WSR 11-02-008
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 10-323—Filed December 23, 2010, 1:48 p.m., effective December 31, 2010, 12:01 p.m.]

Effective Date of Rule: December 31, 2010, 12:01 p.m.

Purpose: Amend personal use fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-36000M; 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, 2 and those portions of Razor Clam Area 3 open for harvest. Washington department of health has 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Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.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: December 23, 2010.

James B. Scott, Jr.
for Philip Anderson
Director

NEW SECTION

WAC 220-56-36000M 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. December 31 through 11:59 p.m. January 1, 2011, razor clam digging is allowed in Razor Clam Area 1. Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

2. Effective 12:01 p.m. December 31 through 11:59 p.m. January 2, 2011, 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. Effective 12:01 p.m. December 31 through 11:59 p.m. January 1, 2011, razor clam digging is allowed in that portion Razor Clam Area 3 that is between the Grays Harbor North Jetty and the southern boundary of the Quinault Indian Nation (Grays Harbor County) and that portion of Razor Clam Area 3 that is between Olympic National Park South Beach Campground access road (Kalaloch area, Jefferson County) and Browns Point (Kalaloch area, Jefferson County). Digging is allowed from 12:01 p.m. to 11:59 p.m. each day only.

4. 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.

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

REPEALER

The following section of the Washington Administrative Code is repealed effective 12:01 a.m. January 3, 2011:

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

WSR 11-02-024
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)

[Filed December 29, 2010, 1:19 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Upon order of the governor, the medicaid purchasing administration (MPA) must reduce its budget expenditures for the current fiscal year ending June 30, 2011, by 6.3%. To achieve this expenditure reduction, MPA is eliminating the following optional medical service(s) for adults twenty-one years of age and older: Eyeglass frames, lenses, and contact lenses.

Citation of Existing Rules Affected by this Order: Amending WAC 388-544-0100, 388-544-0250, 388-544-0300, 388-544-0325, 388-544-0350, 388-544-0400, 388-544-0500, 388-544-0550, and 388-544-0575.

Statutory Authority for Adoption: RCW 74.08.090.

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; 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: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the Governor required DSHS and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3%. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments. Delaying the adoption of these cuts to optional services could jeopardize the state's ability to maintain the mandatory medicaid services for the majority of DSHS clients.

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 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 9, 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 9, Repealed 0.

Date Adopted: December 23, 2010.

Katherine I. Vasquez
Rules Coordinator

VISION CARE-CLIENTS TWENTY YEARS OF AGE AND YOUNGER

AMENDATORY SECTION (Amending WSR 08-14-052, filed 6/24/08, effective 7/25/08)

WAC 388-544-0100 Vision care—Eligible clients—Twenty years of age and younger. This section applies to eligible clients who are twenty years of age and younger.

(1) Vision care ((~~services are~~)) is available to clients who are eligible for services under the following medical assistance programs ((~~only~~)):

(a) Categorically needy program (CN or CNP);

(b) Categorically needy program - state children's health insurance program (CNP-SCHIP);

(c) Children's healthcare programs as defined in WAC 388-505-0210;

(d) Limited casualty program - medically needy program (LCP-MNP);

(e) Disability lifeline (formerly general assistance (GA-U/ADATSA)) (within Washington state or designated border cities); and

(f) ((~~Emergency medical only programs when the services are directly related to an~~)) Alien emergency medical (AEM) as described in WAC 388-438-0115, when the medical services are necessary to treat a qualifying emergency medical condition only.

(2) Eligible clients who are enrolled in a department contracted managed care organization (MCO) are eligible under fee-for-service for covered vision care ((~~services~~)) that are not covered by their plan and subject to the provisions of this chapter and other applicable WAC.

AMENDATORY SECTION (Amending WSR 08-14-052, filed 6/24/08, effective 7/25/08)

WAC 388-544-0250 Vision care—Covered eye services (examinations, refractions, visual field testing, and vision therapy). (((~~(1) The department covers, without prior authorization, eye examinations and refraction services with the following limitations:~~

~~(a) Once every twenty-four months for asymptomatic clients twenty-one years of age or older;~~

~~(b) Once every twelve months for asymptomatic clients twenty years of age or younger; or~~

~~(c) Once every twelve months, regardless of age, for asymptomatic clients of the division of developmental disabilities.~~

~~(2) The department covers additional examinations and refraction services outside the limitations described in subsection (1) of this section when:~~

~~(a) The provider is diagnosing or treating the client for a medical condition that has symptoms of vision problems or disease;~~

~~(b) The client is on medication that affects vision; or~~

~~(c) The service is necessary due to lost or broken eyeglasses/contacts. In this case:~~

~~(i) No type of authorization is required for clients twenty years of age or younger or for clients of the division of developmental disabilities, regardless of age.~~

~~(ii) Providers must follow the department's expedited prior authorization process to receive payment for clients twenty one years of age or older. Providers must also document the following in the client's file:~~

~~(A) The eyeglasses or contacts are lost or broken; and~~

~~(B) The last examination was at least eighteen months ago.~~

~~(3) The department covers visual field exams for the diagnosis and treatment of abnormal signs, symptoms, or injuries. Providers must document all of the following in the client's record:~~

~~(a) The extent of the testing;~~

~~(b) Why the testing was reasonable and necessary for the client; and~~

~~(c) The medical basis for the frequency of testing.~~

~~(4) The department covers orthoptics and vision training therapy. Providers must obtain prior authorization from the department~~)) See WAC 388-531-1000 Opthalmic services.

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.

AMENDATORY SECTION (Amending WSR 08-14-052, filed 6/24/08, effective 7/25/08)

WAC 388-544-0300 Vision care—Covered eyeglasses (frames and/or lenses) and repair ((~~services~~))—Clients twenty years of age and younger. This section applies to eligible clients who are twenty years of age and younger.

(1) The department covers eyeglasses, without prior authorization, ((~~as follows:~~

~~(a)~~)) once every twelve months for eligible clients when the following clinical criteria are met:

((~~(i)~~)) (a) The eligible client has a stable visual condition;

((~~(ii)~~)) (b) The eligible client's treatment is stabilized;

((~~(iii)~~)) (c) The prescription is less than eighteen months old; and

((~~(iv)~~)) (d) One of the following minimum correction needs in at least one eye is documented in the client's file:

((~~(A)~~)) (i) Sphere power equal to, or greater than, plus or minus 0.50 diopter;

((~~(B)~~)) (ii) Astigmatism power equal to, or greater than, plus or minus 0.50 diopter; or

((~~(C)~~)) (iii) Add power equal to, or greater than, 1.0 diopter for bifocals and trifocals.

(~~(b) With the following limitations:~~

~~(i) Once every twenty-four months for clients twenty-one years of age or older;~~

~~(ii) Once every twelve months for clients twenty years of age or younger; or~~

~~(iii) Once every twelve months, regardless of age, for clients of the division of developmental disabilities.~~))

(2) The department covers eyeglasses (frames/lenses), ((~~without prior authorization,~~)) for eligible clients ((~~who are twenty years of age or younger~~)) with a diagnosis of accommodative esotropia or any strabismus correction, without prior authorization. In this case, the limitations of subsection (1) of this section do not apply.

(3) The department covers one pair of back-up eyeglasses for eligible clients who wear contact lenses as their primary visual correction aid (see WAC 388-544-0400(1)) ((~~with the following limitations:~~

~~(a) Once every six years for clients twenty years of age or older;~~

~~(b)~~)) limited to once every two years for eligible clients twenty years of age or younger ((~~or regardless of age for clients of the division of developmental disabilities~~)).

AMENDATORY SECTION (Amending WSR 08-14-052, filed 6/24/08, effective 7/25/08)

WAC 388-544-0325 Vision care—Covered eyeglass frames—Clients twenty years of age and younger. This section applies to eligible clients who are twenty years of age and younger.

(1) The department covers durable or flexible frames, without prior authorization, when the eligible client has a diagnosed medical condition that has contributed to two or more broken eyeglass frames in a twelve-month period. To receive payment, the provider must:

(a) Follow the department's expedited prior authorization process; and

(b) Order the "durable" or "flexible" frames through the department's designated supplier.

(2) The department covers all of the following for eligible clients without prior authorization:

(a) Coating contract eyeglass frames to make the frames nonallergenic. Eligible clients must have a medically diagnosed and documented allergy to the materials in the available eyeglass frames.

(b) Incidental repairs to a client's eyeglass frames. To receive payment, all of the following must be met:

(i) The provider typically charges the general public for the repair or adjustment;

(ii) The contractor's one year warranty period has expired; and

(iii) The cost of the repair does not exceed the department's cost for replacement frames and a fitting fee((~~; and~~

~~(iv) The frequency of the repair does not exceed two per client in a six-month period. This limit does not apply to clients twenty years of age or younger or to clients of the division of developmental disabilities, regardless of age.~~

~~(3) The department covers replacement eyeglass frames that have been lost or broken as follows:~~

~~(a) No type of authorization is required for clients twenty years of age or younger or for clients of the division of developmental disabilities, regardless of age.~~

~~(b) To receive payment for clients twenty-one years of age or older, excluding clients of the division of developmental disabilities, providers must follow the department's expedited prior authorization process~~)).

(c) Replacement eyeglass frames that have been lost or broken.

