WSR 11-22-007
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-283—Filed October 20, 2011, 1:58 p.m., effective October 23, 2011]

Effective Date of Rule: October 23, 2011.

Purpose: Amend recreational fishing rules.

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

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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

Reasons for this Finding: Based on the Hanford Reach Fall Chinook Harvest Management Plan, the 2011 fall chinook return to the Hanford Reach is sufficient to allow additional harvest in the terminal sport fishery. The current in-season estimate for the fall chinook return to the Hanford Reach is 72,904 adults. There is insufficient time to adopt permanent rules.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 20, 2011.

Philip Anderson
Director

NEW SECTION

WAC 232-28-61900E Exceptions to statewide rules—Columbia River. Notwithstanding the provisions of WAC 232-28-619, effective October 23 through October 31, 2011, it is permissible to fish for salmon in waters of the Columbia River from the Highway 395 Bridge upstream to the old Hanford townsite wooden powerline towers. Daily limit of six salmon; up to two adults may be retained. Anglers may not continue to fish for jack salmon once the adult limit is retained. Both hatchery and wild (adipose clipped and unclipped) fall Chinook and coho can be retained during this fishery.

REPEALER

The following section of the Washington Administrative Code is repealed effective November 1, 2011:

WAC 232-28-61900E	Exceptions to statewide rules—Columbia River.

WSR 11-22-011
RESCISSION OF EMERGENCY RULES
OFFICE OF FINANCIAL MANAGEMENT

[Filed October 21, 2011, 12:32 p.m.]

This memo is to rescind the emergency rule filing WSR 11-13-080 that was filed on June 17, 2011. Please rescind effective October 24, 2011.

Should you have any questions regarding this matter, please contact Kristie Wilson at (360) 664-6408.

Eva Santos
State Human Resources Director

WSR 11-22-012
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed October 21, 2011, 12:35 p.m., effective October 26, 2011]

Effective Date of Rule: October 26, 2011.

Purpose: The legislature passed ESHB 1086, which reduces funding for maternity support services and mandates the health care authority to prioritize evidence-based practices for delivery of maternity support services and to target funding for maternity support services by leveraging local public funding for those services. In addition, upon order of the governor, the medicaid purchasing administration must reduce its budget expenditures for the current fiscal year ending June 30, 2011, by 6.3 percent.

Citation of Existing Rules Affected by this Order: Amending WAC 182-533-0300, 182-533-0320, 182-533-0325, 182-533-0370, and 182-533-0380.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: Chapter 5, Laws of 2011, ESHB 1086 and HB 1248 which extends the allowance of emergency rule filing through fiscal year 2013.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, 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: See Purpose statement above. This emergency rule is necessary to continue the emergency rule that is currently in effect under WSR 11-14-027 while the permanent rule-making process initiated under WSR 10-20-165 is completed. The agency anticipates filing the CR-102 for the proposed permanent rule sometime in November 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 5, Repealed 0.

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

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

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 5, Repealed 0.

Date Adopted: October 21, 2011.

Kevin M. Sullivan

Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-533-0300 Services under First Steps. (1) Under the 1989 Maternity Care Access Act, and RCW 74.09.760 through 74.09.910, the ((~~department~~)) agency established First Steps to provide access to services for eligible women and their infants.

(2) The rules for the:

(a) Maternity support services (MSS) component of First Steps are found in WAC ((~~388-533-0310~~)) 182-533-0310 through ((~~388-533-0345~~)) 182-533-0345.

(b) Infant case management (ICM) component of First Steps are found in WAC ((~~388-533-0360~~)) 182-533-0360 through ((~~388-533-0386~~)) 182-533-0386.

(c) Childbirth education (CBE) component of First Steps are found in WAC ((~~388-533-0390~~)) 182-533-0390.

(3) Other services under First Steps include:

(a) Medical services, including full medical coverage, prenatal care, delivery, post-pregnancy follow-up, ((~~dental, vision,~~)) and twelve months family planning services post-pregnancy;

(b) Ancillary services, including but not limited to, expedited medical eligibility determination((~~, case finding and outreach~~)); and

(c) Alcohol and drug assessment and treatment services for pregnant women available statewide and administered by the division of behavioral health and recovery (see WAC ((~~388-533-0701~~)) 182-533-0701).

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-533-0320 Maternity support services—Client eligibility. (1) To receive maternity support services (MSS), a client must:

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

(i) Categorically needy ((~~program (CNP)~~)) (CN);

(ii) ((~~CNP - Children's health insurance program~~)) Children's health care as described in WAC 388-505-0210;

(iii) Medically needy program (MNP); or

(iv) A pregnancy medical program as described in WAC 388-462-0015.

(b) Be within the eligibility period of a maternity cycle as defined in WAC ((~~388-533-0315~~)) 182-533-0315; and

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

(2) Clients who meet the eligibility criteria in this section may receive:

(a) An in-person screening by a provider who meets the criteria established in WAC ((~~388-533-0325~~)) 182-533-0325. Clients are screened for risk factors related to issues that may impact their birth outcomes.

(b) Up to the maximum number of MSS units of service allowed per client as determined by the ((~~department~~)) agency and published in the ((~~department's~~)) agency's current billing instructions and/or numbered memoranda. The ((~~department~~)) agency may determine the maximum number of units allowed per client when directed by the legislature to achieve targeted expenditure levels for payment of maternity support services for any specific biennium.

