seeking reimbursement of uninsured medical expenses must provide proof of payment of at least five hundred dollars in uninsured medical expenses for services provided in the last twenty-four months.

(c) There is no minimum dollar amount required when asking for an annual review concerning the monthly payment toward the premium paid by the other party or the state.

(d) At least twelve months must have passed since:

(i) The date the last notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support on behalf of the party seeking reimbursement became a final order; or

(ii) The last administrative order or decision based on a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support on behalf of that party became a final administrative order.

(3) In the event that DCS has served both a notice of support owed under WAC 388-14A-3310 and a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support under WAC 388-14A-3312 on the same case, each type of notice of support owed has its own twelve-month cycle for annual review.

(4) For purposes of this section, the twelve-month cycle for annual review runs separately for the NCP and for the CP, depending on which one is the party seeking reimbursement.

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-3320 What happens at a hearing on a notice of support owed? (1) A hearing on a notice of support owed is only for interpreting the order for support and any modifying orders and not for changing or deferring the support provisions of the order.

(2) A hearing on a notice of support owed served under WAC 388-14A-3310 is only to determine:

(a) The amount of monthly support as a fixed dollar amount;

(b) Any accrued arrears through the date of hearing; and

(c) If a condition precedent in the order to begin or adjust the support obligation was met.

(3) A hearing on a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support served under WAC 388-14A-3312 is only to determine:

(a) Issues regarding unreimbursed medical expenses, such as:

(i) Whether the parent on whom the notice was served is obligated under the support order to pay for uninsured medical expenses for the children covered by the order;

(((~~(b)~~))) (ii) The total amount of uninsured medical expenses paid by the party seeking reimbursement;

(((~~(c)~~))) (iii) The obligated parent's share of the uninsured medical expenses;

(((~~(d)~~))) (iv) The amount, if any, the obligated parent has already paid to the party seeking reimbursement; and

(((~~(e)~~))) (v) The amount owed by the obligated parent to the party seeking reimbursement for unreimbursed medical expenses.

(b) Issues regarding a monthly payment toward the premium paid for coverage for the children, such as:

(i) Whether the support order requires the obligated parent to pay when the obligated parent does not provide coverage;

(ii) Whether the obligated parent is currently providing coverage, or did so during the time period in question;

(iii) The amount of the premium paid by the other parent or by the state to cover the child(ren);

(iv) The obligated parent's proportionate share of the premium;

(v) The amount, if any, the obligated parent has already contributed toward health insurance premiums paid by the other parent or the state for the time period in question; and

(vi) The monthly amount to be paid by the obligated parent as his or her proportionate share of the health insurance premium.

(4) If the administrative law judge (ALJ) determines that the uninsured medical expenses claimed by the parent seeking reimbursement do not amount to at least five hundred dollars, the ALJ:

(a) May not dismiss the notice on this basis;

(b) Must make the determination listed in subsection (3) above.

(5) The hearing is not for the purpose of setting a payment schedule on the support debt.

(6) Either the noncustodial parent (NCP) or payee may request a hearing on a notice of support owed served under WAC 388-14A-3310.

(7) Either the obligated parent or the party seeking reimbursement may request a hearing on a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support served under WAC 388-14A-3312.

(8) The party who requested the hearing has the burden of proving any defenses to liability that apply under WAC 388-14A-3370 or that the amounts stated in the notice of support owed are incorrect.

(9) The office of administrative hearings (OAH) sends a notice of hearing to the NCP, to the division of child support (DCS), and to the custodial parent (CP). The NCP and the CP each may participate in the hearing as an independent party.

(10) If only one party appears and wishes to proceed with the hearing, the administrative law judge (ALJ) holds a hearing and issues an order based on the evidence presented or continues the hearing. See WAC 388-14A-6110 and 388-14A-6115 to determine if the ALJ enters an initial order or a final order.

(a) An order issued under this subsection includes an order of default against the nonappearing party and limits the appeal rights of the nonappearing party to the record made at the hearing.

(b) If neither the NCP nor the CP appears or wishes to proceed with the hearing, the ALJ issues an order of default against both parties.

(11) If either party requests a late hearing on a notice of support owed, that party must show good cause for filing the late hearing request, as provided in WAC 388-14A-3500.

(12) For purposes of this section, the terms "payee" and "CP" are used interchangeably and can mean either the CP, the payee under the order or both, except that a CP who is not also the payee under the support order may not ask DCS to serve a notice of support owed for ((~~unreimbursed~~)) medical ((~~expenses~~)) support under WAC 388-14A-3312.

AMENDATORY SECTION (Amending WSR 01-03-089, filed 1/17/01, effective 2/17/01)

WAC 388-14A-3400 Are there limitations on how much of my income is available for child support? (1) There are two kinds of limitations based on your income when we set your child support obligation:

(a) The monthly basic child support ((~~amount~~)) obligation for all of your biological or legal children cannot exceed forty-five percent of your monthly net income, unless there are special circumstances as provided in chapter 26.19 RCW; and

(b) The monthly basic child support ((~~amount~~)) obligation cannot reduce your net monthly income below ((~~the one person need standard (WAC 388-478-0015)~~)) one hundred twenty-five percent of the federal poverty level, unless there are special circumstances as provided in chapter 26.19 RCW.

(2) RCW 74.20A.090 limits the amount that can be withheld from your wages for child support to fifty percent of your net monthly earnings.

AMENDATORY SECTION (Amending WSR 04-17-119, filed 8/17/04, effective 9/17/04)

WAC 388-14A-4100 How does the division of child support enforce my obligation to provide health insurance for my children? (1) If a child support order requires ((~~the noncustodial parent (NCP)~~)) a parent to provide health insurance for the children, the division of child support (DCS) attempts to enforce that requirement according to the terms of the order. ((~~The following subsections describe the different types of premium limitations that could apply to a support order~~)) A parent required to provide medical support or health insurance coverage for a child is called the obligated parent, and can be either the custodial parent (CP) or the noncustodial parent (CP).

(2) When DCS is enforcing a support order which contains a specific dollar limit for the cost of health insurance premiums or provides for coverage which is available at no cost to the ((~~NCP~~)) obligated parent, DCS does not require the ((~~NCP~~)) obligated parent to provide health insurance if coverage is not available within the limitations of the order.

(3) When DCS is enforcing a support order entered in Washington on or after October 1, 2009, which provides that either or both parents must provide coverage and/or a proportionate share of uninsured medical expenses as part of the medical support obligation under RCW 26.09.105, the rules in this subsection apply unless the support order specifies differently:

(a) The obligated parent must provide health insurance for dependent children covered by the order if coverage is:

(i) Available or becomes available through private insurance which is not provided through the obligated parent's employer or union; or

(ii) Available or becomes available through the obligated parent's employment or union at a cost of not greater than twenty-five percent of the obligated parent's basic support obligation.

(b) If the obligated parent does not provide proof of coverage or if coverage is not available, DCS may serve a notice of support owed under WAC 388-14A-3312 to determine the monthly amount that the obligated parent must pay as his or her proportionate share of any premium paid by the other parent or by the state on behalf of the child(ren).

(4) When DCS is enforcing a support order entered ((~~on or after~~)) in Washington between May 13, 1989 and September 30, 2009, unless the support order specifies differently, the ((~~NCP~~)) obligated parent must provide health insurance for dependent children if coverage is:

(a) Available or becomes available through the ((~~NCP's~~)) obligated parent's employment or union; and

(b) Available at a cost of not greater than twenty-five per cent of the ((~~NCP's~~)) obligated parent's basic support obligation.

(((~~4~~))) (5) When DCS is enforcing a Washington support order entered prior to May 13, 1989, unless the support order specifies differently, the ((~~NCP~~)) obligated parent must provide health insurance for dependent children if coverage is available or becomes available through the ((~~NCP's~~)) obligated parent's employment or union:

(a) For a maximum of twenty-five dollars per month, if the order specifies that the ((~~NCP~~)) obligated parent must provide coverage only if it is available at a reasonable cost; or

(b) For any premium amount whatsoever, if the order does not specify reasonable cost.

(((~~5~~))) (6) When DCS is enforcing a support order entered by a court or administrative tribunal that is not located in Washington, unless the order provides differently, DCS enforces the medical support obligation as provided in subsection (4) of this section.

(7) DCS serves a notice of intent to enforce a health insurance obligation if the support order:

(a) Requires the ((~~NCP~~)) obligated parent either to provide health insurance coverage or prove that coverage is not available; and

(b) Does not inform the ((~~NCP~~)) obligated parent that failure to provide health insurance or prove it is not available may result in enforcement of the order without notice to the ((~~NCP~~)) obligated parent.

(((~~6~~))) (8) DCS serves the notice of intent to enforce a health insurance obligation on the ((~~NCP~~)) obligated parent by certified mail, return receipt requested, or by personal service.

(((~~7~~))) (9) The notice advises the ((~~NCP~~)) obligated parent that ((~~the NCP~~)) he or she must submit proof of coverage, proof that coverage is not available, or proof that the ((~~NCP~~)) obligated parent has applied for coverage, within twenty days of the date of service of the notice.

(((~~8~~))) (10) The notice advises the ((~~NCP~~)) obligated parent that, if health insurance is not yet available, the ((~~NCP~~)) obligated parent must immediately notify DCS if health insurance coverage becomes available through the ((~~NCP's~~)) obligated parent's employer or union.