AMENDATORY SECTION (Amending WSR 08-14-052, filed 6/24/08, effective 7/25/08)

WAC 388-544-0350 Vision care—Covered eyeglass lenses ((~~and services~~))—Clients twenty years of age and younger. This section applies to eligible clients who are twenty years of age and younger.

(1) The department covers the following plastic scratch-resistant eyeglass lenses without prior authorization:

(a) Single vision lenses;

(b) Round or flat top D-style bifocals;

(c) Flat top trifocals; and

(d) Slab-off and prism lenses (including Fresnel lenses).

(2) Eyeglass lenses, as described in subsection (1) of this section must be placed into a frame that is, or was, purchased by the department.

(3) The department covers, without prior authorization, the following lenses for eligible clients when the clinical criteria are met:

(a) High index lenses. Providers must follow the department's expedited prior authorization process. The eligible client's medical need in at least one eye must be diagnosed and documented as:

(i) A spherical refractive correction of plus or minus six diopters or greater; or

(ii) A cylinder correction of plus or minus three diopters or greater.

(b) Plastic photochromatic lenses. The eligible client's medical need must be diagnosed and documented as ocular albinism or retinitis pigmentosa.

(c) Polycarbonate lenses. The eligible client's medical need must be diagnosed and documented as one of the following:

(i) Blind in one eye and needs protection for the other eye, regardless of whether a vision correction is required;

(ii) Infants and toddlers with motor ataxia;

(iii) Strabismus or amblyopia ((~~for clients twenty years of age or younger; or~~

~~(iv) For clients of the division of developmental disabilities~~)).

(d) Bifocal lenses to be replaced with single vision or trifocal lenses, or trifocal lenses to be replaced with bifocal or single vision lenses when:

(i) The eligible client has attempted to adjust to the bifocals or trifocals for at least sixty days; and

(ii) The eligible client is unable to make the adjustment; and

(iii) The trifocal lenses being replaced are returned to the provider.

(4) The department covers, without prior authorization, the tinting of plastic lenses when the eligible client's medical need is diagnosed and documented as one or more of the following chronic (expected to last longer than three months) eye conditions causing photophobia:

(a) Blindness;

(b) Chronic corneal keratitis;

(c) Chronic iritis, iridocyclitis;

(d) Diabetic retinopathy;

(e) Fixed pupil;

(f) Glare from cataracts;

(g) Macular degeneration;

(h) Migraine disorder;

(i) Ocular albinism;

(j) Optic atrophy and/or optic neuritis;

(k) Rare photo-induced epilepsy conditions; or

(l) Retinitis pigmentosa.

(5) The department covers replacement lenses for eligible clients without prior authorization when the lenses are lost or broken ((~~as follows:~~

~~(a) No type of authorization is required for clients twenty years of age and younger or for clients of the division of developmental disabilities, regardless of age.~~

~~(b) Providers must follow the expedited prior authorization process to receive payment for clients twenty-one years of age or older~~)).

(6) The department covers replacement lenses, without prior authorization, when the eligible client meets one of the clinical criteria. To receive payment, providers must follow the expedited prior authorization process. The clinical criteria are:

(a) Eye surgery or the effects of prescribed medication or one or more diseases affecting vision:

(i) The client has a stable visual condition;

(ii) The client's treatment is stabilized;

(iii) The lens correction must have a 1.0 or greater diopter change between the sphere or cylinder correction in at least one eye; and

(iv) The previous and new refraction are documented in the client's record.

(b) Headaches, blurred vision, or visual difficulty in school or at work. In this case, all of the following must be documented in the client's file:

(i) Copy of current prescription (less than eighteen months old);

(ii) Date of last dispensing, if known;

(iii) Absence of a medical condition that is known to cause temporary visual acuity changes (e.g., diabetes, pregnancy, etc.); and

(iv) A refractive change of at least .75 diopter or greater between the sphere or cylinder correction in at least one eye.

AMENDATORY SECTION (Amending WSR 08-14-052, filed 6/24/08, effective 7/25/08)

WAC 388-544-0400 Vision care—Covered contact lenses ((~~and services~~))—Clients twenty years of age and younger. This section applies to eligible clients who are twenty years of age and younger.

(1) The department covers contact lenses, without prior authorization, as the eligible client's primary refractive correction method when the eligible client has a spherical correction of plus or minus 6.0 diopters or greater in at least one eye. See subsection (4) of this section for exceptions to the plus or minus 6.0 diopter criteria. The spherical correction may be from the prescription for the glasses or the contact lenses and may be written in either "minus cyl" or "plus cyl" form.

(2) The department covers the following contact lenses with limitations:

(a) Conventional soft contact lenses or rigid gas permeable contact lenses that are prescribed for daily wear; or

(b) Disposable contact lenses that are prescribed for daily wear and have a monthly or quarterly planned replacement schedule, as follows:

(i) Twelve pairs of monthly replacement contact lenses; or

(ii) Four pairs of three-month replacement contact lenses.

(3) The department covers soft toric contact lenses, without prior authorization, for eligible clients with astigmatism when the following clinical criteria are met:

(a) The eligible client's cylinder correction is plus or minus 1.0 diopter in at least one eye; and

(b) The eligible client meets the spherical correction listed in subsection (1) of this section.

(4) The department covers contact lenses, without prior authorization, when the following clinical criteria are met. In these cases, the limitations in subsection (1) of this section do not apply.

(a) For eligible clients diagnosed with high anisometropia.

(i) The eligible client's refractive error difference between the two eyes is at least plus or minus 3.0 diopters between the sphere or cylinder correction; and

(ii) Eyeglasses cannot reasonably correct the refractive errors.

(b) Specialty contact lens designs for eligible clients who are diagnosed with one or more of the following:

(i) Aphakia;

(ii) Keratoconus; or

(iii) Corneal softening.

(c) Therapeutic contact bandage lenses only when needed immediately after eye injury or eye surgery.

(5) The department covers replacement contact lenses for eligible clients, limited to once every twelve months, when lost or damaged ((~~as follows:~~

~~(a) Authorization is not required for clients twenty years of age or younger or for clients of the division of developmental disabilities, regardless of age.~~

~~(b) Providers must follow the expedited prior authorization process to receive payment for clients twenty-one years of age or older~~)).

(6) The department covers replacement contact lenses for eligible clients without prior authorization when all of the following clinical criteria ((~~are~~)) is met:

(a) ((~~The clinical criteria are:~~

~~(i)~~)) One of the following caused the vision change:

(((~~(A)~~))) (i) Eye surgery;

(((~~(B)~~))) (ii) The effect(s) of prescribed medication; or

(((~~(C)~~))) (iii) One or more diseases affecting vision.

(((~~(ii)~~))) (b) The client has a stable visual condition;

(((~~(iii)~~))) (c) The client's treatment is stabilized; and

(((~~(iv)~~))) (d) The lens correction has a 1.0 or greater diopter change in at least one eye between the sphere or cylinder correction. The previous and new refraction must be documented in the client's record.

(((~~(b) No type of authorization is required for clients twenty years of age and younger or for clients of the division of developmental disabilities, regardless of age.~~

~~(c) To receive payment for clients twenty one years of age or older, providers must follow the expedited prior authorization process.~~))

AMENDATORY SECTION (Amending WSR 08-14-052, filed 6/24/08, effective 7/25/08)

WAC 388-544-0500 Vision care—Covered ocular prosthetics. ((~~The department covers ocular prosthetics when provided by any of the following:~~

~~(1) An ophthalmologist;~~

~~(2) An ocularist; or~~

~~(3) An optometrist who specializes in prosthetics~~)) See WAC 388-531-1000 Opthalmic services.

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.

AMENDATORY SECTION (Amending WSR 08-14-052, filed 6/24/08, effective 7/25/08)

WAC 388-544-0550 Vision care—Covered eye surgery. (((~~(1) The department covers cataract surgery, without prior authorization, when the following clinical criteria are met:~~

~~(a) Correctable visual acuity in the affected eye at 20/50 or worse, as measured on the Snellen test chart; or~~

~~(b) One or more of the following conditions:~~

~~(i) Dislocated or subluxated lens;~~

~~(ii) Intraocular foreign body;~~

~~(iii) Ocular trauma;~~

~~(iv) Phacogenic glaucoma;~~

~~(v) Phacogenic uveitis;~~

~~(vi) Phacoanaphylactic endopthalmitis; or~~

~~(vii) Increased ocular pressure in a person who is blind and is experiencing ocular pain.~~

~~(2) The department covers strabismus surgery as follows:~~

~~(a) For clients seventeen years of age and younger. The provider must clearly document the need in the client's record. The department does not require authorization for clients seventeen years of age and younger; and~~

~~(b) For clients eighteen years of age and older, when the clinical criteria are met. To receive payment, providers must follow the expedited prior authorization process. The clinical criteria are:~~

~~(i) The client has double vision; and~~

~~(ii) The surgery is not being performed for cosmetic reasons.~~

~~(3) The department covers blepharoplasty or blepharoptosis surgery when all of the clinical criteria are met. To receive payment, providers must follow the department's expedited prior authorization process. The clinical criteria are:~~

~~(a) The client's excess upper eyelid skin is blocking the superior visual field; and~~

~~(b) The blocked vision is within ten degrees of central fixation using a central visual field test~~)) See WAC 388-531-1000 Opthalmic services.

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.