(3) Clients meeting the eligibility criteria in this section who are enrolled in ((~~a department-contracted~~)) an agency-contracted managed care ((~~plan~~)) organization (MCO), are eligible for MSS outside their plan.

(4) See chapter ((~~388-534~~)) 182-534 WAC for clients eligible for coverage under the early periodic screening, diagnosis and treatment (EPSDT) program.

(5) Clients receiving MSS before ((~~July 1, 2009~~)) March 1, 2011, are subject to the transition plan as determined and published by the ((~~department~~)) agency in numbered memoranda.

(6) Clients who do not agree with ((~~a department~~)) an agency decision regarding eligibility for MSS have a right to a fair hearing under chapter 388-02 WAC.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-533-0325 Maternity support services—Provider requirements. (1) To be paid for providing maternity support services (MSS) and infant case management (ICM) services to eligible clients, an agency or entity must:

(a) Be currently approved as an MSS/ICM provider by the ((~~department of health (DOH)~~)) medicaid agency;

(b) Be enrolled as an eligible provider with the ((~~department of social and health services' (department's) health and~~

~~recovery services administration (HRSA)~~)) medicaid agency (see WAC ((~~388-502-0010~~)) 182-502-0010);

(c) Ensure that staff providing services meet the minimum regulatory and educational qualifications for the scope of services provided; and

(d) Meet the requirements in this chapter, chapter ((~~388-502~~)) 182-502 WAC and the ((~~department's~~)) medicaid agency's current published billing instructions and numbered memoranda.

(2) An individual or service organization that has a written agreement with an agency or entity that meets the requirements in subsection (1) of this section may also provide MSS and ICM services to eligible clients.

(a) The ((~~department~~)) medicaid agency requires the agency or entity to:

(i) Keep a copy of the written agreement on file;

(ii) Ensure that an individual or service organization staff member providing MSS/ICM services meets the minimum regulatory and educational qualifications required of an MSS/ICM provider;

(iii) Assure that the individual or service organization provides MSS/ICM services under the requirements of this chapter; and

(iv) Maintain professional, financial, and administrative responsibility for the individual or service organization.

(b) The agency or entity is responsible to:

(i) Bill for services using the agency's or entity's assigned provider number; and

(ii) Reimburse the individual or service organization for MSS/ICM services provided under the written agreement.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-533-0370 Infant case management—Eligibility. (1) To receive infant case management (ICM), an infant must:

(a) Be covered under one of the medical assistance programs listed in WAC ((~~388-533-0320~~)) 182-533-0320(1);

(b) Meet the age requirement for ICM which is the day after the maternity cycle (defined in WAC ((~~388-533-0315~~)) 182-533-0315) ends, through the last day of the month of the infant's first birthday;

(c) Reside with at least one parent (see WAC ((~~388-533-0315~~)) 182-533-0315 for definition of parent);

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

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

(2) Infants who meet the eligibility criteria in subsection (1) of this section, and the infant's parent(s), are eligible to receive:

(a) An in-person screening by a provider who meets the criteria established in WAC ((~~388-533-0375~~)) 182-533-0375. Infants and their parent(s) are screened for risk factors related to issues that may impact the infant's welfare, health, and/or safety.

(b) Up to the maximum number of ICM units of service allowed per client as determined by the ((~~department~~)) agency and published in the ((~~department's~~)) agency's current billing instructions and/or numbered memoranda. The ((~~department~~)) agency may determine the maximum number of units allowed per client when directed by the legislature to achieve targeted expenditure levels for payment in any specific biennium.

(3) Clients meeting the eligibility criteria in subsection (1) of this section who are enrolled in ((~~a department-contracted~~)) an agency-contracted managed care ((~~plan~~)) organization (MCO) are eligible for ICM services outside their plan.

(4) See chapter ((~~388-534~~)) 182-534 WAC for clients eligible for coverage under the early periodic screening, diagnosis and treatment (EPSDT) program.

(5) Clients receiving ICM before ((~~July 1, 2009~~)) March 1, 2011, are subject to the transition plan as determined and published by the ((~~department~~)) agency in numbered memoranda.

(6) Clients who do not agree with ((~~a department~~)) an agency decision regarding eligibility for ICM have a right to a fair hearing under chapter 388-02 WAC.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-533-0380 Infant case management—Covered services. (1) The ((~~department~~)) agency covers infant case management (ICM) services subject to the restrictions and limitations in this section and other applicable WAC.

(2) Covered services include:

(a) An initial in-person screening for ICM services which includes an assessment of risk factors, and the development of an individualized care plan;

(b) Case management services and care coordination;

(c) Linking and referring the infant and parent(s) to other services or resources;

(d) Advocating for the infant and parent(s);

(e) Follow-up contact(s) with the parent(s) to ensure the care plan continues to meet the needs of the infant and parent(s); and

(f) Additional services as determined and published in the maternity support services/infant case management (MSS/ICM) billing instructions.

(3) The ((~~department~~)) agency pays for covered ICM services according to WAC ((~~388-533-0386~~)) 182-533-0386.

WSR 11-22-014
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-284—Filed October 21, 2011, 1:59 p.m., effective October 28, 2011, 12:01 p.m.]