(((~~9~~))) (11) When DCS enforces an ((~~NCP's~~)) obligated parent's health insurance obligation, such enforcement may include asking the employer and the plan administrator to enroll the ((~~NCP~~)) obligated parent in a health insurance plan available through the employer.

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.

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-4110 If my support order requires me to provide ((~~health insurance~~)) medical support for my children, what do I have to do? (1) Once a support order is entered requiring ((~~health insurance~~)) medical support, the obligated parent must take the following actions within twenty days:

(a) Provide health insurance coverage; and

(b) Provide proof of coverage to the other parent and to the division of child support (DCS), such as:

(i) The name of the insurer providing the health insurance coverage;

(ii) The names of the beneficiaries covered;

(iii) The policy number;

(iv) That coverage is current; and

(v) The name and address of the obligated parent's employer.

(2) If health insurance coverage that is accessible to the children named in the order is available, the obligated parent must:

(a) Provide for coverage for the children without waiting for an open enrollment period, as provided under RCW 48.01.235 (4)(a); and

(b) Submit proof of coverage as outlined in subsection (1)(b) above.

(3) If health insurance is not immediately available to the obligated parent, as soon as health insurance becomes available, the obligated parent must:

(a) Provide for coverage for the children named in the order; and

(b) Submit proof of coverage as outlined in subsection (1)(b) above.

(4) Medical assistance provided by the department under chapter 74.09 RCW does not substitute for health insurance.

(5) DCS may serve a notice of support owed for medical support under WAC 388-14A-3312 to establish either or both of the following:

(a) Either parent's share of uninsured medical expenses owed to the other parent; or

(b) Either parent's monthly payment toward the premium paid for coverage by the other parent or the state, if:

(i) Health insurance coverage is not available through the parent's employer or union or is not otherwise provided; and

(ii) The support order provides for the payment of a monthly payment toward the premium when the obligated parent does not provide coverage.

(6) See WAC 388-14A-4165 for a description of what happens when the combined total of a noncustodial parent's current support obligation, arrears payment and health insurance premiums to be withheld by the employer exceeds the fifty per cent limitation for withholding.

(7) Both parents must notify DCS any time there is a change to the health insurance coverage for the children named in the order.

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

NEW SECTION

WAC 388-14A-4111 When may DCS decline a request to enforce a medical support obligation? The division of child support (DCS) may decline to enforce a medical support obligation using the remedies available under RCW 26.09.105, 26.18.170 and 26.23.110 if one or more of the following apply:

(1) The medical support obligation is imposed by a child support order that was not entered in a court or administrative forum of the state of Washington;

(2) The department of social and health services is not paying public assistance or providing foster care services;

(3) The party requesting enforcement of the medical support obligation does not have an open IV-D case with DCS for the child;

(4) The party requesting enforcement of the medical support obligation is not a parent of the child for whom the medical support obligation was established;

(5) The party requesting enforcement of the medical support obligation is not a former recipient of public assistance as described in WAC 388-14A-2000 (2)(d);

(6) DCS has not received a request for services from a child support agency in another state or a child support agency of an Indian tribe or foreign country;

(7) The party requesting enforcement of the medical support obligation has not applied for full support enforcement services;

(8) The party requesting enforcement of the medical support obligation does not qualify as a party who can receive child support enforcement services from DCS under WAC 388-14A-2000;

(9) The case does not meet the requirements for provision of support enforcement services from DCS under WAC 388-14A-2010;

(10) DCS denies the application under WAC 388-14A-2020; or

(11) The case meets one or more of the reasons set out in WAC 388-14A-4112(2) that DCS does not enforce a custodial parent's obligation to provide medical support.

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-4112 When does the division of child support enforce a custodial parent's obligation to provide ((~~health insurance coverage~~)) medical support? (1) A noncustodial parent (NCP) may file an application for full child support enforcement services and specifically request that the division of child support (DCS) enforce the ((~~health insurance~~)) medical support obligation of the custodial parent (CP). DCS does not enforce the CP's medical support obligation unless the NCP files an application for services under WAC 388-14A-2000 (2)(c). The NCP must specify whether he or she is requesting that DCS enforce one or both parts of the CP's medical support obligation:

(a) The CP's proportionate share of uninsured medical expenses; or

(b) The CP's obligation to provide health insurance coverage (including the possibility of a monthly payment toward the premium paid for coverage when appropriate).

(2) A medical support obligation includes providing health insurance coverage or contributing a monthly payment toward the premium paid for coverage when appropriate, and paying a proportionate share of any uninsured medical expenses for the children.

(a) DCS may enforce the CP's obligation to pay a proportionate share of any uninsured medical expenses for the children under WAC 388-14A-3312.

(b) DCS may decide whether it is appropriate to enforce the CP's obligation to provide health insurance coverage or contribute a monthly payment toward the premium paid for coverage under subsection (3) of this section.

(3) DCS does not enforce a custodial parent's obligation to provide health insurance coverage or pay a monthly payment toward the premium paid for coverage when:

(a) The support order does not include a medical support obligation which includes providing health insurance ((~~obligation~~)) or paying monthly payment toward the premium paid for coverage for the CP.

(b) The NCP is already providing health insurance coverage for the children covered by the order.

(c) The amount that the CP would have to pay for the premium for health insurance exceeds the NCP's monthly support obligation for the children.

(d) The children are covered by health insurance provided by someone else.

(e) The children are receiving medicaid.

(f) The children are receiving TANF.

(g) The CP does not reside in Washington state.

(h) The CP is a tribal member living on or near the reservation.

(i) The CP is receiving child support enforcement services through a tribal IV-D program.

(((~~(3)~~))) (4) If none of the conditions under subsection (((~~(2)~~))) (3) exist, DCS may enforce the CP's obligation to provide health insurance coverage when the CP has health insurance available at a reasonable cost through the CP's employer or union.

(((~~(4)~~))) (5) A "reasonable cost" for health insurance coverage is defined as twenty-five percent of the basic support

obligation for the children covered by the order, unless the support order provides a different limitation.

AMENDATORY SECTION (Amending WSR 01-03-089, filed 1/17/01, effective 2/17/01)

WAC 388-14A-4115 Can my support order reduce my support obligation if I pay for health insurance? (1) Some support orders reduce the noncustodial parent's ((~~support obligation~~)) transfer payment based on health insurance premiums paid by the noncustodial parent (NCP).

(2) An NCP is entitled to the reduction for premiums paid only if((~~:~~

(~~a)~~)) the NCP submits proof of the cost of coverage ((~~as provided in WAC 388-14A-4110 (1)(b); and~~

(~~b) NCP actually pays the required premium~~)) which is actually being provided at the time the support order is entered, so that the amounts can be included in the worksheet calculation.

(((~~(3) If the NCP fails to submit proof or pay the premium, the division of child support (DCS) collects the NCP's adjusted basic support obligation without a reduction for health insurance premium payments.~~)))

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-4120 DCS uses the National Medical Support Notice to enforce an obligation to provide health insurance coverage. (1) The division of child support (DCS) uses a notice of enrollment called the National Medical Support Notice (NMSN) to enforce an obligated parent's obligation to provide health insurance coverage under chapter 26.18 RCW.

(2) DCS sends the NMSN to the obligated parent's employer in one of the following ways:

(a) In the same manner as a summons in a civil action,

(b) By certified mail, return receipt requested,

(c) By regular mail, or

(d) By electronic means as provided in WAC 388-14A-4040 (1)(d).

(3) DCS sends the NMSN without notice to the obligated parent, who could be either the noncustodial parent (NCP) or the custodial parent (CP) when:

(a) A court or administrative order requires the obligated parent to provide insurance coverage for a dependent child;

(b) The obligated parent fails to provide health insurance (either by not covering the child or by letting the coverage lapse) or fails to provide proof of coverage;

(c) The requirements of RCW 26.23.050 are met; and

(d) DCS has reason to believe that coverage is available through the obligated parent's employer or union.

(4) If sending the NMSN does not result in coverage for the child, DCS may seek to enforce the obligated parent's medical support obligation by other means, as provided in RCW 26.18.170 and WAC 388-14A-4110.

AMENDATORY SECTION (Amending WSR 04-17-119, filed 8/17/04, effective 9/17/04)

WAC 388-14A-4165 What happens when a noncustodial parent does not earn enough to pay child support plus the health insurance premium? (1) Under RCW 26.23.060(3), a payroll deduction may not exceed fifty percent of the noncustodial parent's disposable earnings in each pay period.

(2) When the division of child support (DCS) enforces a child support obligation through an income withholding action and also enforces a health insurance obligation, the noncustodial parent's employer often must withhold amounts for:

(a) Current child support;

(b) Child support arrears; and

(c) Health insurance premiums.

(3) When the employer or plan administrator must enroll the noncustodial parent (NCP) in a health insurance plan in order to enroll the children (see WAC 388-14A-4140), the premium amount for the NCP's coverage is included in the amounts to withhold under subsection (2) above. If the NCP is already enrolled in a plan, the premium amount for the NCP's coverage is not included the amounts to withhold under that subsection.

(4) If the combined amounts for current support, support arrears and health insurance premiums are more than fifty percent of the noncustodial parent's disposable earnings, the employer must notify DCS immediately.