AMENDATORY SECTION (Amending WSR 08-14-052, filed 6/24/08, effective 7/25/08)

WAC 388-544-0575 Vision care—Noncovered ((~~services,~~)) eyeglasses((~~,~~)) and contact lenses. (1) The department does not cover the following:

(a) Executive style eyeglass lenses;

(b) Bifocal contact lenses;

(c) Daily and two week disposable contact lenses;

(d) Extended wear soft contact lenses, except when used as therapeutic contact bandage lenses or for aphakic clients;

(e) Custom colored contact lenses;

(f) ((~~Services for cosmetic purposes only;~~

~~(g)~~)) Glass lenses;

(((~~(h) Group vision screening for eyeglasses;~~

~~(i)~~))) (g) Nonglare or anti-reflective lenses;

(((~~(j)~~))) (h) Progressive lenses;

(((~~(k) Refractive surgery of any type that changes the eye's refractive error. The intent of the refractive surgery procedure is to reduce or eliminate the need for eyeglass or contact lens corrections. This does not include intraocular lens implantation following cataract surgery.~~

~~(l)~~))) (i) Sunglasses and accessories that function as sunglasses (e.g., "clip-ons");

(((~~(m)~~))) (j) Upgrades at private expense to avoid the department's contract limitations (e.g., frames that are not

available through the department's contract or noncontract frames or lenses for which the client or other person pays the difference between the department's payment and the total cost).

(2) An exception to rule (ETR), as described in WAC 388-501-0160, may be requested for a noncovered service.

WSR 11-02-025
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)

[Filed December 29, 2010, 1:23 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Upon order of the governor, the medicaid purchasing administration (MPA) must reduce its budget expenditures for the current fiscal year ending June 30, 2011, by 6.3%. To achieve this expenditure reduction, MPA is eliminating the following optional medical service(s) for adults twenty-one years of age and older: Hearing devices to include hearing aids, bone anchored hearing aids (BAHA), cochlear implants, and parts and batteries for such equipment, including repairs.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-547-0300, 388-547-0400, 388-547-0500 and 388-547-0600; and amending WAC 388-547-0100, 388-547-0700, and 388-547-0800.

Statutory Authority for Adoption: RCW 74.08.090.

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; 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: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required DSHS and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3%. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments. Delaying the adoption of these cuts to optional services could jeopardize the state's ability to maintain the mandatory medicaid services for the majority of DSHS clients.

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.

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Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 3, Repealed 4.

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 4.

Date Adopted: December 23, 2010.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 09-12-034, filed 5/27/09, effective 7/1/09)

WAC 388-547-0100 Hearing aids—General—For clients twenty-years of age and younger. Unless otherwise defined in WAC 388-547-0200, the terms within this chapter are intended to correspond with the terms in chapter 18.35 RCW.

(1) The department covers the hearing aids ((~~services~~)) listed in this chapter, according to department rules and subject to the limitations and requirements in this chapter. See also WAC 388-531-0375 audiology services.

(2) The department pays for hearing aids ((~~and services~~)) when:

(a) Covered((~~. Refer to WAC 388-547-0400 for covered hearing aids and services for clients twenty-one years of age and older; and refer to WAC 388-547-0800 for covered hearing aids and services for clients twenty years of age and younger~~));

(b) Within the scope of an eligible client's medical care program;

(c) Medically necessary as defined under WAC 388-500-0005;

(d) Authorized, as required within this chapter, chapters 388-501 and 388-502 WAC, and the department's published billing instructions and numbered memoranda; and

(e) Billed according to this chapter, chapters 388-501 and 388-502, and the department's published billing instructions and numbered memoranda; and

(f) The client((~~:~~

~~(i)~~)) is twenty years of age or younger and completes a hearing evaluation, including an audiogram and/or developmentally appropriate diagnostic physiologic test results performed and/or interpreted by a hearing healthcare professional((~~;~~

~~(ii) Is referred by a hearing healthcare professional for a hearing aid; and~~

~~(iii) For clients twenty-one years of age and older only, has an average degree of hearing loss at forty-five decibels (dBHL) in the better ear based on a pure-tone audiometric evaluation by a licensed audiologist or licensed hearing instrument fitter/dispenser at one thousand, two thousand,~~

~~three thousand, and four thousand hertz (Hz) with effective masking as indicated~~)).

(3) The department requires prior authorization for covered hearing aids ((~~services~~)) when the clinical criteria set forth in this chapter are not met. The department evaluates these requests on a case-by-case basis to determine whether they are medically necessary, according to the process found in WAC 388-501-0165.

AMENDATORY SECTION (Amending WSR 09-12-034, filed 5/27/09, effective 7/1/09)

WAC 388-547-0700 Hearing aids—Eligibility—Clients twenty years of age and younger. (1) Clients twenty years of age and younger who are receiving services under ((~~any~~)) a medical assistance program((~~, except for the family planning only program and the TAKE CHARGE program~~)):

(a) Are eligible for covered hearing aids ((~~and services~~)) under this chapter and for the audiology services under WAC ((~~388-545-0700~~)) 388-531-0375;

(b) Must have a complete hearing evaluation, including an audiogram and/or developmentally appropriate diagnostic physiologic test results performed by a hearing healthcare professional; and

(c) Must be referred by a licensed audiologist, otorhinolaryngologist or otologist for a hearing aid.

(2) Clients who are enrolled in a department-contracted managed care ((~~plan~~)) organization (MCO) are eligible under fee-for-service for covered hearing aid services that are not covered by their plan, subject to the provisions of this chapter and other applicable WAC. However, clients enrolled in a department-contracted MCO must obtain replacement parts for cochlear implants and bone anchored hearing aids (BAHA) through their MCO.

AMENDATORY SECTION (Amending WSR 09-12-034, filed 5/27/09, effective 7/1/09)

WAC 388-547-0800 Hearing aids—((~~Covered services~~)) Coverage—Clients twenty years of age and younger. (1) The department covers new, nonrefurbished, monaural or binaural hearing aid(s), which includes the ear mold, for eligible clients twenty years of age and younger. In order for the provider to receive payment, the hearing aid must meet the client's specific hearing needs and be under warranty for a minimum of one year.

(2) The department pays for:

(a) Replacement hearing aid(s), which includes the ear mold, when:

(i) The client's hearing aid(s) are:

(A) Lost;

(B) Beyond repair; or

(C) Not sufficient for the client's hearing loss; and

(ii) All warranties are expired.

(b) Replacement ear mold(s) when the client's existing ear mold is damaged or no longer fits the client's ear.

(c) A maximum of two repairs, per hearing aid, per year, when the repair is less than fifty percent of the cost of a new hearing aid. To receive payment, all of the following must be met:

(i) All warranties are expired; and

(ii) The repair is under warranty for a minimum of ninety days.

(d) A rental hearing aid(s) for up to two months while the client's own hearing aid is being repaired. In the case of a rental hearing aid(s), the department pays separately for an ear mold(s).

(3) The department pays for unilateral cochlear implant and osseointegrated hearing aids (BAHA) replacement parts when:

(a) The manufacturer's warranty has expired;

(b) The part is for immediate use, not a back-up part;

(c) The part needs to be replaced due to normal wear and tear and is not related to misuse or abuse of the item (see WAC 388-502-0160); and

(d) The part is not an external speech processor.

(4) The department covers for one cochlear implant external speech processor, including maintenance and repair.

(5) The department covers one BAHA speech processor, including maintenance and repair.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-547-0300	Hearing aids—Eligibility—Clients twenty-one years of age and older.
WAC 388-547-0400	Hearing aids—Covered services—Clients twenty-one years of age and older.
WAC 388-547-0500	Hearing aids—Noncovered services—Clients twenty-one years of age and older.
WAC 388-547-0600	Hearing aids—Prior authorization—Clients twenty-one years of age and older.

WSR 11-02-026
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)

[Filed December 29, 2010, 1:26 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Upon order of the governor, the medicaid purchasing administration (MPA) must reduce its budget expenditures for the current fiscal year ending June 30, 2011, by 6.3%. To achieve this expenditure reduction, MPA is eliminating a number [of] optional medical services from program benefits packages for clients twenty-one years of age and older. These medical services include vision, hearing, and dental care. Sections in chapter 388-501 WAC are being amended to reflect and support these program cuts.

Citation of Existing Rules Affected by this Order: Amending WAC 388-501-0050, 388-501-0060, 388-501-0065, 388-501-0070, and 388-502-0160.

Statutory Authority for Adoption: RCW 74.08.090.

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; 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: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required DSHS and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3%. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments. Delaying the adoption of these cuts to optional services could jeopardize the state's ability to maintain the mandatory medicaid services for the majority of DSHS clients.

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 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 5, 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 5, Repealed 0.

Date Adopted: December 23, 2010.

Katherine I. Vasquez

Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 11-03 issue of the Register.

WSR 11-02-027
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)

[Filed December 29, 2010, 1:26 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Upon order of the governor, the medicaid purchasing administration (MPA) must reduce its budget expenditures for the current fiscal year ending June 30, 2011, by 6.3%. To achieve this expenditure reduction, MPA is eliminating optional medical services from program benefit packages for clients twenty-one years of age and older. These medical services include vision, hearing, and dental. Chapter 388-531 WAC is being amended to include medical services previously listed in the programs to be eliminated that are necessary to, and included within, appropriate mandatory medical services under federal statutes and rules.