Effective Date of Rule: October 28, 2011, 12:01 p.m.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-36000V; 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 opened 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: October 21, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-56-36000V 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. October 28 through 11:59 p.m. October 29, 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. October 28 through 11:59 p.m. October 29, 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. October 28 through 11:59 p.m. October 29, 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). 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. October 30, 2011:

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

WSR 11-22-015
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-287—Filed October 21, 2011, 3:53 p.m., effective October 21, 2011, 3:53 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-47-41100X; and amending WAC 220-47-411.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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

Reasons for this Finding: Harvestable coho are available and agreement was reached with comanagers to extend the fishery. 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: October 21, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-47-41100X Puget Sound gill nets—Open periods. Notwithstanding the provisions of WAC 220-47-411, it is unlawful to take, fish for, or possess salmon taken will gill net gear for commercial purposes from Puget Sound Salmon Management and Catch Reporting Area 6D, except during the following periods:

AREA	TIME	DATE(S)	MINIMUM MESH
6D: Skiff gill net only, definition WAC 220-16-046 and lawful gear description WAC 220-47-302.	7 AM - 7 PM	10/24 - 10/28	5"

Note: In Area 6D, it is unlawful to use other than 5-inch minimum mesh in the skiff gill net fishery. It is unlawful to retain Chinook or chum salmon taken in Area 6D at any time. In Area 6D, any Chinook or chum salmon required to be released must be removed from the net by cutting the meshes ensnaring the fish.

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.

Reviser's note: The unnecessary underscoring 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 7:01 p.m. October 28, 2011:

WAC 220-47-41100X	Puget Sound gill nets—Open periods.

WSR 11-22-020
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-286—Filed October 24, 2011, 11:58 a.m., effective October 25, 2011, 7:10 p.m.]

Effective Date of Rule: October 25, 2011, 7:10 p.m.

Purpose: Amend recreational 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: Condit Dam on the White Salmon River will be breached on Wednesday, October 26, 2011. This will result in a large input of water and sediment into the lower river. It will also result in unstable and potentially unsafe river and bank conditions this winter. Conditions will be monitored and when they stabilize, seasons are expected to resume. 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 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: October 24, 2011.

Philip Anderson
Director

NEW SECTION

WAC 232-28-61900G Exceptions to statewide rules—White Salmon River. Notwithstanding the provisions of WAC 232-28-619, effective 7:10 p.m. October 25, 2011, until further notice, it is unlawful to fish in waters of the White Salmon River (including Northwestern Reservoir).

WSR 11-22-021
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-285—Filed October 24, 2011, 4:34 p.m., effective October 26, 2011, 6:00 p.m.]

Effective Date of Rule: October 26, 2011, 6:00 p.m.

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

Citation of Existing Rules Affected by this Order: Repealing WAC 220-32-05700D and 220-32-05700E; and amending WAC 220-32-057.

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

Other Authority: *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546); *Northwest Gillnetters Ass'n v. Sandison*, 95 Wn.2d 638, 628 P.2d 800 (1981); Washington fish and wildlife com-

mission policies concerning Columbia River fisheries; 40 Stat. 515 (Columbia River compact).

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

Reasons for this Finding: Closes Bonneville Pool (SMCRA 1F) in the sturgeon set-line commercial treaty fishery in Zone 6, effective 6:00 p.m., October 26, as harvest is nearing the guideline for that area. SMCRA 1G and 1H remain open as scheduled through 6:00 p.m., October 31. Allows sales only of sturgeon, (including platform and hook and line). Sturgeon remain available for harvest based on the 2011 sturgeon guidelines. Conforms state rules to tribal rules. Consistent with compact action of October 24, 2011. There is insufficient time to promulgate permanent rules.

The Yakama, Warm Springs, Umatilla, and Nez Perce Indian tribes have treaty fishing rights in the Columbia River and inherent sovereign authority to regulate their fisheries. Washington and Oregon also have some authority to regulate fishing by treaty Indians in the Columbia River, authority that the states exercise jointly under the congressionally ratified Columbia River compact. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969).

The tribes and the states adopt parallel regulations for treaty Indian fisheries under the supervision of the federal courts. A court order sets the current parameters. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546). Some salmon and steelhead stocks in the Columbia River are listed as threatened or endangered under the federal ESA. On May 5, 2008, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allow for some incidental take of these species in the fisheries as described in the 2008-2017 *U.S. v. Oregon* Management Agreement. Columbia River fisheries are monitored very closely to ensure consistency with court orders and ESA guidelines. Because conditions change rapidly, the fisheries are managed almost exclusively by emergency rule. As required by court order, the Washington (WDFW) and Oregon (ODFW) departments of fish and wildlife convene public hearings and invite tribal participation when considering proposals for new emergency rules affecting treaty fishing rights. *Sohappy*, 302 F. Supp. at 912. WDFW and ODFW then adopt regulations reflecting agreements reached.

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

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

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 2.

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

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

Date Adopted: October 24, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-32-05700E Columbia River sturgeon seasons above Bonneville Dam. Notwithstanding the provisions of WAC 220-32-057, effective immediately, it is unlawful to take, fish for or possess sturgeon for commercial purposes in Columbia River Salmon Management and Catch Reporting Areas 1F, 1G, and 1H, except that those individuals possessing treaty fishing rights under the Yakama, Warm Springs, Umatilla, and Nez Perce treaties may fish for sturgeon with set-line gear under the following provisions:

1. **Open period:** 6:00 p.m. October 26 through 6:00 p.m. October 31, 2011.