(5) In certain circumstances, DCS may adjust the amount to be withheld for support arrears so that the total amount withheld does not exceed fifty percent of the noncustodial parent's disposable earnings.

(6) If the noncustodial parent's current support obligation plus health insurance premiums exceeds fifty percent of the noncustodial parent's disposable earnings, DCS:

(a) Enforces the child support obligation through income withholding; but

(b) Is not able to enforce the noncustodial parent's health insurance obligation at that time.

(7) In the situation described in subsection (6), DCS may establish a monthly payment toward the premium, as described in WAC 388-14A-3312, even if the combined amount for the current support obligation and the monthly payment toward the premium exceeds fifty percent of the NCP's disposable earnings.

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.

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-4175 ((~~Is an employer~~)) Who is required to notify the division of child support when insurance coverage for the children ends? (1) Once the division of child support (DCS) has notified an employer that a parent is obligated by a support order to provide health insurance coverage for the children named in the order, the National Medical Support Notice (NMSN) or other notice of

enrollment remains in effect as specified in WAC 388-14A-4170.

(2) If coverage for the children is terminated, the employer must notify DCS within thirty days of the date coverage ends.

(3) A parent who is required by a child support order to provide health insurance coverage for his or her children must notify DCS and the other parent within thirty days of the date coverage for the children ends. This requirement applies whether the obligated parent is the custodial parent or the noncustodial parent.

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-4180 When must the division of child support communicate with the DSHS health and recovery services administration? (1) The division of child support (DCS) must inform the DSHS health and recovery services administration (HRSA) of the existence of a new or modified court or administrative order for child support when the order includes a requirement for medical support. HRSA is the part of DSHS which provides services for the state of Washington under Title XIX of the federal Social Security Act.

(2) DCS must provide HRSA with the following information:

(a) Title IV-A case number, Title IV-E foster care case number, medicaid number or the individual's Social Security number;

(b) Name of the obligated parent;

(c) Social Security number of the obligated parent;

(d) Name and Social Security number of the child(ren) named in the order;

(e) Home address of the obligated parent;

(f) Name and address of the obligated parent's employer;

(g) Information regarding the obligated parent's health insurance policy; and

(h) Whether the child(ren) named in the order are covered by the policy.

(3) DCS must periodically communicate with HRSA to determine if there have been any lapses (stops and starts) in the obligated parent's health insurance coverage for medicaid applicants.

(4) Before DCS may serve a notice of support owed for medical support under WAC 388-14A-3312 to establish an obligated parent's monthly payment toward the premium paid by the state for coverage, HRSA must provide information regarding the premium paid for each child covered by the notice.

(a) DCS distributes to HRSA any collections based on the obligation established under WAC 388-14A-3312 when the child receives state-financed medical coverage through the department under chapter 74.09 RCW for which there is an assignment.

(b) Such collections are retained by the department to reimburse the state, subject to the limitations in WAC 388-14A-2035(4).

AMENDATORY SECTION (Amending WSR 09-02-059, filed 1/5/09, effective 1/27/09)

WAC 388-14A-5002 How does DCS distribute support collections in a nonassistance case? (1) A nonassistance case is one where the family has never received a cash public assistance grant.

(2) The division of child support (DCS) applies support collections within each Title IV-D nonassistance case:

(a) First, to satisfy the current support obligation for the month DCS received the collection;

(b) Second, to any current medical support obligation owed to the family;

(c) Third, to the noncustodial parent's support debts owed to the family;

((~~(c) Third~~)) (d) Fourth, to prepaid support as provided for under WAC 388-14A-5008.

(3) DCS uses the fee retained under WAC 388-14A-2200 to offset the fee amount charged by the federal government for IV-D cases that meet the fee criteria in WAC 388-14A-2200(1).

AMENDATORY SECTION (Amending WSR 09-02-059, filed 1/5/09, effective 1/27/09)

WAC 388-14A-5003 How does DCS distribute support collections in an assistance case? (1) An assistance case is one where the family is currently receiving a TANF grant.

(2) The division of child support (DCS) distributes support collections within each Title IV-D assistance case:

(a) First, to satisfy the current support obligation for the month DCS received the collection;

(b) Second, to satisfy any current medical support obligation owed for the month DCS received the collection;

(c) Third, to satisfy support debts which are permanently assigned to the department ((~~to reimburse the cumulative amount of assistance which has been paid to the family~~));

((~~(c) Third~~)) (d) Fourth:

(i) To satisfy support debts which are temporarily assigned to the department to reimburse the cumulative amount of assistance paid to the family; or

(ii) To satisfy support debts which are conditionally assigned to the department. Support collections distributed to conditionally assigned arrears are disbursed according to WAC 388-14A-2039.

((~~(d) Fourth~~)) (e) Fifth, to satisfy support debts owed to the family;

((~~(e) Fifth~~)) (f) Sixth, to prepaid support as provided for under WAC 388-14A-5008.

AMENDATORY SECTION (Amending WSR 09-02-059, filed 1/5/09, effective 1/27/09)

WAC 388-14A-5004 How does DCS distribute support collections in a former assistance case? (1) A former assistance case is one where the family is not currently receiving a TANF grant, but has at some time in the past.

(2) Subject to the exceptions provided under WAC 388-14A-5005, the division of child support (DCS) distributes

support collections within each Title IV-D former-assistance case:

(a) First, to satisfy the current support obligation for the month DCS received the collection;

(b) Second, to satisfy support debts owed to the family;

(c) Third, to satisfy support debts which are conditionally assigned to the department. These collections are disbursed according to WAC 388-14A-2039;

(d) Fourth, to medical support debt owed to the family;

(e) Fifth, to satisfy support debts which are permanently assigned to the department to reimburse the cumulative amount of assistance which has been paid to the family; and

((~~(e) Fifth~~)) (f) Sixth, to prepaid support as provided for under WAC 388-14A-5008.

AMENDATORY SECTION (Amending WSR 09-02-059, filed 1/5/09, effective 1/27/09)

WAC 388-14A-5005 How does DCS distribute federal tax refund offset collections? The division of child support (DCS) distributes federal tax refund offset collections in accordance with 42 U.S.C. Sec. 657, as follows:

(1) First, to satisfy the current support obligation for the month in which DCS received the collection.

(2) Second, DCS distributes any amounts over current support depending on the type of case to which the collection is distributed:

(a) In a never assistance case, all remaining amounts are distributed to family arrears, meaning those arrears which have never been assigned.

(b) In a former assistance case, all remaining amounts are distributed first to family arrears, then to permanently assigned arrears, then to conditionally assigned arrears, and then to assigned medical support arrears.

(c) In a current assistance case, all remaining amounts are distributed first to permanently assigned arrears, then to temporarily assigned arrears (if they exist), then to conditionally assigned arrears, and then to family arrears.

(3) Federal tax refund offset collections distributed to assigned support are retained by the state to reimburse the cumulative amount of assistance which has been paid to the family.

(4) DCS may distribute federal tax refund offset collections only to certified support debts and to current support obligations on cases with certified debts. DCS must refund any excess to the noncustodial parent (NCP).

(5) DCS may retain the twenty-five dollar annual fee required under the federal deficit reduction act of 2005 and RCW 74.20.040 from federal tax refund offset collections distributed to nonassistance cases.

(6) When the Secretary of the Treasury, through the federal Office of Child Support Enforcement (OCSE), notifies DCS that a collection from a federal tax refund offset is from a tax refund based on a joint return, DCS follows the procedures set forth in WAC 388-14A-5010.

AMENDATORY SECTION (Amending WSR 09-02-059, filed 1/5/09, effective 1/27/09)

WAC 388-14A-5006 How does DCS distribute support collections when the paying parent has more than one case? When the NCP has more than one Title IV-D case, the division of child support (DCS) distributes support collections:

(1) First, to the current support obligation on each Title IV-D case, in proportion to the amount of the current support order on each case; and

(2) Second, to the current monthly payment toward the premium, on each Title IV-D case for which a monthly payment toward the premium has been established and is being enforced, in proportion to the amount of the current monthly payment toward the premium owed by the NCP on each case;

(3) Third, to the total of the support debts whether owed to the family or to the department for the reimbursement of public assistance on each Title IV-D case, in proportion to the amount of support debt owed by the NCP on each case; and

((~~(3) Third~~)) (4) Fourth, within each Title IV-D case according to WAC 388-14A-5002, 388-14A-5003, or 388-14A-5004.

AMENDATORY SECTION (Amending WSR 01-24-078, filed 12/3/01, effective 1/3/02)

WAC 388-14A-5007 If the paying parent has more than one case, can DCS apply support money to only one specific case? (1) The division of child support (DCS) applies amounts to a support debt owed for one family or household and distributes the amounts accordingly, rather than make a proportionate distribution between support debts ((~~owned~~)) owed to different families, when:

(a) Proportionate distribution is administratively inefficient; or

(b) The collection resulted from the sale or disposition of a specific piece of property against which a court awarded the custodial parent (CP) a judgment lien for child support; or

(c) The collection is the result of a contempt order which provides that DCS must distribute the amounts to a particular case.

(2) If the collection is the result of an automated enforcement of interstate (AEI) transaction under RCW 74.20A.188, DCS applies the payment as provided in WAC 388-14A-5006, even if the requesting state wants the payment applied to a specific case.