Citation of Existing Rules Affected by this Order: Amending WAC 388-531-0100, 388-531-0150, 388-531-0200, 388-531-0250, 388-531-0400, 388-531-1000, and 388-531-1300.

Statutory Authority for Adoption: RCW 74.08.090.

Other Authority: Section 209(1), chapter 37, Laws of 2010 (ESSB 6444).

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; 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: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required DSHS and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3%. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments. Delaying the adoption of these cuts to optional services could jeopardize the state's ability to maintain the mandatory medicaid services for the majority of DSHS clients.

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 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 2, Amended 7, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 2, Amended 7, Repealed 0.

Date Adopted: December 23, 2010.

Katherine I. Vasquez
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 11-03 issue of the Register.

WSR 11-02-028
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)

[Filed December 29, 2010, 1:31 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Upon order of the governor, the medicaid purchasing administration (MPA) must reduce its budget expenditures for the current fiscal year ending June 30, 2011, by 6.3%. To achieve this expenditure reduction, MPA is eliminating the following optional medical service(s): School-based healthcare services.

Citation of Existing Rules Affected by this Order: Repealing 388-537-0100, 388-537-0200, 388-537-0300, 388-537-0350, 388-537-0400, 388-537-0500, 388-537-0600, 388-537-0700, and 388-537-0800.

Statutory Authority for Adoption: RCW 74.08.090.

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; 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: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required DSHS and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3%. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments. Delaying the adoption of these cuts to optional services could jeopardize the state's ability to maintain the mandatory medicaid services for the majority of DSHS clients.

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 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 9.

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 9.

Date Adopted: December 17, 2010.

Katherine I. Vasquez
Rules Coordinator

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-537-0100	School-based healthcare services for children in special education—Purpose.
WAC 388-537-0200	School-based healthcare services for children in special education—Definitions.
WAC 388-537-0300	School-based healthcare services for children in special education—Client eligibility.
WAC 388-537-0350	School-based healthcare services for children in special education—Provider qualifications.
WAC 388-537-0400	School-based healthcare services for children in special education—Covered services.
WAC 388-537-0500	School-based healthcare services for children in special education—Noncovered services.
WAC 388-537-0600	School-based healthcare services for children in special education—School district requirements for billing and payment.
WAC 388-537-0700	School-based healthcare services for children in special

	education—School district documentation requirements.
WAC 388-537-0800	School-based healthcare services for children in special education—Program monitoring/audits.

WSR 11-02-029
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)

[Filed December 29, 2010, 1:36 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Upon order of the governor, the medicaid purchasing administration (MPA) must reduce its budget expenditures for the current fiscal year ending June 30, 2011, by 6.3%. To achieve this expenditure reduction, MPA is eliminating the following optional medical service(s): State payment of medicare prescription drug copayments for full-benefit dual-eligible clients.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-517-0500.

Statutory Authority for Adoption: RCW 74.08.090.

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; 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: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required DSHS and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3%. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments. Delaying the adoption of these cuts to optional services could jeopardize the state's ability to maintain the mandatory medicaid services for the majority of DSHS clients.

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 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 1.

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 1.

Date Adopted: December 17, 2010.

Katherine I. Vasquez
Rules Coordinator

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-517-0500	State payment of medicare prescription drug copayments for full-benefit dual-eligible clients.

WSR 11-02-030
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Purchasing Administration)

[Filed December 29, 2010, 1:38 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Upon order of the governor, the medicaid purchasing administration (MPA) must reduce its budget expenditures for the current fiscal year ending June 30, 2011, by 6.3%. To achieve this expenditure reduction, MPA is eliminating the following optional medical service(s): Nonemergency dental and dental-related services for clients age twenty-one and older.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-535-1247, 388-535-1255, 388-535-1257, 388-535-1259, 388-535-1261, 388-535-1263, 388-535-1266, 388-535-1267, 388-535-1269, 388-535-1271 and 388-535-1280; and amending WAC 388-535-1060, 388-535-1065, 388-535-1084, 388-535-1090, 388-535-1099, 388-535-1100, 388-535-1350, 388-535-1400, 388-535-1450, 388-535-1500, and 388-535-1550.

Statutory Authority for Adoption: RCW 74.08.090.

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; 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: Governor Gregoire issued Executive Order 10-04 on September 13, 2010, under the authority of RCW 43.88.110(7). In the executive order, the governor required DSHS and all other state agencies to reduce their expenditures in state fiscal year 2011 by approximately 6.3%. As a consequence of the executive order, funding will no longer be available as of January 1, 2011, for the benefits that are being eliminated as part of these regulatory amendments. Delaying the adoption of these cuts to optional services could jeopardize the state's ability to maintain the mandatory medicaid programs for the majority of DSHS clients.

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 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 11, Repealed 11.

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 11, Repealed 11.

Date Adopted: December 23, 2010.

Katherine I. Vasquez
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 11-03 issue of the Register.

WSR 11-02-031
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed December 29, 2010, 1:41 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Under section 6014 of the Deficit Reduction Act of 2005 (DRA), medicaid will not pay for long-term care services for individuals whose equity interest in their home exceeds $500,000. Effective January 1, 2011, these limits are to be increased each year by the percentage increase in the consumer price index-urban (CPIU).

Because 2011 is the first year the excess home equity limits are indexed to the CPIU, those limits will actually increase by 1.1 percent next year, rounded to the nearest $1,000.

Effective January 1, 2011, the excess home equity limits will be $506,000.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.057, 74.09.500, and 74.09.530.

Other Authority: Deficit Reduction Act of 2005 (DRA).

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: Federal standard change of the excess home equity provisions effective January 1, 2011, based on the consumer price index-urban (CPIU).

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 1, 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 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: December 23, 2010.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 09-12-058, filed 5/28/09, effective 7/1/09)

WAC 388-513-1350 Defining the resource standard and determining resource eligibility for long-term care (LTC) services. This section describes how the department defines the resource standard and countable or excluded resources when determining a client's eligibility for LTC services. The department uses the term "resource standard" to describe the maximum amount of resources a client can have and still be resource eligible for program benefits.

(1) The resource standard used to determine eligibility for LTC services equals:

(a) Two thousand dollars for:

(i) A single client; or

(ii) A legally married client with a community spouse, subject to the provisions described in subsections (8) through (11) of this section; or

(b) Three thousand dollars for a legally married couple, unless subsection (3) of this section applies.

(2) When both spouses apply for LTC services the department considers the resources of both spouses as available to each other through the month in which the spouses stopped living together.

(3) When both spouses are institutionalized, the department will determine the eligibility of each spouse as a single client the month following the month of separation.

(4) If the department has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, (but after eligibility has been established and services authorized for the institutional spouse), then the department applies the standard described in subsection (1)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the department applies (1)(b) of this section for a couple.

(5) When a single institutionalized individual marries, the department will redetermine eligibility applying the rules for a legally married couple.

(6) The department applies the following rules when determining available resources for LTC services:

(a) WAC 388-475-0300, Resource eligibility;

(b) WAC 388-475-0250, How to determine who owns a resource; and

(c) WAC 388-470-0060(6), Resources of an alien's sponsor.

(7) For LTC services the department determines a client's countable resources as follows:

(a) The department determines countable resources for SSI-related clients as described in WAC 388-475-0350 through 388-475-0550 and resources excluded by federal law with the exception of:

(i) WAC 388-475-0550(16);

(ii) WAC 388-475-0350 (1)(b) clients who have submitted an application for LTC services on or after May 1, 2006 and have an equity interest greater than five hundred thousand dollars in their primary residence are ineligible for LTC services. This exception does not apply if a spouse or blind, disabled or dependent child under age twenty-one is lawfully residing in the primary residence. Clients denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver described in WAC 388-513-1367. Effective January 1, 2011, the excess home equity limits will increase to five hundred six thousand dollars. On January 1, 2012 and on January 1 of each year thereafter, this standard may be increased or decreased by the percentage increased or decreased in the consumer price index-urban (CPIU). For current excess home equity standard starting January 1, 2011 and each year thereafter, see http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(b) For an SSI-related client one automobile per household is excluded regardless of value if it is used for transportation of the eligible individual/couple.

(i) For an SSI-related client with a community spouse, the value of one automobile is excluded regardless of its use or value.

(ii) A vehicle not meeting the definition of automobile is a vehicle that has been junked or a vehicle that is used only as a recreational vehicle.

(c) For an SSI-related client, the department adds together the countable resources of both spouses if subsections (2), (5) and (8)(a) or (b) apply, but not if subsection (3) or (4) apply.

(d) For an SSI-related client, excess resources are reduced:

(i) In an amount equal to incurred medical expenses such as:

(A) Premiums, deductibles, and coinsurance/copayment charges for health insurance and medicare;

(B) Necessary medical care recognized under state law, but not covered under the state's medicaid plan;

(C) Necessary medical care covered under the state's medicaid plan incurred prior to medicaid eligibility.

(ii) As long as the incurred medical expenses:

(A) Are not subject to third-party payment or reimbursement;

(B) Have not been used to satisfy a previous spend down liability;

(C) Have not previously been used to reduce excess resources;

(D) Have not been used to reduce client responsibility toward cost of care;

(E) Were not incurred during a transfer of asset penalty described in WAC 388-513-1363, 388-513-1364, 388-513-1365 and 388-513-1366; and

(F) Are amounts for which the client remains liable.