2. **Area:** SMCRA 1G, 1H

3. **Gear:** Set-lines. Fishers are encouraged to use circle hooks and avoid J-hooks. It is unlawful to use setline gear with more than 100 hooks per set-line, with hooks less than the minimum size of 9/0, with treble hooks, without visible buoys attached, and with buoys that do not specify operator and tribal identification.

Traditional platform and hook and line gear is also allowed, which includes hoop nets, dip bag nets, and rod and reel with hook and line gear.

4. **Allowable Sales:** Sturgeon caught in SMCRA 1G and 1H that are between 43 and 54 inches in fork length. Sturgeon within the size limits stated above, and caught in platform and hook and line fishery may be sold if caught during the open periods and area of the set-line fishery.

5. **Sanctuaries:** Standard sanctuaries applicable to these gear types. No Spring Cr. Sanctuary.

6. **Additional Regulations:** 24-hour quick reporting required for Washington wholesale dealers, pursuant to WAC 220-69-240.

7. **Miscellaneous:** It is unlawful to sell, barter, or attempt to sell or barter sturgeon eggs that have been removed from the body cavity of a sturgeon prior to sale of the sturgeon to a wholesale dealer licensed under chapter 75.28 RCW, or to sell or barter sturgeon eggs at retail. It is unlawful to deliver to a wholesale dealer licensed under chapter 75.28 RCW any sturgeon that are not in the round with the head and tail intact.

Reviser's note: The unnecessary underscoring 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 6:00 p.m. October 26, 2011:

WAC 220-32-05700D	Columbia River sturgeon seasons above Bonneville.

The following section of the Washington Administrative Code is repealed effective 6:01 p.m. October 31, 2011:

WAC 220-32-05700E	Columbia River sturgeon seasons above Bonneville.

WSR 11-22-028
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Medicaid Program)

[Filed October 25, 2011, 11:07 a.m., effective October 27, 2011]

Effective Date of Rule: October 27, 2011.

Purpose: To establish hearing rules related to medicaid funded services to implement the requirements of 2E2SBH [2E2SHB] 1738, section 53, effective July 1, 2011, for the transition of the single state medicaid agency to the Washington health care authority.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-526-2610.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: 2E2SHB 1738, section 53.

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 year 2009, 2010, 2011, 2012 or 2013, 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: 2E2SHB 1738, section 53(10) states that the authority "shall adopt any rules it deems necessary to implement this section" dealing with hearing rights. Further, in section 130, the bill states that "this act is necessary for the *immediate* preservation of the public peace, health, or safety of the state government and its existing public institution, and takes effect July 1, 2011." Delaying this adoption could jeopardize the agency's ability to provide general hearing rules and procedures that apply to the resolution of disputes between medical assistance clients and the various medical services programs established under chapter 74.09 RCW. This emergency rule is necessary to continue the current emergency rule adopted under WSR 11-14-040 while the permanent rule-making process is completed. The agency filed CR-101 preproposal statement of inquiry under WSR 11-19-004 on September 7, 2011, and is currently following the permanent rules process with internal drafting of the rules, conducting meetings in-house, and scheduling a discussion meeting with interested stakeholders.

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 137, 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 137, Amended 0, Repealed 1.

Date Adopted: October 20, 2011.

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 11-23 issue of the Register.

WSR 11-22-030
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-288—Filed October 25, 2011, 2:15 p.m., effective October 27, 2011, 7:00 p.m.]

Effective Date of Rule: October 27, 2011, 7:00 p.m.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-04000G and 220-52-04600K; and amending WAC 220-52-040 and 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: The provisions of this rule are in conformity with agreed plans with applicable tribes, which have been entered as required by court order. The Puget Sound commercial season is structured to meet harvest allocation objectives. The current commercial allocation in Region 2 West will be reached by October 27, 2011. 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: October 25, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-52-04000H Commercial crab fishery—Lawful and unlawful gear, methods, and other unlawful acts. Notwithstanding the provisions of WAC 220-52-040:

(1) Additional area gear limits. The following Marine Fish-Shellfish Management and Catch Reporting Areas are restricted in the number of pots fished, operated, or used by a person or vessel, and it is unlawful for any person to use, maintain, operate, or control pots in excess of the following limits:

(a) No commercial gear is allowed in that portion of Marine Fish-Shellfish Management and Catch Reporting Area 25A west of the 123° 7.0' longitude line projected from the new Dungeness light due south to the shore of Dungeness Bay.

(2) Effective immediately until further notice, it is unlawful for any person to fish for crabs for commercial purposes with more than 50 pots per license per buoy tag number in Crab Management Region 1 (Marine Fish-Shellfish Management and Catch Reporting Areas 20A, 20B, 21A, 21B, 22A, 22B.

(3) Effective immediately until further notice, it is unlawful for any person to fish for crabs for commercial purposes with more than 75 pots per license per buoy tag number in Crab Management sub-area 3-2 (Marine Fish-Shellfish Management and Catch Reporting Areas 25A, 25E, 23D).

(4) Effective immediately until 7:00 p.m. October 27, 2011, it is unlawful for any person to fish for crabs for commercial purposes with more than 50 pots per license per buoy tag number in Crab Management Region 2 West (Marine Fish-Shellfish Management and Catch Reporting Areas 26A-West, 25B, 25D).

(5) The remaining buoy tags per license per region must be onboard the designated vessel and available for inspection.

NEW SECTION

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

(1) 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.