AMENDATORY SECTION (Amending WSR 08-12-029, filed 5/29/08, effective 7/1/08)

WAC 388-14A-6300 Duty of the administrative law judge in a hearing to determine the amount of a support obligation. (1) A support order entered under this chapter must conform to the requirements set forth in RCW 26.09.-105 and 26.18.170, and in RCW 26.23.050 (3) and (5). The administrative law judge (ALJ) must comply with the DSHS rules on child support and include a Washington state child support schedule worksheet when entering a support order.

(2) In hearings held under this chapter to contest a notice and finding of financial responsibility or a notice and finding of parental responsibility or other notice or petition, the ALJ must determine:

(a) The noncustodial parent's obligation to provide support under RCW 74.20A.057;

(b) The names and dates of birth of the children covered by the support order;

(c) The net monthly income of the noncustodial parent (NCP) and any custodial parent (CP);

(d) The NCP's share of the basic support obligation and any adjustments to that share, according to his or her circumstances;

(e) If requested by a party, the NCP's share of any special child-rearing expenses in a sum certain amount per month;

(f) A statement that either or both parents are obligated to provide medical support under RCW 26.09.105 and 26.18.170, including but not limited to the following:

(i) A requirement that either or both parents are obligated to provide health insurance coverage for the child covered by the support order if coverage that can be extended to cover the child is or becomes available through the parent's employment or union;

(ii) Notice that if proof of health insurance coverage or proof that the coverage is unavailable is not provided to DCS within twenty days, DCS may seek direct enforcement through the obligated parent's employer or union without further notice to the parent; and

(iii) The reasons for not ordering health insurance coverage if the order fails to require such coverage;

(g) A provision which determines the mother and the father's proportionate share of uninsured medical expenses;

(h) The NCP's accrued debt and order payments toward the debt in a monthly amount to be determined by the division of child support (DCS);

(i) The NCP's current and future monthly support obligation as a per month per child amount and order payments in that amount; and

(j) The NCP's total current and future support obligation as a sum certain and order payments in that amount.

(3) Having made the determinations required in subsection (2) above, the ALJ must order the NCP to make payments to the Washington state support registry (WSSR).

(4) The ALJ must allow DCS to orally amend the notice at the hearing to conform to the evidence. The ALJ may grant a continuance, when necessary, to allow the NCP or the CP additional time to present rebutting evidence or argument as to the amendment.

(5) The ALJ may not require DCS to produce or obtain information, documents, or witnesses to assist the NCP or CP in proof of defenses to liability. However, this rule does not apply to relevant, nonconfidential information or documents that DCS has in its possession.

(6) In a hearing held on a notice of support owed for medical support issued under WAC 388-14A-3312, the ALJ must determine either or both of the following, depending on what was requested in the notice:

(a) The amount owed by the obligated parent to the other for unreimbursed medical expenses;

(b) The monthly amount to be paid by the obligated parent as his or her proportionate share of the health insurance premium paid by the other parent or the state.

((~~(a)~~)) (7) The ALJ does not specify how the amounts owed by the obligated parent should be paid.

((~~(b)~~)) (8) In the event that DCS has served a notice under WAC 388-14A-3312 on both the NCP and the CP, the ALJ must issue a separate administrative order for each notice issued, and may not set off the debts against each other.

AMENDATORY SECTION (Amending WSR 06-16-073, filed 7/28/06, effective 8/28/06)

WAC 388-14A-8130 How does DCS complete the WSCSS worksheets when setting a joint child support obligation when the parents of a child in foster care are married and residing together? (1) When the division of child support (DCS) is setting a joint support obligation for married parents who reside together, DCS follows the steps set out in this section for completing the worksheets under the Washington state child support schedule (WSCSS).

(2) DCS calculates each parent's income under the rules set out in WAC 388-14A-3205, and then calculates the income of the marital community by combining both parents' income in ((~~the "Father"~~)) one column of the worksheet and does not put any income in the ((~~"Mother"~~)) other column.

(3) DCS calculates the joint support obligation using the limitations contained in RCW 26.19.065:

(a) The joint child support obligation may not exceed forty-five percent of the net income of the marital community except for good cause.

(b) Even ((~~with~~)) though there are two parents involved, DCS uses the one-person amount when determining the ((~~need standard~~)) one hundred twenty-five percent of federal poverty level limitation.

(c) Despite the application of any limitations, there is a presumptive minimum obligation of ((~~twenty-five~~)) fifty dollars per month per child.

(((~~(c)~~))) (d) DCS or the administrative law judge (ALJ) may find reasons for deviation and must support those reasons with appropriate findings of fact in the support order.

(4) As described in subsection (2) of this section, the support obligation in the ((~~"Father"~~)) column of the WSCSS worksheet which contains information regarding both parents is the joint support obligation of the parents. ((~~The support obligation in the "Mother" column of the WSCSS worksheet is irrelevant for purposes of this particular support calculation.~~))

(5) DCS determines the joint support obligation of the parents without regard to the cost of foster care placement, as provided in WAC 388-14A-8105.

WSR 09-22-011
EMERGENCY RULES
DEPARTMENT OF EARLY LEARNING

[Filed October 22, 2009, 11:45 a.m., effective October 22, 2009, 11:45 a.m.]

Effective Date of Rule: Immediately.

Purpose: The department of early learning (DEL) is amending WAC 170-151-230 School-age child care centers, 170-295-3060 Child care centers, and 170-296-0870 Family home child care, regarding the use of hand sanitizer gels with children in DEL-licensed child care. These emergency rules would allow licensed child care providers to use "over-the-

counter" hand sanitizer gels with children over twelve months of age after obtaining written authorization from the child's parent or guardian.

Citation of Existing Rules Affected by this Order: Amending WAC 170-151-230, 170-295-3060, and 170-296-0870.

Statutory Authority for Adoption: RCW 43.215.200.

Other Authority: Chapter 43.215 RCW.

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

Reasons for this Finding: The rule is needed to protect the health and safety of children in DEL-licensed child care to help control the spread of communicable diseases in child care at a time when the presence of pandemic flu - such as the H1N1 "swine flu" virus - is an imminent statewide, national and worldwide concern. According to the federal Centers for Disease Control and Prevention (CDC), in 2009 children under five years old have had the highest hospitalization rate for H1N1 influenza nationwide, and in recent months had the second highest rates of H1N1 infection overall. The CDC also notes that children under two years old also have a highest risk of severe complications from seasonal flu viruses.*

When used after hand washing with soap and warm water, alcohol-based hand sanitizer gels and similarly formulated products are considered effective in limiting the spread of viruses and bacteria. However, these gels are regulated by the United States Food and Drug Administration as over-the-counter (OTC) drugs. Under the current DEL child care licensing rules, OTC drugs are considered "nonprescription medications." The rules list specific nonprescription drugs that may be administered with parent/guardian permission, but the lists do not include hand sanitizing gels. If not listed, the rules require licensed child care centers and school-age centers to obtain a physician's written authorization - specific to the medication and each child - before administering other nonprescription medications. The family home child care rule also does not list hand sanitizers among nonprescription medications that licensed providers may administer with written parent/guardian permission. This creates a barrier to child care providers using OTC hand sanitizer products to help limit the spread of H1N1 and other communicable diseases.

The World Health Organization has issued a Phase 6 pandemic flu alert worldwide for the H1N1 influenza virus, the highest possible alert status. The Washington state department of health (DOH) has filed emergency rules requiring heightened surveillance of H1N1 cases statewide, and DOH has urged DEL to immediately revise its rules regarding the use of alcohol-based OTC hand sanitizer in licensed child care centers during the current outbreak of H1N1 and other influenza.

*Source: "*Technical Report for State and Local Public Health Officials and Child Care and Early Childhood Providers on CDC Guidance on Helping Child Care and Early Learning Programs Respond during the 2009-2010 Influenza Season."* Centers for Disease Control and Prevention. September 4, 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 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 3, 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: October 22, 2009.

Dr. Elizabeth M. Hyde
Director

AMENDATORY SECTION (Amending WSR 06-15-075, filed 7/13/06, effective 7/13/06)

WAC 170-151-230 What requirements must I meet for medication management? You may have a policy of not giving medication to the child in care. If your center's health care plan includes giving medication to the child in care, you:

(1) Must give medications, prescription and nonprescription, only on the written approval of a parent, person, or agency having authority by court order to approve medical care;

(2) Must give prescription medications:

(a) Only as specified on the prescription label; or

(b) As authorized, in writing, by a physician or other person legally authorized to prescribe medication.

(3) Must give the following classifications of nonprescription medications, with written parent authorization, only at the dose, duration, and method of administration specified on the manufacturer's label for the age or weight of the child needing the medication:

(a) Antihistamines;

(b) Nonaspirin fever reducers/pain relievers;

(c) Nonnarcotic cough suppressants;

(d) Decongestants;

(e) Anti-itching ointments or lotions, intended specifically to relieve itching;

(f) Diaper ointments and powders, intended specifically for use in the diaper area of the child; ((~~and~~))

(g) Sun screen; and

(h) Hand sanitizers.