(e) Expenses not allowed to reduce excess resources or participation in personal care:

(i) Unpaid expense(s) prior to waiver eligibility to an adult family home (AFH) or boarding home is not a medical expense.

(ii) Personal care cost in excess of approved hours determined by the CARE assessment described in chapter 388-106 WAC is not a medical expense.

(f) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program:

(A) Gross income must be at or below the special income level (SIL), 300% of the federal benefit rate (FBR).

(B) In a medical institution, excess resources and income must be under the state medicaid rate.

(C) For CN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for CN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.

(ii) For LTC services provided under the medically needy (MN) program when excess resources are added to nonexcluded income, the combined total is less than the:

(A) Private medical institution rate plus the amount of recurring medical expenses for institutional services; or

(B) Private hospice rate plus the amount of recurring medical expenses, for hospice services in a medical institution.

(C) For MN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for MN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.

(g) For a client not related to SSI, the department applies the resource rules of the program used to relate the client to medical eligibility.

(8) For legally married clients when only one spouse meets institutional status, the following rules apply. If the client's current period of institutional status began:

(a) Before October 1, 1989, the department adds together one-half the total amount of countable resources held in the name of:

(i) The institutionalized spouse; or

(ii) Both spouses.

(b) On or after October 1, 1989, the department adds together the total amount of nonexcluded resources held in the name of:

(i) Either spouse; or

(ii) Both spouses.

(9) If subsection (8)(b) of this section applies, the department determines the amount of resources that are allocated to the community spouse before determining countable resources used to establish eligibility for the institutionalized spouse, as follows:

(a) If the client's current period of institutional status began on or after October 1, 1989 and before August 1, 2003, the department allocates the maximum amount of resources ordinarily allowed by law. Effective January 1, 2009, the maximum allocation is one hundred and nine thousand five hundred and sixty dollars. This standard increases annually on January 1st based on the consumer price index. (For the current standard starting January 2009 and each year thereafter, see long-term care standards at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml); or

(b) If the client's current period of institutional status began on or after August 1, 2003, the department allocates the greater of:

(i) A spousal share equal to one-half of the couple's combined countable resources as of the beginning of the current period of institutional status, up to the amount described in subsection (9)(a) of this section; or

(ii) The state spousal resource standard of forty-five thousand one hundred four dollars effective July 1, 2007 through June 30, 2009. Effective July 1, 2009 this standard increases to forty-eight thousand six hundred thirty-nine dollars (this standard increases every odd year on July 1st). This increase is based on the consumer price index published by the federal bureau of labor statistics. For the current standard starting July 2009 and each year thereafter, see long-term care standards at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(10) The amount of the spousal share described in (9)(b)(i) can be determined anytime between the date that the current period of institutional status began and the date that eligibility for LTC services is determined. The following rules apply to the determination of the spousal share:

(a) Prior to an application for LTC services, the couple's combined countable resources are evaluated from the date of the current period of institutional status at the request of either member of the couple. The determination of the spousal share is completed when necessary documentation and/or verification is provided; or

(b) The determination of the spousal share is completed as part of the application for LTC services if the client was institutionalized prior to the month of application, and declares the spousal share exceeds the state spousal resource standard. The client is required to provide verification of the couple's combined countable resources held at the beginning of the current period of institutional status.

(11) The amount of allocated resources described in subsection (9) of this section can be increased, only if:

(a) A court transfers additional resources to the community spouse; or

(b) An administrative law judge establishes in a fair hearing described in chapter 388-02 WAC, that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.

(12) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsection (5) or (13)(a), (b), or (c) of this section applies.

(13) A redetermination of the couple's resources as described in subsection (7) is required, if:

(a) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status;

(b) The institutionalized spouse's countable resources exceed the standard described in subsection (1)(a), if subsection (8)(b) applies; or

(c) The institutionalized spouse does not transfer the amount described in subsections (9) or (11) to the community spouse or to another person for the sole benefit of the community spouse as described in WAC 388-513-1365(4) by either:

(i) The first regularly scheduled eligibility review; or

(ii) The reasonable amount of additional time necessary to obtain a court order for the support of the community spouse.

WSR 11-02-033
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed December 29, 2010, 1:49 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: The purpose of the new language in chapters 388-71, 388-112, 388-829A and 388-829C WAC is to implement and clarify the training requirements and the criminal history background check requirements as directed in chapter 74.39A RCW.

Chapter 74.39A RCW requires training for long-term care workers which includes seventy-five hours of entry-level training and also requires federal and state criminal history background checks for all long-term care workers. This law increases the basic training hour requirements for long-term care workers from thirty-two hours to seventy-five hours and increases their continuing education hour requirement from ten to twelve hours annually.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-71-05665 through 388-71-05905, 388-112-0025, 388-112-0030, 388-112-0050, 388-112-0060, 388-112-0065, 388-112-0080, 388-112-0085, 388-112-0090, 388-112-0095, 388-112-0100, 388-112-0105, 388-112-0245, 388-112-02610 - 388-112-02630, and 388-112-0375; and amending WAC 388-71-0500, 388-71-0505, 388-71-0510, 388-71-0513, 388-71-0515, 388-71-0520, 388-71-0540, 388-71-0546, 388-71-0551, 388-71-0560, 388-112-0001, 388-112-0005, 388-112-0010, 388-112-0015, 388-112-0035,

388-112-0040, 388-112-0045, 388-112-0055, 388-112-0070, 388-112-0075, 388-112-0110, 388-112-0115, 388-112-0120, 388-112-0125, 388-112-0130, 388-112-0135, 388-112-0140, 388-112-0145, 388-112-0150, 388-112-0155, 388-112-0160, 388-112-0165, 388-112-0195, 388-112-0200, 388-112-0205, 388-112-0210, 388-112-0220, 388-112-0225, 388-112-0230, 388-112-0235, 388-112-0240, 388-112-0255, 388-112-0260, 388-112-0270, 388-112-0295, 388-112-0300, 388-112-0315, 388-112-0320, 388-112-0325, 388-112-0330, 388-112-0335, 388-112-0340, 388-112-0345, 388-112-0350, 388-112-0355, 388-112-0360, 388-112-0365, 388-112-0370, 388-112-0380, 388-112-0385, 388-112-0390, 388-112-0395, 388-112-0405, 388-112-0410, 388-829A-050, and 388-829C-040.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520; Washington state 2009-11 budget (ESHB 1244, section 206(5)).

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: Emergency adoption of these rules is necessary in order to comply with state law which requires implementation of these training rules by January 1, 2011. These rules were to be adopted by August 1, 2010. However, given the significant number of stakeholder comments received after the CR-102 hearing, the department needed to fully vet the additional comments and thus the rules could not be adopted by August 1, 2010. They must now be adopted as emergency rules in order to comply with the January 1, 2011, legislatively-mandated date for implementation.

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 83, Amended 67, Repealed 74.

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 83, Amended 67, Repealed 74.

Date Adopted: December 17, 2010.

Katherine I. Vasquez

Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 11-04 issue of the Register.

WSR 11-02-034
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed December 29, 2010, 1:51 p.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: HB 3225 modified appropriations for the 2009-11 operating budget. The state general fund appropriations were reduced by $490.4 million, while the total budgeted amount was reduced by $336.5 million. The department appropriations included a reduction of $856,000 GF-S for the remaining of SFY 2011 which can be achieved by decreasing of diversion cash assistance (DCA) from $1250 to $1000.

Purpose: The department is proposing to amend by emergency adoption WAC 388-432-0005 to reduce the availability of DCA from $1250.00 in [a] twelve-month period to $1000.00. This reduction was approved as part of the supplemental omnibus operating budget, HB 3225, by the legislature during the December 11, 2010, special session, and it is not carried forward in the governor's proposed budget for 2011-13.

Citation of Existing Rules Affected by this Order: Amending WAC 388-432-0005.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090.

Other Authority: HB 3225.

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: It is essential to reduce the maximum diversion cash assistance availability to be in place by January 1, 2011, as this reduction is necessary to achieve a balanced WorkFirst budget for the current fiscal year. The proposed amendments are necessary for the program to contain costs and ensure the program's fiscal stability.

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 0, Repealed 0.

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

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

Date Adopted: December 23, 2010.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-24-064, filed 11/30/10, effective 12/31/10)

WAC 388-432-0005 Can I get help from DSHS for a family emergency without receiving monthly cash assistance? DSHS has a program called diversion cash assistance (DCA). If your family needs an emergency cash payment but does not need ongoing monthly cash assistance, you may be eligible for this program.

(1) To get DCA, you must:

(a) Meet all the eligibility rules for temporary assistance for needy families (TANF)/state family assistance (SFA) except:

(i) You do not have to participate in WorkFirst requirements as defined in chapter 388-310 WAC; and

(ii) You do not have to assign child support rights or cooperate with division of child support as defined in chapter 388-422 WAC.

(b) Have a current bona fide or approved need for living expenses;

(c) Provide proof that your need exists; and

(d) Have or expect to get enough income or resources to support yourselves for at least twelve months.

(2) You may get DCA to help pay for one or more of the following needs:

(a) Child care;

(b) Housing;

(c) Transportation;

(d) Expenses to get or keep a job;

(e) Food costs, but not if an adult member of your family has been disqualified for food stamps; or

(f) Medical costs, except when an adult member of your family is not eligible because of failure to provide third party liability (TPL) information as defined in WAC 388-505-0540.