(2) Effective immediately until 7:00 p.m. October 27, 2011, 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 26A-W in Useless Bay north and east of a line from the south end of the Double Bluff State Park seawall
(47°58.782'N, 122°30.840'W) projected 110 degrees true to the boulder on shore (47°57.690'N, 122°26.742'W).

(3) 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 123° 7.0' 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.

(c) Crab Management Region 2 East (Marine Fish-Shellfish Management and Catch Reporting Areas 24A, 24B, 24C, 24D, 26A-East) and sub-area 3-1 (Marine Fish-Shellfish Management and Catch Reporting Areas 23A and 23B).

(4) Effective 7:00 p.m. October 27, 2011, until further notice, the following areas are closed to commercial crab fishing:

(a) Crab Management Region 2 West (Marine Fish-Shellfish Management and Catch Reporting Areas 26A-West, 25B, 25D).

REPEALER

The following sections of the Washington Administrative Code are repealed effective 7:00 p.m. October 27, 2011:

WAC 220-52-04000G	Commercial crab fishery—Lawful and unlawful gear, methods, and other unlawful acts. (11-275)
WAC 220-52-04600K	Puget Sound crab fishery—Seasons and areas. (11-275)

WSR 11-22-038
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed October 27, 2011, 9:36 a.m., effective October 27, 2011, 9:36 a.m.]

Effective Date of Rule: Immediately.

Purpose: The department of social and health services, division of child support (DCS) is filing this second emer-

gency rule to maintain the status quo as we complete the regular rule adoption process amending various sections of chapter 388-14A WAC to implement sections 9, 10 and 11 of ESSB 5921 (chapter 42, Laws of 2011).

THESE RULES ARE EXACTLY THE SAME AS THE PRIOR EMERGENCY RULES.

The statutory changes took effect on July 1, 2011. DCS adopted emergency rules under WSR 11-14-086 in order to have our rule changes effective by July first.

At the same time we filed this emergency rule-making order, DCS filed a CR-101 Preproposal statement of inquiry, to start the regular rule-making process. DCS filed the CR-102 Notice of proposed rule making, as WSR 11-20-098; the public rule-making hearing for adoption of permanent rules is set for November 8, 2011.

Citation of Existing Rules Affected by this Order: New sections WAC 388-14A-2007 Does an application for subsidized child care automatically become an application for support enforcement services?, 388-14A-2042 What happens if I don't cooperate with DCS while I receive a child care subsidy? and 388-14A-2093 Who is mailed notice of DCS' intent to close a case when the custodial parent receives a child care subsidy or a working connections child care subsidy?; and amending WAC 388-14A-2040 Do I have to cooperate with the division of child support in establishing or enforcing child support?, 388-14A-2041 What happens if I don't cooperate with DCS while I receive public assistance?, 388-14A-2045 What can I do if I am afraid that cooperating with the division of child support will be harmful to me or to my children?, 388-14A-2050 Who decides if I have good cause not to cooperate?, and 388-14A-2075 What happens if the division of child support determines that I am not cooperating?

Statutory Authority for Adoption: ESSB 5921 (chapter 42, Laws of 2011); RCW 34.05.020, 34.05.220, 34.05.350, 74.08.090, 74.20.040.

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 year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: The statutory changes were effective July 1, 2011, and DCS adopted emergency rules effective that date. This second emergency filing is necessary to maintain the status quo until the permanent rules are final.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 3, Amended 5, Repealed 0.

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

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

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 3, Amended 5, Repealed 0.

Date Adopted: October 19, 2011.

Katherine I. Vasquez
Rules Coordinator

NEW SECTION

WAC 388-14A-2007 Does an application for subsidized child care automatically become an application for support enforcement services? (1) As a condition of receiving a child care subsidy or a working connections child care (WCCC) subsidy, the applicant or recipient must seek child support enforcement services, unless the department finds that the applicant or recipient has good cause not to cooperate.

(a) An application for a subsidy does not automatically become an application for support enforcement services.

(b) The person receiving the subsidy must file a signed application for support enforcement services as described in WAC 388-14A-2000 and 388-14A-2010, unless the person is also receiving cash assistance.

(2) Payment for subsidized child care services or WCCC services constitutes an authorization to DCS to provide the recipient of the subsidy with support enforcement services, but the recipient must submit a signed application, as provided in subsection (1) of this section.

(3) DCS collects, but does not retain, child support payments unless there is also an assignment of rights based on receipt of cash assistance or medical assistance.

(4) If DCS documents failure to cooperate by the custodial parent (CP), and that cooperation is essential for the next step in enforcement, DCS closes the child support enforcement case under WAC 388-14A-2080(8) or as that section may hereinafter be amended.

(5) If the person receiving the subsidy requests that DCS stop providing services and there is no current assignment of medical or support rights, DCS closes the child support enforcement case under WAC 388-14A-2080(4) or as that section may hereinafter be amended.

(6) If DCS closes a case as provided in subsection (4) or (5) of this section, DCS notifies the community services division (CSD) that the recipient of the subsidy has failed to cooperate with DCS. Any sanctions for failure to cooperate are determined by the CSO or the department of early learning (DEL).

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

WAC 388-14A-2040 Do I have to cooperate with the division of child support in establishing or enforcing child support? (1) You must cooperate with the division of child

support (DCS) when you receive public assistance unless the department determines there is good cause not to cooperate under WAC 388-422-0020.