(4) Must give other nonprescription medication:

(a) Not included in the categories listed in subsection (3) of this section; or

(b) Taken differently than indicated on the manufacturer's label; or

(c) Lacking labeled instructions, only when disbursement of the nonprescription medication is as required under subsection (4)(a), (b), and (c) of this section:

(i) Authorized, in writing, by a physician; or

(ii) Based on established medical policy approved, in writing, by a physician or other person legally authorized to prescribe medication.

(5) Must accept from the child's parent, guardian, or responsible relative only medicine in the original container, labeled with:

(a) The child's first and last names;

(b) The date the prescription was filled; or

(c) The medication's expiration date; and

(d) Legible instructions for administration, such as manufacturer's instructions or prescription label.

(6) Must keep medication, refrigerated or nonrefrigerated, in an orderly fashion and inaccessible to the child;

(7) Must store external medication in a compartment separate from internal medication;

(8) Must keep a record of medication disbursed;

(9) Must return to the parent or other responsible party, or must dispose of medications no longer being taken; and

(10) May, at your option, permit self-administration of medication by a child in care if:

(a) The child is physically and mentally capable of properly taking medication without assistance;

(b) You include in the child's file a parental or physician's written statement of the child's capacity to take medication without assistance; and

(c) You have stored the child's medications and other medical supplies so the medications and medical supplies are inaccessible to other children in care.

AMENDATORY SECTION (Amending WSR 06-15-075, filed 7/13/06, effective 7/13/06)

WAC 170-295-3060 Who can provide consent for me to give medication to the children in my care? (1) Parents must give written consent before you give any child any medication. The parent's written consent must include:

(a) Child's first and last name;

(b) Name of medication;

(c) Reason for giving medication;

(d) Amount of medication to give;

(e) How to give the medication (route);

(f) How often to give the medication;

(g) Start and stop dates;

(h) Expected side effects; and

(i) How to store the medication consistent with directions on the medication label.

(2) The parent consent form is good for the number of days stated on the medication bottle for prescriptions. You may not give medication past the days prescribed on the medication bottle even if there is medication left.

(3) You may give the following medications with written parent consent if the medication bottle label tells you how much medication to give based on the child's age and weight:

(a) Antihistamines;

(b) Nonaspirin fever reducers/pain relievers;

(c) Nonnarcotic cough suppressants;

(d) Decongestants;

(e) Ointments or lotions intended to reduce or stop itching or dry skin;

(f) Diaper ointments and nontalc powders, intended only for use in the diaper area; ((~~and~~))

(g) Sun screen for children over six months of age; and

(h) Hand sanitizers for children over twelve months of age.

(4) All other over the counter medications must have written directions from a health care provider with prescriptive authority before giving the medication.

(5) You may not mix medications in formula or food unless you have written directions to do so from a health care provider with prescriptive authority.

(6) You may not give the medication differently than the age and weight appropriate directions or the prescription directions on the medication label unless you have written directions from a health care provider with prescriptive authority before you give the medication.

(7) If the medication label does not give the dosage directions for the child's age or weight, you must have written instructions from a health care provider with prescriptive authority in addition to the parent consent prior to giving the medication.

(8) You must have written consent from a health care provider with prescriptive authority prior to providing:

(a) Vitamins;

(b) Herbal supplements; and

(c) Fluoride.

AMENDATORY SECTION (Amending WSR 06-15-075, filed 7/13/06, effective 7/13/06)

WAC 170-296-0870 How do I manage medications for children? You must meet specific requirements for managing prescription and nonprescription medication for children under your care. Only you or another, primary staff person may perform the functions described in this section.

(1) You must have written approval of the child's parent or legal guardian to give the child any medication. This approval must not exceed thirty days.

(2) You must:

(a) Keep a written record of all medications you give a child;

(b) Return any unused medication to the parent or legal guardian of the child;

(c) Give certain classifications of nonprescription medications, only with the dose and directions on the manufacturer's label for the age or weight of the child needing the medication. These nonprescribed medications include but are not limited to:

(i) Nonaspirin, fever reducers or pain relievers;

(ii) Nonnarcotic cough suppressants;

(iii) Decongestants;

(iv) Anti-itching ointments or lotions intended specifically to relieve itching;

(v) Diaper ointments and talc free powders intended specifically for use in the diaper area of children; ((~~and~~))

(vi) Sun screen; and

(vii) Hand sanitizers for children over twelve months of age.

(3) You must not administer any nonprescribed medication for the purpose of sedating a child;

(4) You must not administer any prescribed medication in an amount or frequency other than that prescribed by a physician, psychiatrist or dentist;

(5) You must not give one child's medications to another child; and

(6) You must not use any prescribed medication to control a child's behavior unless a physician prescribes the medication for management of the child's behavior.

WSR 09-22-028
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed October 27, 2009, 8:34 a.m., effective October 28, 2009]

Effective Date of Rule: October 28, 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. The department plans to file a proposed rule-making notice in November of this 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 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: October 21, 2009.

Stephanie E. Vaughn
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~~)) six and one-half or less percent of the county's allocated funds for county administrative expenses. A county may utilize more than ((~~seven~~)) six and one-half 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 09-22-029

EMERGENCY RULES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(Health and Recovery Services Administration)

[Filed October 27, 2009, 8:35 a.m., effective October 28, 2009]

Effective Date of Rule: October 28, 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 operating budget 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. This emergency filing is necessary to continue the current emergency rules filed as WSR 09-14-086 on June 30, 2009, while the department prepares drafts of the permanent rule to share with providers for their input. Following this, the department plans to formally adopt the permanent rules in early 2010.

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: October 19, 2009.

Stephanie E. Vaughn

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 January 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:

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

(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 09-22-030
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed October 27, 2009, 8:38 a.m., effective October 28, 2009]

Effective Date of Rule: October 28, 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.

Other Authority: 42 U.S.C. 1396a(bb), RCW 74.09.510, 74.09.522, 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. This emergency filing is necessary to continue the current emergency rules filed as WSR 09-14-085 on June 30, 2009, while the department completes the permanent rule-making process. The permanent rules are currently at external review. The department anticipates filing the CR-102 for public hearing within the month of December 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: October 16, 2009.

Stephanie E. Vaughn
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.

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: October 16, 2009.

Stephanie E. Vaughn
Rules Coordinator

WSR 09-22-031
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed October 27, 2009, 8:41 a.m., effective October 28, 2009]

Effective Date of Rule: October 28, 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 operating budget the 2009-2011 final legislative budget.

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.

Other Authority: Chapter 564, Laws of 2009 (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 fully meet the legislatively-mandated appropriation reduction for the DME program for fiscal years 2010-2011. This emergency filing is necessary to continue the current emergency rule filed as WSR 09-14-083 on June 30, 2009, while the department completes the permanent rule-making process. The permanent rule has been proposed under WSR 09-20-063 and the public hearing is scheduled for November 10, 2009. The department anticipates adopting the permanent rule in early 2010.

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) in the medical assistance fee schedule using one or more of the following:

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

~~(b) Manufacturers' catalogs and commercial data bases for price comparisons~~)) The 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 (CMS).

(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~~)) The department's pricing cluster is made up of all the brands for which the department obtains pricing information. 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 when establishing the pricing cluster:

(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 per 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 09-22-032
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed October 27, 2009, 8:43 a.m., effective October 28, 2009]

Effective Date of Rule: October 28, 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 disproportionate share hospital (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: Chapter 564, Laws of 2009 (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 fully meet the legislatively-mandated appropriation reduction for inpatient and outpatient hospital services for fiscal years 2010-2011. This emergency filing is necessary to continue the current emergency rule filed as WSR 09-14-088 on June 30, 2009, while the department prepares drafts for the permanent rule to share with providers for their input. Following this, the department plans to formally adopt the permanent rules in early 2010.

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: October 14, 2009.

Stephanie E. Vaughn
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 pay-

ments 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 09-22-033
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed October 27, 2009, 8:46 a.m., effective October 28, 2009]

Effective Date of Rule: October 28, 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 twenty percent 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 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 388-533-0315, 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: Chapter 564, Laws of 2009 (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: This emergency filing is necessary to continue the current emergency rule for sections in chapter 388-533 WAC with respect to maternity support services, filed as WSR 09-14-091 on June 30, 2009, while the department researches comments received from stakeholders on this rule during the regular rule-making process. Following this, the department plans to formally adopt the permanent rule in early 2010.

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: October 16, 2009.

Stephanie E. Vaughn
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 09-22-034
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed October 27, 2009, 8:50 a.m., effective October 28, 2009]

Effective Date of Rule: October 28, 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 twenty percent 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: Chapter 564, Laws of 2009 (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: This emergency filing is necessary to continue the current emergency rule for sections in chapter 388-533 WAC with respect to infant case management services, filed as WSR 09-14-092 on June 30, 2009, while the department researches comments received from stakeholders on this rule during the permanent rule-making process. Following this, the department plans to formally adopt the permanent rule in early 2010.

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: October 6, 2009.

Stephanie E. Vaughn
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 09-22-035
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)

[Filed October 27, 2009, 8:51 a.m., effective October 28, 2009]

Effective Date of Rule: October 28, 2009.

Purpose: These amendments are required to meet the 2009-2011 final legislative budget reductions in 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 ESHB 1244 for the durable medical equipment (DME) for fiscal years 2010-2011. This emergency filing is necessary to continue the current emergency rule filed as WSR 09-14-090 on June 30, 2009, while the department completes the permanent rule-making process. The CR-102 is filed and the public hearing is scheduled for October 27, 2009. Following this, the department plans to formally adopt the permanent rule in early 2010.