(3) DCA payments are limited to:

(a) One thousand ((~~two hundred fifty~~)) dollars once in a twelve-month period which starts with the month the DCA benefits begin; and

(b) The cost of your need.

(4) We do not budget your income or make you use your resources to lower the amount of DCA payments you can receive.

(5) DCA payments can be paid:

(a) All at once; or

(b) As separate payments over a thirty-day period. The thirty-day period starts with the date of your first DCA payment.

(6) When it is possible, we pay your DCA benefit directly to the service provider.

(7) You are not eligible for DCA if:

(a) Any adult member of your assistance unit got DCA within the last twelve months;

(b) Any adult member of your assistance unit gets TANF/SFA;

(c) Any adult member of your assistance unit is not eligible for cash assistance for any reason unless one parent in a two-parent-assistance unit is receiving SSI; or

(d) Your assistance unit does not have a needy adult (such as when you do not receive TANF/SFA payment for yourself but receive it for the children only).

(8) If you apply for DCA after your TANF/SFA grant has been terminated, we consider you an applicant for DCA.

(9) If you apply for TANF/SFA and you received DCA less than twelve months ago:

(a) We set up a DCA loan.

(i) The amount of the loan is one-twelfth of the total DCA benefit times the number of months that are left in the twelve-month period.

(ii) The first month begins with the month DCA benefits began.

(b) We collect the loan only by reducing your grant. We take five percent of your TANF/SFA grant each month.

(10) If you stop getting TANF/SFA before you have repaid the loan, we stop collecting the loan unless you get back on TANF/SFA.

WSR 11-02-041
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Administration)

[Filed December 30, 2010, 10:22 a.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: Amending WAC 388-106-0125 to reduce personal care hours in order to implement Governor's Executive Order 10-04 to reduce current year spending by 6.287%. In addition, the governor's proposed 2011 supplemental budget proposes an average ten percent acuity-based reduction in personal care hours. The actual reduction will range between six percent and eighteen percent per client depending on acuity.

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

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

Other Authority: Governor's Executive Order 10-04.

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: State law authorizes and directs the governor to implement across-the-board reductions of allotments of appropriations to avoid a projected cash deficit. Governor's Executive Order 10-04 reduces current year spending by 6.287%, and the department is proposing these amendments to stay within the reduced appropriation.

In addition, the governor's proposed 2011 supplemental budget proposes an average ten percent acuity-based reduction in personal care hours.

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 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

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

Date Adopted: December 30, 2010.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-11-050, filed 5/12/10, effective 6/12/10)

WAC 388-106-0125 If I am age twenty-one or older, how does CARE use criteria to place me in a classification group for in-home care? CARE uses the criteria of cognitive performance score as determined under WAC 388-106-0090, clinical complexity as determined under WAC 388-106-0095, mood/behavior and behavior point score as determined under WAC 388-106-0100, ADLS as determined under WAC 388-106-0105, and exceptional care as determined under WAC 388-106-0110 to place you into one of the following seventeen in-home groups. CARE classification is determined first by meeting criteria to be placed into a group, then you are further classified based on ADL score or behavior point score into a classification sub-group following a classification path of highest possible base hours to lowest qualifying base hours.

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

(a) **Group E High** with ((~~416~~)) 393 base hours if you have an ADL score of 26-28; or

(b) **Group E Medium** with ((~~346~~)) 327 base hours if you have an ADL score of 22-25.

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

(a) **Group D High** with ((~~277~~)) 260 base hours if you have an ADL score of 25-28; or

(b) **Group D Medium-High** with ((~~234~~)) 215 base hours if you have an ADL score of 18-24; or

(c) **Group D Medium** with ((~~185~~)) 168 base hours if you have an ADL score of 13-17; or

(d) **Group D Low** with ((~~138~~)) 120 base hours if you have an ADL score of 2-12.

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

(a) **Group C High** with ((~~194~~)) 176 base hours if you have an ADL score of 25-28; or

(b) **Group C Medium-High** with ((~~174~~)) 158 base hours if you have an ADL score of 18-24; or

(c) **Group C Medium** with ((~~132~~)) 115 base hours if you have an ADL score of 9-17; or

(d) **Group C Low** with ((~~87~~)) 73 base hours if you have an ADL score of 2-8.

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

(a) **Group B High** with ((~~147~~)) 129 base hours if you have an ADL score of 15-28; or

(b) **Group B Medium** with ((~~82~~)) 69 base hours if you have an ADL score of 5-14; or

(c) **Group B Low** with ((~~47~~)) 39 base hours if you have an ADL score of 0-4; or

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

(a) **Group B High** with ((~~147~~)) 129 base hours if you have a behavior point score 12 or greater; or

(b) **Group B Medium-High** with ((~~101~~)) 84 base hours if you have a behavior point score greater than 6; or

(c) **Group B Medium** with ((~~82~~)) 69 base hours if you have a behavior point score greater than 4; or

(d) **Group B Low** with ((~~47~~)) 39 base hours if you have a behavior point score greater than 1.

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

(a) **Group A High** with ((~~71~~)) 59 base hours if you have an ADL score of 10-28; or

(b) **Group A Medium** with ((~~56~~)) 47 base hours if you have an ADL score of 5-9; or

(c) **Group A Low** with ((~~26~~)) 22 base hours if you have an ADL score of 0-4.

WSR 11-02-043
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Administration)

[Filed December 30, 2010, 11:00 a.m., effective January 1, 2011]

Effective Date of Rule: January 1, 2011.

Purpose: The department is adding new WAC 388-71-06020 through 388-71-06420. As a result of the 2009-2011

supplemental operating budget (ESSB 6444), the home care quality authority is no longer funded, and the home care referral registry program has moved to the aging and disability services administration's home and community services division effective July 1, 2010.

This CR-103E replaces emergency rules filed as WSR 10-22-069 to include an amendment to WAC 388-71-06160, which will require individual providers to complete a background check every two years instead of every twelve months. This change is necessary to manage budget shortfalls, as required by Governor's Executive Order 10-04, which reduces current year spending by 6.287%.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

Other Authority: Washington state 2009-2011 supplemental operating budget (ESSB 6444); Governor's Executive Order 10-04.

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 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: These amendments are necessary to address the state's revenue shortfall as outlined in the 2009-2011 supplemental operating budget (ESSB 6444). The home care quality authority is no longer funded, and the home care referral registry moved to the home and community services division effective July 1, 2010. This CR-103E replaces emergency rules filed as WSR 10-22-069 to make additional amendments while the department completes adoption of permanent rules. A CR-101 was filed as WSR 10-14-052, and a CR-102 was filed as WSR 10-24-103.

Number of Sections Adopted in Order to Comply with Federal Statute: New 23, 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 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 23, Amended 0, Repealed 0.

Date Adopted: December 23, 2010.

Katherine I. Vasquez
Rules Coordinator

Referral registry

NEW SECTION

WAC 388-71-06020 What is the purpose of WAC 388-71-06020 through 388-71-06420? The purpose of this chapter is to ensure compliance by the department with the provisions of RCW 74.39.250. The department is authorized to adopt rules under the provisions of the Administrative Procedure Act, chapter 34.05 RCW.

NEW SECTION

WAC 388-71-06040 What definitions apply to WAC 388-71-06020 through 388-71-06420? The following definitions apply to this chapter:

"AAA" refers to the local area agency on aging.

"ALJ" refers to administrative law judge.

"Consumer/employer" refers to an adult or child with functional or developmental disabilities who qualifies for and uses personal care or respite care paid for through medicaid or state-only funds.

"Consumer representative" refers to an individual who is acting on behalf of the consumer/employer.

"Department" means the department of social and health services.

"DSHS" refers to the department of social and health services.

"Emergency provider" means an individual provider who is employed as a back-up for a provider who did not show up or who was unable to work due to unexpected circumstances.

"Employer" refers to the consumer.

"HCRR" refers to the home care referral registry.

"Home care referral registry operations" refers to the activities carried out at the local level to recruit and register individual providers or prospective individual providers for the referral registry and assist consumers to utilize the referral registry to find qualified individual providers.

"Individual provider" means a person, regardless of relationship, including a personal aide working for a consumer under self-directed care, who has a contract with the department of social and health services to provide personal care or respite care services to adults or children with functional or developmental disabilities and is reimbursed for those services through medicaid or state-only funding.

"IP" refers to an individual provider.

"Malfeasance" means any unlawful act committed by the provider, whether in the course of employment or otherwise.

"Mandatory reporter" is an employee of DSHS; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian science practitioner; or health care provider subject to chapter 18.130 RCW.

"Misfeasance" means performance of a workplace duty in an improper manner; including events which jeopardize

the health and safety of persons, unresolved pattern of performance, issues related to truth or dishonesty, including failure to report a criminal conviction.

"OAH" refers to the office of administrative hearings.

"Prospective individual provider" refers to someone who is seeking employment with a consumer/employer.

"Provider" means an individual provider.

"Referral registry" is a data base that is designed to assist consumers with finding individual providers and to assist individual providers to find employment.

"Respite provider" means an individual provider who is employed on a prearranged short-term basis to fill in for a routine caregiver.

"Routine provider" means an individual provider who is employed on a regularly scheduled basis.