(2) You must cooperate with the division of child support (DCS) when you receive a child care subsidy or a working connections child care (WCCC) subsidy, unless the department determines there is good cause not to cooperate under WAC 388-422-0020 or another specific DEL rule.

(3) As described in WAC 388-14A-2080, DCS may close a nonassistance case if the custodial parent (CP) fails to cooperate, if cooperation is essential for the next step in enforcement.

(4) For purposes of this section and WAC 388-14A-2075, cooperating with DCS includes cooperating with those acting on behalf of DCS (its "representatives"), namely the prosecuting attorney, the attorney general, or a private attorney paid per RCW 74.20.350. In cases where paternity is at issue, the custodial parent (CP) of a child who receives assistance must cooperate whether or not the parent receives assistance.

((~~(2)~~)) (5) Cooperation means giving information, attending interviews, attending hearings, or taking actions to help DCS establish and collect child support. This information and assistance is necessary for DCS to:

(a) Identify and locate the responsible parent;

(b) Establish the paternity of the child(ren) on assistance in the CP's care; and

(c) Establish or collect support payments or resources such as property due the CP or the child(ren).

((~~(3)~~)) (6) The CP must also cooperate by sending to DCS any child support received by the CP while on assistance, as required by RCW 74.20A.275 (3)(c). If the client keeps these payments, known as retained support, the CP must sign an agreement to repay under RCW 74.20A.275, and the CP must honor that agreement.

((~~(4)~~)) (7) The cooperation requirements of subsections (1), (4) and ((~~(2)~~)) (5) above, but not subsection ((~~(3)~~)) (6), apply to a recipient of medicaid-only assistance.

(8) The cooperation requirements of subsections (2), (4) and (5) above, but not subsection (6), apply to a recipient of a child care subsidy or a WCCC subsidy.

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

WAC 388-14A-2041 What happens if I don't cooperate with DCS while I receive public assistance? (1) If you receive public assistance, there may be penalties, called sanctions, for not cooperating with the division of child support (DCS). These sanctions and the noncooperation process are described in WAC 388-14A-2075. You may be sanctioned if:

(a) You do not go to scheduled interviews and answer questions;

(b) There is credible evidence showing that you could have given the information but did not;

(c) You have been giving inconsistent or false information without a good reason; or

(d) You refuse to sign or honor a repayment agreement under WAC 388-14A-2040(3).

(2) You must be given the opportunity to swear you do not have the information.

(3) You cannot be sanctioned because you provided information on a possible parent who was then excluded by genetic testing. In this event you must continue to cooperate in naming other possible parents and taking part in any resulting genetic testing.

(4) You may not be able to help DCS if you do not know, do not possess, or cannot reasonably obtain the requested information. To avoid a sanction, you must, under penalty of perjury, swear or attest to your lack of information in an interview held by DCS or its representative.

(5) If you fear that cooperation may cause harm to you or your children, you may contact the community services division (CSD) to claim good cause not to cooperate under WAC 388-422-0020.

NEW SECTION

WAC 388-14A-2042 What happens if I don't cooperate with DCS while I receive a child care subsidy? (1) If the division of child support (DCS) closes your nonassistance case either at your request or based on your failure to cooperate while you are a recipient of a child care subsidy or a working connections child care (WCCC) subsidy, DCS notifies the community services division (CSD) that your case was closed.

(2) Any sanctions for your failure to cooperate are determined by CSD or the department of early learning (DEL).

(3) If you fear that cooperation may cause harm to you or your children, you may contact the community services division (CSD) to claim good cause not to cooperate under WAC 388-422-0020 or another specific DEL rule.

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

WAC 388-14A-2045 What can I do if I am afraid that cooperating with the division of child support will be harmful to me or to my children? (1) If a custodial parent (CP) receiving public assistance fears that the establishment or enforcement of support may result in harm to the CP or the children, the CP may be excused from the cooperation requirements. ((~~You can~~)) The CP must contact the community services office (CSO) to claim good cause not to cooperate under WAC 388-422-0020. ((~~Go to the community services office (CSO) to claim good cause.~~))

(2) If a CP who is not receiving public assistance but is receiving a child care subsidy or a working connections child care (WCCC) subsidy fears that the establishment or enforcement of support may result in harm to the CP or the children, the CP may be excused from the cooperation requirements. The CP must contact the CSO to claim good cause not to cooperate under WAC 388-422-0020 or another specific DEL rule.

(3) If a CP who is not receiving public assistance, a child care subsidy or a WCCC subsidy fears that the establishment or enforcement of support may result in harm to the CP or the children, the CP should tell the division of child support (DCS) that family violence is an issue in the case, so that

DCS may take appropriate action. The CP may ask DCS to close the nonassistance support enforcement case.

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

WAC 388-14A-2050 Who decides if I have good cause not to cooperate? (1) The community services office (CSO) decides whether you have good cause not to cooperate with the division of child support (DCS). You must tell the CSO if you want to claim good cause.

(a) The CSO determines good cause under WAC 388-422-0020 or another specific DEL rule.

(b) You may claim good cause at the time you apply for public assistance or for a child care or working connections child care (WCCC) subsidy, or at any time thereafter.

(2) When you make a claim of good cause not to cooperate, DCS does not take any action on ((~~the~~)) your case while the CSO is reviewing your good cause claim.

(3) If you are not receiving public assistance but are applying for a child care subsidy or a WCCC subsidy, you may be granted good cause and not have to apply for child support enforcement services.