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: October 14, 2009.

Stephanie E. Vaughn
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 09-23 issue of the Register.

WSR 09-22-036
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed October 27, 2009, 9:21 a.m., effective October 28, 2009]

Effective Date of Rule: October 28, 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. This emergency filing is necessary to continue the current emergency rules filed as WSR 09-14-087 on June 30, 2009, while the department completes the permanent rule-making process. The department has completed the external stakeholder review and is preparing to file the CR-102 (proposed rule making) for public hearing. Following this, the department anticipates adopting the permanent rules in early 2010.

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: October 14, 2009.

Stephanie E. Vaughn
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 09-22-037
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed October 27, 2009, 9:23 a.m., effective October 28, 2009]

Effective Date of Rule: October 28, 2009.

Purpose: Under sections 201 and 209, chapter 564, Laws of 2009 (ESHB 1244) 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 endo-

dontic 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: Sections 201 and 209, chapter 564, Laws of 2009 (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. This emergency filing is necessary to continue the current emergency rules filed as WSR 09-14-093 on June 30, 2009, while the department prepares drafts for the permanent rule to share with providers for their input. Following this, the department plans to formally adopt the permanent rules in early 2010.

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: October 14, 2009.

Stephanie E. Vaughn
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 09-23 issue of the Register.

WSR 09-22-038
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed October 27, 2009, 9:25 a.m., effective October 28, 2009]

Effective Date of Rule: October 28, 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 litigation.

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

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

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

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 09-07-039. The department proposed the rule as WSR 09-15-161 and held a public hearing on August 25, 2009, and received no public comment.

The department filed an initial emergency as WSR 09-14-084 on June 30, 2009. The department is requesting to have this emergency rule extended pending the outcome of litigation. For the current status of the litigation contact Meredith Kelly at (360) 725-3524.

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: October 9, 2009.

Stephanie E. Vaughn
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 09-22-039
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 09-248—Filed October 27, 2009, 1:57 p.m., effective October 28, 2009]

Effective Date of Rule: October 28, 2009.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-07300G; and amending WAC 220-52-073.

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: Harvestable amounts of red and green sea urchins exist in the areas described. Prohibiting all diving from licensed sea urchin harvest vessels within Sea Urchin District 3 when those vessels have red sea urchin on-board discourages the taking of red urchins from the district (currently closed to red urchin harvest) and reporting the catch to the adjacent harvest district. Prohibiting transport of urchins from Districts 1 and 2 to other districts will prevent spoiling of product, promote accurate catch accounting, and provide for an orderly fishery. Prohibition of all diving from licensed sea urchin harvest vessels prior to scheduled sea urchin openings discourages the practice of fishing on closed days and hiding the unlawful catch underwater until the legal opening. There is insufficient time to promulgate 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: October 27, 2009.

Philip Anderson
Director

NEW SECTION

WAC 220-52-07300H Sea urchins. Notwithstanding the provisions of WAC 220-52-073, effective October 28, 2009, until further notice, it is unlawful to take or possess sea urchins taken for commercial purposes except as provided for in this section:

(1) Green sea urchins: Sea Urchin Districts 1 and 2 are open only on Monday through Thursday of each week. The maximum daily landing of green sea urchins allowed in Sea Urchin Districts 1 and 2 is 1,000 pounds per valid designated sea urchin harvest license. Sea Urchin Districts 3, 4, 6, and 7 are open only on Monday through Friday of each week.

(2) Red sea urchins: Sea Urchin Districts 1, 2, and 4 are open only on Monday through Friday of each week.

(3) It is unlawful to dive for any purpose from a commercially licensed sea urchin fishing vessel in Sea Urchin District 3 when the vessel has red sea urchins on-board.

(4) Red and green sea urchins harvested in Sea Urchin Districts 1 and 2 must be landed within Sea Urchin Districts 1 and 2.

(5) It is unlawful to dive for any purpose from a commercially licensed sea urchin fishing vessel on Saturday and Sunday of each week, except by written permission from the Director.

REPEALER

The following section of the Washington Administrative Code is repealed effective October 28, 2009:

WAC 220-52-07300G Sea urchins. (09-206)

WSR 09-22-041

EMERGENCY RULES

DEPARTMENT OF FISH AND WILDLIFE

[Order 09-247—Filed October 27, 2009, 3:14 p.m., effective November 1, 2009, 8:00 a.m.]

Effective Date of Rule: November 1, 2009, 8:00 a.m.

Purpose: Amend personal use fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-33000F and 220-56-33000G; and amending WAC 220-56-330.

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: This rule reopens the recreational crab fishery and adjusts the open days per week. Available harvest shares allow the areas to be opened in this rule. The quota has been reached in Marine Area 12. 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 Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 27, 2009.

Philip Anderson

Director

NEW SECTION

WAC 220-56-33000G Crab—Areas and seasons. Notwithstanding the provisions of WAC 220-56-330, it is unlawful to fish for or possess crab taken for personal use from Puget Sound, with the following exceptions:

(1) Effective 8:00 a.m. November 1, 2009, through 5:00 p.m. January 2, 2010, a person may fish for crab seven days a week for personal use in Marine Area 4 east of the Bonilla-Tatoosh line; Marine Area 5; that portion of Marine Area 9 north and east of a line projected from Foulweather Bluff to Olele Point; Marine Area 10; and Marine Area 13.

REPEALER

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

WAC 220-56-33000F	Crab—Areas and seasons. Order Number 09-232.

The following section of the Washington Administrative Code is repealed effective 5:01 p.m. January 2, 2010:

WAC 220-56-33000G	Crab—Areas and seasons.

WSR 09-22-042

EMERGENCY RULES

DEPARTMENT OF FISH AND WILDLIFE

[Order 09-249—Filed October 27, 2009, 4:04 p.m., effective October 27, 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 (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 220-33-01000U and 220-33-01000V; 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 final non-Indian commercial fishing periods targeting coho in lower river and chinook in the upper river. No sturgeon retention. Harvestable salmon remain available. The lower boundary at Zone 2 with the Grays River sanctuary is intended to provide additional protection for Grays River chum salmon. All seasons are consistent with the 2008-2017 *U.S. v. Oregon* management agreement, the 2009 non-Indian salmon allocation agreement, and the 2006-2009 sturgeon accord. The regulation is

consistent with compact action of October 26, 2009. There is insufficient time to promulgate permanent rules.

Washington and Oregon jointly regulate Columbia River fisheries under the congressionally ratified Columbia River compact. Four Indian tribes have treaty fishing rights in the Columbia River. The treaties preempt state regulations that fail to allow the tribes an opportunity to take a fair share of the available fish, and the states must manage other fisheries accordingly. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969). A 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 ESA. 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 ESA, and commission guidelines. Because conditions change rapidly, the fisheries are managed almost exclusively by emergency rule. Representatives from the Washington (WDFW) and Oregon (ODFW) departments of fish and wildlife convene public hearings and take public testimony when considering proposals for new emergency rules. WDFW and ODFW then adopt regulations reflecting agreements reached.

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 0, Repealed 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: October 27, 2009.

Philip Anderson
Director

NEW SECTION

WAC 220-33-01000V Columbia River season below Bonneville. Notwithstanding the provisions of WAC 220-33-010 and WAC 220-33-020, it is unlawful for a person to take or possess salmon or sturgeon for commercial purposes from Columbia River Salmon Management and Catch Reporting Areas (SMCRA) 1A, 1B, 1C, 1D, and 1E, except as provided in the following subsections.

(1) Mainstem Columbia River

(a) SEASON: 7:00 PM October 27 to 7:00 AM October 28, 2009

(b) AREA: SMCRA 1D and 1E (Zones 4 - 5)

(c) GEAR: 8-inch minimum mesh size. Drift gillnets only. Monofilament gear is allowed.

(d) SANCTUARIES: Lewis-A, Sandy, and Washougal rivers.

(e) ALLOWABLE SALES: Salmon.

(2) Mainstem Columbia River

(a) SEASON: 7:00 AM to 7:00 PM October 28, 2009

(b) AREA: SMCRA 1B, 1C (Zones 2 - 3)

(c) GEAR: No minimum mesh size. Drift gillnets only. Monofilament gear is allowed.

(d) SANCTUARIES: Elokomin-A, Cowlitz, Kalama-A, Lewis-A

(e) ALLOWABLE SALES: Salmon.

(3) Blind Slough/Knappa Slough Select Area.

(a) SEASON: Monday, Tuesday, Wednesday, and Thursday nights immediately through October 30, 2009. Open hours are 6 PM - 8 AM.

(b) AREA: Blind Slough and Knappa Slough. An area closure of an approximately 100-foot radius at the mouth of Big Creek is defined by markers. Concurrent jurisdiction waters include all areas in Knappa Slough and downstream of the Railroad Bridge in Blind Slough.

(c) GEAR: 9 3/4-inch maximum mesh size. Gillnet. Monofilament gear is allowed. Maximum net length of 100 fathoms. No weight restriction on lead line. Use of additional weights or anchors attached directly to the lead line is allowed. Nets not specifically authorized for use in this fishery may be onboard the vessel if properly stored. A properly stored net is defined as a net on a drum that is fully covered by a tarp (canvas or plastic) and bound with a minimum of ten revolutions of rope with a diameter of 3/8 (0.375) inches or greater.