NEW SECTION

WAC 388-71-06060 What is the purpose of the referral registry? The purpose of the referral registry was to increase consumer/employer choice while providing assistance in finding individual providers and prospective individual providers. In addition, the referral registry:

(1) Takes into account the consumer/employer needs and preferences when identifying potential individual providers;

(2) Provides for reasonable standards of accountability providers and prospective individual providers listed through the registry;

(3) Is voluntary for individual providers and prospective individual providers and consumers/employers;

(4) Promotes job opportunities for individual providers and prospective individual providers;

(5) Provides access to the data base for consumer/employers who want to query a referral independently; and

(6) Increases a consumer/employer's choice of individual providers and prospective individual providers via an established pool of available individual providers and prospective individual providers on the registry.

NEW SECTION

WAC 388-71-06080 Who is eligible to request a referral from the referral registry? The following people are eligible to request a referral from the referral registry:

(1) Consumer/employers who are adults or children with functional or developmental disabilities who qualify for and use personal care or respite care paid for through medicaid or state-only funds.

(2) People who are authorized to request a referral on behalf of a consumer including family members, area agency on aging case managers, department social workers and/or a consumer representative.

NEW SECTION

WAC 388-71-06100 What is the difference between an individual provider and a prospective individual provider? The difference between an individual provider and a prospective individual provider is

(1) An individual provider is someone who has signed a department contract.

(2) A prospective individual provider is someone who is seeking employment with a consumer/employer and who has not yet signed a DSHS contract.

NEW SECTION

WAC 388-71-06120 What qualifies an individual provider or prospective individual provider to be on the referral registry? In order for an individual provider or prospective individual provider to be qualified to be on the referral registry, the individual provider or prospective individual provider must:

(1) Prior to January 1, 2012 satisfactorily complete a Washington state patrol background check and not be convicted of a disqualifying crime or negative action based on the applicable department list of disqualifying crimes and negative actions; and

(2) Complete an FBI fingerprint-based background check if the person has lived in the state of Washington less than three consecutive years immediately before the background check. An individual provider or prospective individual provider that has lived in Washington state less than three consecutive years may be included on the referral registry for a one hundred twenty-day provisional period as allowed by law or program rules when:

(a) A fingerprint-based background check is pending; and

(b) The individual provider or prospective individual provider is not disqualified based on the immediate result of the Washington state patrol background check.

(3) Not be listed on any long-term care abuse and neglect registry used by the department;

(4) Be eighteen years of age or older;

(5) Provide a valid Washington state driver's license or other valid picture identification;

(6) Have a Social Security card or proof of authorization to work in the United States as required on the employment verification form; and

(7) Comply with requirements listed in WAC 388-71-06180 and other applicable requirements in chapter 388-71 WAC.

(8) Effective January 1, 2012, be screened through the department's fingerprint-based background check, as required by RCW 74.39A.055.

NEW SECTION

WAC 388-71-06130 What information will be considered cause for denying an individual provider or prospective individual provider placement on the referral registry? An individual provider or prospective individual provider will be denied placement on the referral registry when:

(1) A background check that reveals a disqualifying crime or negative action listed on an applicable department list of disqualifying crimes and/or negative actions;

(2) He or she is listed on any state abuse or neglect registry;

(3) He or she is subject to a current and valid protective order that was issued in the state of Washington barring or

restricting contact with children, vulnerable adults or persons with disabilities;

(4) The department individual provider contract is denied; or

(5) He or she is found ineligible per WAC 388-71-0540.

NEW SECTION

WAC 388-71-06135 What information may be considered cause for denying an individual provider or prospective individual provider placement on the referral registry? The following information may be considered cause for denying an individual provider or prospective individual provider placement on the referral registry:

(1) He or she failed to disclose pending charges, criminal convictions, or negative actions on background authorization form;

(2) The department has a reasonable, good faith belief that he or she is unable to meet the care needs of consumers;

(3) The background check reveals an offense or pattern of offenses, not listed on the applicable list of disqualifying crimes, that the department determines may put consumers at risk; or

(4) Information found in WAC 388-71-0543.

NEW SECTION

WAC 388-71-06140 How does an individual provider or prospective individual provider apply to be on the referral registry? In order for an individual provider or prospective individual provider to apply to be on the registry, he or she must:

(1) Contact their local home care referral registry operations;

(2) Request and complete an application packet; and

(3) Meet the qualifications specified in WAC 388-71-06120.

NEW SECTION

WAC 388-71-06160 Does an individual provider or prospective individual provider have any ongoing responsibilities in order to continue to be listed on the referral registry? (1) In order for an individual provider or prospective individual provider to stay on the registry, he or she must:

(a) Contact the referral registry office once a month to verify that the information in the system is accurate and up-to-date; and

(b) Successfully complete the criminal history background check process a minimum of every two years, described in WAC 388-71-06130 and 388-71-0513.

(2) Failure to comply with ongoing responsibilities will result in placing the individual provider or prospective individual provider in an "inactive" status. The provider will not be referred to a consumer/employer when in "inactive" status.

NEW SECTION

WAC 388-71-06180 Are there any training requirements for being on the referral registry? In order for an individual provider or prospective individual provider to be listed on the referral registry, he or she must complete the "Becoming a Professional IP" training prior to being referred to a consumer, unless the person has already worked as an individual provider for more than three months under DSHS contract. All other mandatory training requirements for long-term care workers per chapter 388-71 WAC are applicable.

NEW SECTION

WAC 388-71-06200 Will an individual provider or prospective individual provider be removed from the referral registry? An individual provider or prospective individual provider will be removed from the referral registry when he or she:

(1) Fails to meet the qualifications identified in WAC 388-71-06120 and 388-71-06180;

(2) Committed misfeasance in the performance of his or her duties as an individual provider;

(3) Committed malfeasance in the performance of his or her duties as an individual provider;

(4) Requests that their name be removed from the registry;

(5) Has his or her individual provider contract with the department terminated for cause;

(6) Has a cause for denial, as listed in WAC 388-71-06130, exists; or

(7) Fails to meet qualifications found in WAC 388-71-0510 and 388-71-0540.

NEW SECTION

WAC 388-71-06220 What is the procedure for removing an individual provider or prospective individual provider from the referral registry? The procedure for removing an individual provider or prospective individual provider from the referral registry is as follows:

The department and/or its designee, will review all complaints and disqualification information received and:

(1) For those complaints that fall under the legal jurisdiction of law enforcement or adult protective services (APS) or child protective services (CPS), an immediate referral will be made to the appropriate agency.

(a) The department may initiate an emergency proceeding to inactivate the individual provider or prospective individual provider on the registry pending the investigation.

(b) If APS, CPS, and/or law enforcement declines the referral, the complaint will proceed to assessment, recommendation and decision.

(c) If APS, CPS, and/or law enforcement accepts the complaint, then action beyond the emergency adjudicative process per RCW 34.05.479 will be stayed pending APS, CPS, and/or law enforcement action.

(2) For those complaints not forwarded to APS, CPS, or law enforcement, the department will conduct an internal assessment.

(a) Upon assessment, a decision will be made and notification will be sent, in writing to the individual provider or prospective individual provider.

(b) The individual provider or prospective individual provider has the right to appeal an adverse decision.

(c) The appeal must be sent in writing to the office of administrative hearings (OAH) as designated on the formal notice within twenty-eight days of the date the formal notice was mailed by the department.

(d) OAH will schedule the hearing and notify interested parties.

(e) An administrative law judge (ALJ) from OAH will act as presiding officer for the adjudicative proceeding as provided in RCW 34.05.425 (1)(c).

(f) The ALJ will render an initial decision.

(g) The initial decision will be reviewed and final agency action will be taken by the department board of appeals, either adopting, modifying, or reversing the initial decision.

(h) The final order is the final department action and will be provided to all interested parties and to the individual provider or prospective individual provider along with information regarding the right to seek judicial review in superior court when applicable.

(i) The final order will include, or incorporate by reference to the initial order, all matters required by RCW 34.05.-461(3).

NEW SECTION

WAC 388-71-06240 What is the procedure for the denial of an individual provider or prospective individual provider's application to be on the referral registry? Upon receipt of an individual provider or prospective individual provider's application to be on the referral registry, the department will utilize the following procedure to determine whether the individual provider or prospective individual provider meets the minimum qualifications and whether he or she will be able to appropriately meet the care needs of consumers:

(1) An internal assessment will be conducted, a decision will be made and notification will be sent, in writing to the individual provider or prospective individual provider.

(2) The individual provider or prospective individual provider has the right to appeal an adverse decision.

(3) The appeal must be sent in writing to the office of administrative hearings (OAH) as designated on the formal notice within twenty-eight days of the date the formal notice was mailed by DSHS.

(4) OAH will schedule the hearing and notify interested parties.

(5) An administrative law judge from OAH will act as presiding officer for the adjudicative proceeding as provided in RCW 34.05.425 (1)(c).

(6) The ALJ will render an initial decision.

(7) The initial decision will be reviewed and final department action will be taken by the department board of appeals, either adopting, modifying, or reversing the initial decision.

(8) The final order is the final department action and will be provided to all interested parties and to the individual provider or prospective individual providers along with information regarding the right to seek judicial review in superior court when applicable.

(9) The final order will include, or incorporate by reference to the initial order, all matters required by RCW 34.05-.461(3).