AMENDATORY SECTION (Amending WSR 03-20-072, filed 9/29/03, effective 10/30/03)

WAC 388-14A-2075 What happens if the division of child support determines that I am not cooperating? (1) When the division of child support (DCS) or its representatives believe ((~~you are~~)) that a custodial parent (CP) who receives cash assistance or medical assistance not cooperating as defined in WAC 388-14A-2040, DCS sends a notice to ((~~you~~)) the CP and to the community service office (CSO) ((~~stating~~)) about the noncooperation ((~~and explaining~~)).

(a) The notice contains the following information:

(((~~a~~))) (i) How the noncooperation was determined, including what actions were required;

(((~~b~~))) (ii) What actions ((~~you~~)) the CP must take to resume cooperation;

(((~~c~~))) (iii) That this notice was sent to the CSO;

(((~~d~~))) (iv) That ((~~you~~)) the CP may contact the CSO immediately if ((~~you~~)) the CP disagrees with the notice, needs help in order to cooperate, or believes the actions required are unreasonable; and

(((~~e~~))) (v) That the CSO may sanction ((~~you~~)) the CP by either reducing or terminating the grant.

(((~~2~~))) (b) The CSO sends a notice of planned action to ((~~you~~)) the CP as provided by WAC 388-472-0005 (1)(i).

(((~~3~~))) (c) Either the notice of alleged noncooperation or the CSO's notice of planned action may serve as the basis for a sanction.

(((~~4~~))) (d) If the noncooperation was due to missing an interview without reasonable excuse, ((~~you~~)) the CP will be considered to be cooperating when ((~~you~~)) the CP appears for a rescheduled interview and either provides information or attests to the lack of information. DCS or its representative must reschedule the interview within seven business days from the date ((~~you~~)) the CP contacts them to reschedule an interview.

(((~~5~~))) (e) If the noncooperation was due to not taking a required action, cooperation resumes when ((~~you~~)) the CP takes that action.

(((~~6~~))) (2) There is no hearing right for a notice of noncooperation, but ((~~you can~~)) the CP may request a hearing on the sanction imposed by the CSO.

(3) When DCS or its representatives believe that a CP who does not receive public assistance but does receive a child care subsidy or a working connections child care (WCCC) subsidy is not cooperating, and that cooperation is essential for the next step in establishment or enforcement, DCS sends a notice of case closure to the CP.

(a) The notice of case closure contains the following information:

(i) That DCS cannot take the next step in establishment or enforcement because of the CP's failure to cooperate;

(ii) What actions the CP must take to resume cooperation;

(iii) The DCS will notify the CSO of case closure;

(iv) That DCS may close the nonassistance case if the CP does not cooperate within sixty days; and

(v) That the CSO may sanction the CP. Any sanctions for failure to cooperate are determined by the CSO.

(4) If the CP takes the actions required to resume cooperation within sixty days, DCS leaves the case open and continues to establish or enforce the support obligation.

(5) The CP may request a hearing to contest case closure, as described in WAC 388-14A-2095.

(6) If DCS closes the case due to noncooperation, a CP who does not receive public assistance but does receive a child care subsidy or a WCCC subsidy may request a hearing on the sanction imposed by the CSO.

NEW SECTION

WAC 388-14A-2093 Who is mailed notice of DCS' intent to close a case when the custodial parent receives a child care subsidy or a working connections child care subsidy? (1) Unless the department finds good cause not to require it, a recipient of a child care subsidy or a working connections child care (WCCC) subsidy who does not receive cash assistance or medical assistance must apply for support enforcement services.

(2) If the division of child support (DCS) intends to close the case because the custodial parent (CP) who receives a child care or WCCC subsidy fails to cooperate as described in WAC 388-14A-2075(3), DCS sends a copy of the notice of intent to close the case to the CP. DCS also notifies the community services division (CSD).

(3) As provided in WAC 388-14A-2090, DCS does not send a notice of intent to close when the CP requests case closure. When DCS closes a case at the request of a CP who receives a child care or WCCC subsidy, DCS sends a copy of the case closure notice to the CP, and also notifies CSD.

(4) Requesting case closure while receiving a child care or WCCC subsidy counts as a failure to cooperate with DCS.

WSR 11-22-039

EMERGENCY RULES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(Aging and Disability Services Division)

[Filed October 27, 2011, 9:46 a.m., effective October 29, 2011]

Effective Date of Rule: October 29, 2011.

Purpose: Effective July 1, 2011, the department increased the daily medicaid payment rates for clients assessed using the comprehensive assessment reporting evaluation (CARE) tool and who reside in adult family homes or who reside in boarding homes contracted to provide assisted living (AL), adult residential care (ARC), and enhanced adult residential care (EARC) services. Under ESSB [2ESHB] 1087, the 2011/13 biennial operating budget, 2011 1st sp. sess., adult family home rates are enhanced to compensate for the licensing fee increase. Boarding home rates are restored to March 31, 2011, levels. However, because new training requirements are delayed pursuant to ESHB 1548, 2011 1st sp. sess., the previously given rate enhancement for training is removed from the boarding home rate until such time that the new training requirements are reinstated. An extension of the emergency rules is necessary to allow the department time to adopt permanent rules. Preproposal was filed September 6, 2011.

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

Statutory Authority for Adoption: Chapter 74.46 RCW.

Other Authority: Chapter 7, Laws of 2011 1st sp. sess.