(d) ALLOWABLE SALES: Salmon.

(4) Tongue Point/South Channel Select Area.

(a) SEASON: Monday, Tuesday, Wednesday, and Thursday nights immediately through October 30, 2009. Open hours 4 PM - 8 AM.

(b) AREA: Tongue Point and South Channel. All waters in this fishing area are concurrent jurisdiction waters.

(c) GEAR: 6-inch maximum mesh. Gillnet. Monofilament gear is allowed. In the Tongue Point area: Net length maximum of 250 fathoms. Weight not to exceed two pounds on any one fathom on the lead line. Participants in the Tongue Point fishery may have stored onboard their boats gill nets of legal mesh size but with leadline in excess of two pounds per any one fathom. South Channel area: Net length maximum of 100 fathoms. No weight restriction on lead line. Use of additional weights or anchors attached directly to the lead line is allowed.

(d) ALLOWABLE SALES: Salmon.

(5) Deep River Select Area.

(a) SEASON: Monday, Tuesday, Wednesday and Thursday nights immediately through October 30, 2009. Open hours 4 PM - 9 AM.

(b) AREA: The Deep River Select Area. Concurrent jurisdiction waters extend downstream of the Highway 4 Bridge.

(c) GEAR: 6-inch maximum mesh. Gill net. Monofilament gear is allowed. Net length maximum of 100 fathoms, and no weight restriction on the lead line. Use of additional weights or anchors attached directly to the lead line is allowed. Nets may not be tied off to stationary structures. Nets may not fully cross the navigation channel.

(d) ALLOWABLE SALES: Salmon.

(6) Quick Report: 24-hour quick reporting required for Washington wholesale dealers, pursuant to WAC 220-69-240. When quick reporting is required, Columbia River reports must be submitted within 24 hours of the closure of each fishing period. This quick-reporting requirement applies to all seasons described above (Columbia River and Select Areas).

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-33-01000U	Columbia River season below Bonneville (09-237)

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

WAC 220-33-01000V	Columbia River season below Bonneville.

WSR 09-22-049
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 09-251—Filed October 29, 2009, 10:13 a.m., effective November 4, 2009, 12:01 p.m.]

Effective Date of Rule: November 4, 2009, 12:01 p.m.

Purpose: Amend personal use fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-36000Y; and amending WAC 220-56-360.

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: Survey results show that adequate clams are available for harvest in Razor Clam Areas 1 and 2. Washington department of health certified clams from these beaches to be safe for human consumption. 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: October 29, 2009.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 220-56-36000Y Razor clams—Areas and seasons. Notwithstanding the provisions of WAC 220-56-360, it is unlawful to dig for or possess razor clams taken for personal use from any beach in Razor Clam Areas 1, 2, or 3, except as provided for in this section:

1. Effective 12:01 p.m. November 4 through 11:59 p.m. November 4, 2009, and 12:01 p.m. November 6 through 11:59 p.m. November 7, 2009, razor clam digging is allowed in Razor Clam Area 1. Digging is allowed from 12:01 p.m. to 11:59 p.m. only.

2. Effective 12:01 p.m. November 4 through 11:59 p.m. November 7, 2009, razor clam digging is allowed in Razor Clam Area 2. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

3. It is unlawful to dig for razor clams at any time in Long Beach, Twin Harbors Beach or Copalis Beach Clam sanctuaries defined in WAC 220-56-372.

REPEALER

The following section of the Washington Administrative Code is repealed effective 12:01 a.m. November 8, 2009:

WAC 220-56-36000Y	Razor clams—Areas and seasons.

WSR 09-22-055
EMERGENCY RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Health and Recovery Services Administration)
[Filed October 30, 2009, 10:13 a.m., effective November 1, 2009]

Effective Date of Rule: November 1, 2009.

Purpose: These amendments are required to meet the 2009-2011 final legislative budget reductions in sections 201 and 209 of ESHB 1244. Specifically, the department will restrict alien medical services to a federal emergency services component and limit state-only coverage to end-stage renal dialysis, cancer treatment, and nursing facility care.

Citation of Existing Rules Affected by this Order: Amending WAC 388-438-0110.

Statutory Authority for Adoption: RCW 74.04.050, 74.08.090.

Other Authority: Section 1109, chapter 564, Laws of 2009 (ESHB 1244, sections 201 and 209).

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 ESHB 1244 for the alien emergency medical program for state fiscal years 2010-2011. A preproposal statement of inquiry (CR-101) has been filed under WSR 09-18-057 to initiate the permanent rule-making process.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 3, 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 3, Amended 1, Repealed 0.

Date Adopted: October 16, 2009.

Stephanie E. Vaughn
Rules Coordinator

AMENDATORY SECTION (Amending WSR 07-07-024, filed 3/9/07, effective 4/9/07)

WAC 388-438-0110 ((~~The~~)) Alien ((~~emergency~~)) medical (((~~(AEM)~~))) program. (1) ((~~The alien emergency medical (AEM) program is a required federally funded program. It is for aliens who are ineligible for other medicaid programs, due to the citizenship or alien status requirements described in WAC 388-424-0010.~~

(2) ~~Except for the Social Security number, citizenship, or alien status requirements, an alien must meet categorical medicaid eligibility requirements as described in:~~

(a) ~~WAC 388-505-0110, for an SSI-related person;~~

(b) ~~WAC 388-505-0220, for family medical programs;~~

(c) ~~WAC 388-505-0210, for a child under the age of nineteen; or~~

(d) ~~WAC 388-523-0100, for medical extensions.~~

(3) ~~When an alien has monthly income that exceeds the CN medical standards, the department will consider AEM medically needy coverage for children or for adults who are age sixty-five or over or who meet SSI disability criteria. See WAC 388-519-0100.~~

(4) ~~To qualify for the AEM program, the alien must meet one of the criteria described in subsection (2) of this section and have a qualifying emergency medical condition as described in WAC 388-500-0005.~~

(5) ~~The alien's date of arrival in the United States is not used when determining eligibility for the AEM program.~~

(6) ~~The department does not deem a sponsor's income and resources as available to the client when determining eligibility for the AEM program. The department counts only the income and resources a sponsor makes available to the client.~~

(7) ~~Under the AEM program, covered services are limited to those medical services necessary for treatment of the person's emergency medical condition. The following services are not covered:~~

(a) ~~Organ transplants and related services;~~

(b) ~~Prenatal care, except labor and delivery;~~

(c) ~~School-based services;~~

(d) ~~Personal care services;~~

(e) ~~Waiver services;~~

(f) ~~Nursing facility services, unless they are approved by the department's medical consultant; and~~

(g) ~~Hospice services, unless they are approved by the department's medical consultant.~~

(8) ~~The medical service limitations and exclusions described in subsection (7) also apply under the MN program.~~

(9) ~~A person determined eligible for the AEM program is certified for three months. The number of three-month certification periods is not limited, but, the person must continue to meet eligibility criteria in subsection (2) and (4) of this section.~~

(10) ~~A person is not eligible for the AEM program if that person entered the state specifically to obtain medical care~~)) To qualify for an alien medical or long-term care (AMLTC) program a person must:

(a) Be ineligible for medicaid or other DSHS medical program due to the citizenship or alien status requirements described in WAC 388-424-0010;

(b) Meet the requirements described in WAC 388-438-0115, 388-438-0120, or 388-438-0125; and

(c) Meet categorical eligibility criteria for one of the following programs, except for the social security number, citizenship, or alien status requirements:

(i) WAC 388-475-0050, for an SSI-related person;

(ii) WAC 388-505-0220, for family medical programs;

(iii) WAC 388-505-0210, for a child under the age of nineteen;

(iv) WAC 388-462-0015, for a pregnant woman;

(v) WAC 388-462-0020, for the breast and cervical cancer treatment program for women; or

(vi) WAC 388-523-0100, for medical extensions.

(2) AMLTC medically needy (MN) coverage is available for children, adults age sixty-five or over, or persons who meet SSI disability criteria. See WAC 388-519-0100 for MN eligibility and 388-519-0110 for spending down excess income under the MN program.

(3) The department does not consider a person's date of arrival in the United States when determining eligibility for AMLTC.

(4) The department does not consider a sponsor's income and resources when determining eligibility for AMLTC, unless the sponsor makes the income or resources available.

(5) A person is not eligible for AMLTC if that person entered the state specifically to obtain medical care.

(6) A person who the department determines is eligible for AMLTC may be eligible for retroactive coverage as described in WAC 388-416-0015.

(7) Once the department determines financial and categorical eligibility for AMLTC, the department then determines whether a person meets the requirements described in WAC 388-438-0015, 388-438-0120, or 388-438-0125.

NEW SECTION

WAC 388-438-0115 Alien emergency medical program (AEM). (1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 388-438-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets (a) and (b) below, or (c) below:

(a) The department's health and recovery services administration (HRSA) determines that the primary condition requiring treatment meets the definition of an emergency medical condition as defined in WAC 388-500-0005, and the condition is confirmed through review of clinical records; and

(b) The person's qualifying emergency medical condition is treated in one of the following hospital settings:

(i) Inpatient;

(ii) Outpatient surgery;

(iii) Emergency room services, which must include an evaluation and management (E&M) visit by a physician; or

(c) An Involuntary Treatment Act (ITA) or voluntary inpatient community hospital psychiatric admission prior authorized by the department's inpatient mental health designee.