NEW SECTION

WAC 388-71-06260 Who must be notified if a complaint is received about an individual provider? If, in the course of carrying out its duties, the department or its designee, receives a complaint regarding the services being provided by an individual provider, the department, or its designee, must notify the relevant area agency on aging case manager or DSHS social worker regarding such concerns per RCW 74.39A.250 (1)(h).

NEW SECTION

WAC 388-71-06280 Are referral registry staff considered mandatory reporters? Any department staff, or subcontracted staff working for the referral registry are considered mandatory reporters.

NEW SECTION

WAC 388-71-06300 What is reasonable cause for mandatory reporting? RCW 74.34.035 outlines reasonable cause for mandatory reporting.

NEW SECTION

WAC 388-71-06320 Does an individual provider or prospective individual provider have the right to appeal being removed from the referral registry? The individual provider or prospective individual provider or the consumer/employer, to whom the individual provider is providing services, has the right to appeal when he or she is being removed from the referral registry, as provided in RCW 74.39A.250 (1)(e) and WAC 388-71-06240.

A letter will be sent notifying the individual provider or prospective individual provider that he or she is being removed from the registry and will include information pertaining to the appeal and hearing process.

NEW SECTION

WAC 388-71-06340 How does a consumer/employer apply to use the referral registry services? In order to use the referral registry, a consumer/employer or consumer representative must complete the registration process. The registration process conducted by the local home care referral registry operations must confirm that the consumer/employer is qualified to receive personal care or respite care paid for through medicaid or state-only funds.

NEW SECTION

WAC 388-71-06360 How does a consumer/employer obtain a list of names from the referral registry? In order for a consumer/employer or consumer representative to obtain a referral list of names, he or she must complete and submit a request application to the local referral registry. The completed application may indicate the days and times an individual provider is needed, the personal care tasks that need to be performed, and any preferences the consumer/employer may have. Upon completion of the application, a registry coordinator will conduct a query that will gen-

erate a list of names that best match the consumer/employer's specific criteria. The list will be given to the consumer/employer via mail, phone, fax, or email, depending on the consumer/employer's preference, within a reasonable time.

Upon successful submission of a request application, a consumer/employer or consumer representative may request a user name and password to access the registry independently to generate a list of names.

NEW SECTION

WAC 388-71-06380 Who hires an individual provider or prospective individual provider? It is the consumer/employer or consumer representative's responsibility to interview, screen, hire, supervise, and terminate an individual provider or prospective individual provider.

NEW SECTION

WAC 388-71-06400 Does a consumer/employer who is eligible to have his or her individual provider to be paid through medicaid or public funding from DSHS need to gain approval from his/her case manager, social worker or nurse? A consumer/employer who is eligible for his/her individual provider to be paid through medicaid or public funding from the department must be approved by his/her case manager, social worker or nurse. Pursuant to WAC 388-71-0540 through 388-71-0551, DSHS or the AAA may deny payment to the client's choice of an individual provider or prospective individual provider when:

(1) The individual provider or prospective individual does not meet the requirements to contract with DSHS; or

(2) The case manager has a reasonable, good faith belief that the person will be unable to appropriately meet the consumer/employer needs.

NEW SECTION

WAC 388-71-06420 How can a consumer/employer use the referral registry to get an individual provider in an emergency or as a critical personal care back-up? In order to obtain an emergency or critical personal care back-up referral, a consumer/employer must complete an application with the referral registry office. Registry applications can be completed by contacting the local referral registry. Although a consumer/employer must complete the application process, he/she is not required to have previously used the registry prior to requesting a back-up referral.

WSR 11-02-047
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 10-325—Filed December 30, 2010, 4:34 p.m., effective December 30, 2010, 4:34 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-04600A; and amending WAC 220-52-046.

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: Prohibits Dungeness crab license holders and vessels/vessel operators designated on the licenses that participated in the coastal commercial Dungeness crab fishery in the waters from Point Arena, California, to Klipsan Beach, Washington, including Willapa Bay, before the area north of Klipsan Beach opens, from fishing in the area between Klipsan Beach and Oysterville until ten days have elapsed from the time that the area north of Klipsan Beach opens; and from fishing in the area between Oysterville and the United States/Canadian border until thirty-five days have elapsed from the time that the area north of Oysterville opens. There is insufficient time to adopt a permanent rule.

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: December 30, 2010.

Lori Preuss
for Philip Anderson
Director

NEW SECTION

WAC 220-52-04600D Coastal crab seasons. Notwithstanding the provisions of WAC 220-52-046, effective immediately until further notice, it is unlawful to fish for Dungeness crab in Washington coastal waters, the Pacific Ocean, Grays Harbor, Willapa Bay, or the Columbia River, except as provided for in this section.

(1) Open area: The area from Klipsan Beach (46°28.00) to the WA/OR border (46°15.00) and Willapa Bay.

(2) For the purposes of this order, the waters of Willapa Bay are defined to include the marine waters east of a line connecting 46°44.76 N, 124°05.76 W and 46°38.93 N, 124°-04.33 W.

(3) Crab gear may be set beginning at 8:00 a.m., November 28, 2010.

(4) It is permissible to pull crab gear beginning at 12:01 a.m., December 1, 2010.

(5) Dungeness crab license holders, or any vessel or vessel operator designated on the license that participated in the coastal commercial Dungeness crab fishery in the waters from Point Arena, California, to Klipsan Beach, Washington (46°28.00), including Willapa Bay, before the area north of Klipsan Beach (46°28.00) opens, are prohibited from:

a. Fishing in the area between Klipsan Beach (46°28.00) and Oysterville (46°33.00) until 10 days have elapsed from the time that the area north of Klipsan Beach opens; and

b. Fishing in the area between Oysterville (46°33.00) and the U.S. Canadian border until 35 days have elapsed from the time that the area north of Oysterville opens.

(6) All other provisions of the permanent rule remain in effect.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-52-04600A Coastal crab seasons. **10-306**

WSR 11-02-057
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-01—Filed January 4, 2011, 10:34 a.m., effective January 7, 2011, 7:00 p.m.]

Effective Date of Rule: January 7, 2011, 7:00 p.m.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-04000B and 220-52-04600C; and amending WAC 220-52-040 and 220-52-046.

Statutory Authority for Adoption: RCW 77.12.047, 77.04.020, and 77.70.430.

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 regulation closes Puget Sound Crab Management Region 2 West because the state commercial crab harvest will reach its quota for this region on the prescribed date. This regulation maintains the closure of Puget Sound Crab Management Region 2 East because the state commercial crab harvest has reached its quota for that region. 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 2, Amended 0, Repealed 2.

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

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

Date Adopted: January 4, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-52-04600E Puget Sound crab fishery—Seasons and areas. Notwithstanding the provisions of WAC 220-52-046:

(1) Effective 7:00 p.m., January 7, 2011, until further notice, it is unlawful to fish for or possess Dungeness crab for commercial purposes in those waters of Puget Sound Crab Management Region 2 West (which includes Marine Fish-Shellfish Management and Catch Reporting Areas 25B, 25D, and 26A-W).

(2) Effective immediately, until further notice, it is unlawful to fish for or possess Dungeness Crab for commercial purposes in those waters of Puget Sound Crab Management Region 2 East (Marine Fish-Shellfish Management and Catch Reporting Areas 24A, 24B, 24C, 24D and 26A East).

(3) Effective immediately until further notice, it is permissible to fish for Dungeness crab for commercial purposes in the following areas:

(a) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 20A between a line from the boat ramp at the western boundary of Birch Bay State Park to the western point of the entrance of the Birch Bay Marina and a line from the same boat ramp to Birch Point.

(b) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 22B in Fidalgo Bay south of a line projected from the red number 4 entrance buoy at Cape Sante Marina to the northern end of the eastern most oil dock.

(c) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 22A in Deer Harbor north of a line projected from Steep Point to Pole Pass.

(4) Effective immediately until further notice, the following areas are closed to commercial crab fishing:

(a) That portion of Marine Fish-Shellfish Management and Catch Reporting Area 25A west of the 123º7.0' longitude line projected from the new Dungeness light due south to the shore of Dungeness Bay.

(b) That portion of Marine Fish-Shellfish Management and Catch Reporting Area 23D west of a line from the eastern tip of Ediz Hook to the ITT Rayonier Dock.

REPEALER

The following sections of the Washington Administrative Code are repealed effective 7:00 p.m. January 7, 2011:

WAC 220-52-04000B	Commercial crab fishery—Lawful and unlawful gear, methods, and other unlawful acts. (10-322)
WAC 220-52-04600C	Puget Sound crab fishery—Seasons and areas. (10-322)

WSR 11-02-062
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-02—Filed January 4, 2011, 2:28 p.m., effective January 4, 2011, 2:28 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend personal use fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 232-28-619.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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

Reasons for this Finding: The invasive species New Zealand mudsnail is present in the lake. Mudsnails are easily transported on shoes, boots, and fishing gear to which they may attach themselves, therefore, it is necessary to close the lake to fishing to prevent the spread of New Zealand mudsnails. The lake has already been closed to salmon angling. This rule is interim until permanent rules take effect.

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 0.

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

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

Date Adopted: January 4, 2011.

Philip Anderson
Director

NEW SECTION

WAC 232-28-61900L Exceptions to statewide rules—Capitol Lake. Notwithstanding the provisions of WAC 232-28-619, effective immediately until further notice, it is unlawful to fish in waters of Capitol Lake.