(2) If a person meets the criteria in subsection (1), the department will cover and pay for all related medically necessary health care services and professional services provided during this specific emergency room visit, outpatient surgery or inpatient admission. These services include, but are not limited to:

(a) Medications;

(b) Laboratory, x-ray, and other diagnostics and the professional interpretations;

(c) Medical equipment and supplies;

(d) Anesthesia, surgical, and recovery services;

(e) Physician consultation, treatment, surgery, or evaluation services;

(f) Therapy services;

(g) Emergency medical transportation; and

(h) Non-emergency ambulance transportation to transfer the person from a hospital to a long term acute care (LTAC) or an inpatient physical medicine and rehabilitation (PM&R) unit, if that admission is prior authorized by the department as described in subsection (3) of this section.

(3) The department will cover admissions to an LTAC facility or an inpatient PM&R unit if:

(a) The original admission to the community hospital meets the criteria as described in subsection (1) of this section;

(b) The person is transferred directly to this facility from the community hospital; and

(c) The admission is prior authorized according to LTAC and PM&R program rules (see WAC 388-550-2590 for LTAC and WAC 388-550-2561 for PM&R).

(4) The department does not cover any services, regardless of setting, once the person is discharged from the hospital after being treated for a qualifying emergency medical condition authorized by the department under this program. Exception: Pharmacy services prescribed on the same day and associated with the qualifying visit or service (as described in subsection (1) of this section) will be covered and retrospectively reimbursed according to pharmacy program rules.

(5) Inpatient psychiatric care must be prior authorized by the department's inpatient mental health designee according to the requirements in WAC 388-550-2600.

(6) There is no precertification or prior authorization for eligibility under this program.

(7) Under this program, certification is only valid for the period of time the person is receiving services under the criteria described in subsection (1) of this section.

(a) For inpatient care, the period of eligibility is only for the period of time the person is in the hospital, LTAC, or PM&R facility - the admission date through the discharge date. Upon discharge the person is no longer eligible for coverage.

(b) For an outpatient surgery or emergency room service the period of eligibility is only for the date of service. If the person is in the hospital overnight, the eligibility period will be the admission date through the discharge date. Upon release from the hospital, the person is no longer eligible for coverage.

(8) Under this program, any visit or service not meeting the criteria described in subsection (1) of this section is not within the scope of covered services as described in WAC 388-501-0060. This includes, but is not limited to:

(a) Hospital services, care, surgeries, or inpatient admissions to treat any condition which is not considered by the department to be a qualifying emergency medical condition, including but not limited to:

(i) Laboratory x-ray, or other diagnostic procedures;

(ii) Physical, occupational, speech therapy, or audiology services;

(iii) Hospital clinic services; or

(iv) Emergency room visits, surgery, or hospital admissions.

(b) Any services provided during a hospital admission or visit (meeting the criteria described in subsection (1) of this section), which are not related to, or consistent with best practices in treating, the qualifying emergency medical condition;

(c) Organ transplants, including preevaluations and post operative care;

(d) Services provided outside the hospital settings described in subsection (1) of this section, including but not limited to:

(i) Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner;

(ii) Prenatal care, except labor and delivery;

(iii) Laboratory, radiology, and any other diagnostic testing;

(iv) School-based services;

(v) Personal care services;

(vi) Physical, respiratory, occupational, and speech therapy services;

(vii) Waiver services;

(viii) Nursing facility services;

(ix) Home health services;

(x) Hospice services;

(xi) Vision services;

(xii) Hearing services;

(xiii) Dental services;

(xiv) Durable and non durable medical supplies;

(xv) Non-emergency medical transportation;

(xvi) Interpreter services; and

(xvii) Pharmacy services, except as described in subsection (4).

(9) The services listed in subsection (8) of this section are not part of the scope of covered services for this program and therefore the exception to rule process is not available.

(10) Providers must not bill the department for visits or services that do not meet the qualifying criteria described in this section. The department will identify and recover payment for claims paid in error.

NEW SECTION

WAC 388-438-0120 Alien medical for dialysis and cancer treatment (state-only). (1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 388-438-0110 may be eligible for the scope of covered services under this program if the condition requires:

(a) Surgery, chemotherapy, and/or radiation therapy to treat cancer;

(b) Dialysis to treat acute renal failure or end stage renal disease (ESRD); or

(c) Anti-rejection medication, if the person has had an organ transplant.

(2) When related to treating the qualifying medical condition, covered services include but are not limited to:

(a) Physician and ARNP services, except when providing a service that is not within the scope of this medical program (as described in subsection (7) of this section);

(b) Inpatient and outpatient hospital care;

(c) Dialysis;

(d) Surgical procedures and care;

(e) Office or clinic based care;

(f) Pharmacy services;

(g) Laboratory, x-ray, or other diagnostic studies;

(h) Oxygen services;

(i) Respiratory and intravenous (IV) therapy;

(j) Anesthesia services;

(k) Hospice services;

(l) Home health services, limited to two visits;

(m) Durable and non durable medical equipment;

(n) Non-emergency transportation; and

(o) Interpreter services.

(3) All hospice, home health, durable and non durable medical equipment, oxygen and respiratory, IV therapy, and dialysis for acute renal disease services require prior authorization. Any prior authorization requirements applicable to the other services listed above must also be met according to specific program rules.

(4) To be qualified and eligible for coverage for cancer treatment under this program, the diagnosis must be already established or confirmed. There is no coverage for cancer screening or diagnostics for a workup to establish the presence of cancer.

(5) Coverage for dialysis under this program starts the date the person begins dialysis treatment, which may include fistula placement. There is no coverage for diagnostics or pre-dialysis intervention, such as surgery for fistula placement anticipating the need for dialysis, or any services related to preparing for dialysis.

(6) Certification for eligibility will range between one to twelve months depending on the qualifying condition.

(7) The following are not included in the scope of covered services of this program:

(a) Cancer screening or work-ups to detect or diagnose the presence of cancer;

(b) Fistula placement while the person waits to see if dialysis will be required;

(c) Services by any healthcare professional provided to treat a condition not related to, or required to, treat the qualifying condition;

(d) Organ transplants, including preevaluations and post operative care;

(e) Health department services;

(f) School-based services;

(g) Personal care services;

(h) Physical, occupational, and speech therapy services;

(i) Audiology services;

(j) Neurodevelopmental services;

(k) Waiver services;

(l) Nursing facility services;

(m) Home health services, more than two visits;

(n) Vision services;

(o) Hearing services;

(p) Dental services, unless prior authorized and directly related to dialysis or cancer treatment;

(q) Mental health services;

(r) Podiatry services;

(s) Substance abuse services; and

(t) Smoking cessation services.

(8) The services listed in subsection (7) of this section are not part of the scope of covered services for this program and therefore the exception to rule process is not available.

(9) Providers must not bill the department for visits or services that do not meet the qualifying criteria described in this section. The department will identify and recover payment for claims paid in error.

NEW SECTION

WAC 388-438-0125 Alien nursing facility program (state-funded). (1) To be eligible for the state-funded alien nursing facility program described in this section, an adult nineteen years of age or older must meet all of the following conditions:

(a) Have prior approval authorized by the department's aging and disability services administration (ADSA);

(b) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a), (b), (e), and (f);

(c) Reside in a nursing facility as defined in WAC 388-97-0001;

(d) Attain institutional status as described in WAC 388-513-1320;

(e) Meet the functional eligibility described in WAC 388-106-0355 for nursing facility level of care;

(f) Not have a penalty period due to a transfer of assets as described in WAC 388-513-1363, 388-513-1364, 388-513-1365 and 388-513-1366;

(g) Equity interest in a primary residence must be less than five hundred thousand dollars as described in WAC 388-513-1350; and

(h) Annuities owned by the adult or spouse must meet the requirements described in chapter 388-561 WAC.

(2) An adult who is related to the supplemental security income (SSI) program as described in WAC 388-475-0050 (1), (2), and (3) must meet the financial requirements described in WAC 388-513-1325, 388-513-1330, and 388-513-1350.

(3) An adult who does not meet the SSI-related criteria in subsection (2) of this section may be eligible under the family institutional medical program rules described in WAC 388-505-0250 or 388-505-0255.

(4) An adult who is not eligible for CN coverage may qualify for medically needy (MN) coverage under the state-funded alien nursing facility program described in:

(a) WAC 388-513-1395 for adults related to SSI; or

(b) WAC 388-505-0255 for adults related to family institutional medical.

(5) All adults qualifying for the state-funded alien nursing facility program will receive either CN scope of medical coverage described in WAC 388-501-0060.

(6) The department determines how much an individual is required to pay toward the cost of care using the following rules:

(a) For an SSI-related individual, see rules described in WAC 388-513-1380.

(b) For an individual eligible under the family institutional program, see WAC 388-505-0265.

(7) A person is not eligible for state-funded nursing facility care if that person entered the state specifically to obtain medical care.

(8) A person eligible for the state-funded alien nursing facility program is certified for a twelve month period.

(9) The state-funded alien nursing facility program is subject to caseload limits determined by legislative funding.