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 year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: The CR-101 for the permanent rule was filed with the office of the code reviser September 6, 2011. The CR-102 is expected to be filed in October 2011.

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

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

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

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

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

Date Adopted: October 13, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-21-035, filed 10/12/10, effective 10/29/10)

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

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE

KING COUNTY

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$((~~66.65~~)) 66.52	$((~~72.07~~)) 71.94	$((~~47.19~~)) 47.06	$((~~47.19~~)) 47.06	$((~~46.39~~)) 46.61
A Med	$((~~72.15~~)) 72.02	$((~~77.57~~)) 77.44	$((~~53.52~~)) 53.39	$((~~53.52~~)) 53.39	$((~~52.64~~)) 52.86
A High	$((~~80.94~~)) 80.81	$((~~86.36~~)) 86.23	$((~~58.76~~)) 58.63	$((~~58.76~~)) 58.63	$((~~58.90~~)) 59.12
B Low	$((~~66.65~~)) 66.52	$((~~72.07~~)) 71.94	$((~~47.19~~)) 47.06	$((~~47.19~~)) 47.06	$((~~46.62~~)) 46.84
B Med	$((~~74.35~~)) 74.22	$((~~79.77~~)) 79.64	$((~~59.85~~)) 59.72	$((~~59.85~~)) 59.72	$((~~59.19~~)) 59.41
B Med-High	$((~~84.18~~)) 84.05	$((~~89.60~~)) 89.47	$((~~63.63~~)) 63.50	$((~~63.63~~)) 63.50	$((~~63.42~~)) 63.64
B High	$((~~88.61~~)) 88.48	$((~~94.03~~)) 93.90	$((~~72.71~~)) 72.58	$((~~72.71~~)) 72.58	$((~~72.51~~)) 72.73

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
C Low	$((~~72.15~~)) 72.02	$((~~77.57~~)) 77.44	$((~~53.52~~)) 53.39	$((~~53.52~~)) 53.39	$((~~52.64~~)) 52.86
C Med	$((~~80.94~~)) 80.81	$((~~86.36~~)) 86.23	$((~~67.13~~)) 67.00	$((~~67.13~~)) 67.00	$((~~67.22~~)) 67.44
C Med-High	$((~~100.71~~)) 100.58	$((~~106.13~~)) 106.00	$((~~89.42~~)) 89.29	$((~~89.42~~)) 89.29	$((~~88.06~~)) 88.28
C High	$((~~101.71~~)) 101.58	$((~~107.13~~)) 107.00	$((~~90.27~~)) 90.14	$((~~90.27~~)) 90.14	$((~~89.29~~)) 89.51
D Low	$((~~74.35~~)) 74.22	$((~~79.77~~)) 79.64	$((~~72.27~~)) 72.14	$((~~72.27~~)) 72.14	$((~~68.52~~)) 68.74
D Med	$((~~82.59~~)) 82.46	$((~~88.01~~)) 87.88	$((~~83.70~~)) 83.57	$((~~83.70~~)) 83.57	$((~~83.87~~)) 84.09
D Med-High	$((~~106.74~~)) 106.61	$((~~112.16~~)) 112.03	$((~~106.39~~)) 106.26	$((~~106.39~~)) 106.26	$((~~100.92~~)) 101.14
D High	$((~~115.01~~)) 114.88	$((~~120.43~~)) 120.30	$((~~115.01~~)) 114.88	$((~~115.01~~)) 114.88	$((~~114.90~~)) 115.12
E Med	$((~~138.95~~)) 138.82	$((~~144.37~~)) 144.24	$((~~138.95~~)) 138.82	$((~~138.95~~)) 138.82	$((~~138.84~~)) 139.06
E High	$((~~162.89~~)) 162.76	$((~~168.31~~)) 168.18	$((~~162.89~~)) 162.76	$((~~162.89~~)) 162.76	$((~~162.79~~)) 163.01

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE

METROPOLITAN COUNTIES*

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$((~~61.15~~)) 61.02	$((~~66.07~~)) 65.94	$((~~47.19~~)) 47.06	$((~~47.19~~)) 47.06	$((~~46.39~~)) 46.61
A Med	$((~~64.46~~)) 64.33	$((~~69.38~~)) 69.25	$((~~51.41~~)) 51.28	$((~~51.41~~)) 51.28	$((~~50.55~~)) 50.77
A High	$((~~78.74~~)) 78.61	$((~~83.66~~)) 83.53	$((~~56.04~~)) 55.91	$((~~56.04~~)) 55.91	$((~~55.76~~)) 55.98
B Low	$((~~61.15~~)) 61.02	$((~~66.07~~)) 65.94	$((~~47.19~~)) 47.06	$((~~47.19~~)) 47.06	$((~~46.62~~)) 46.84
B Med	$((~~69.94~~)) 69.81	$((~~74.86~~)) 74.73	$((~~56.69~~)) 56.56	$((~~56.69~~)) 56.56	$((~~56.04~~)) 56.26
B Med-High	$((~~79.20~~)) 79.07	$((~~84.12~~)) 83.99	$((~~60.27~~)) 60.14	$((~~60.27~~)) 60.14	$((~~60.10~~)) 60.32
B High	$((~~86.42~~)) 86.29	$((~~91.34~~)) 91.21	$((~~70.66~~)) 70.53	$((~~70.66~~)) 70.53	$((~~70.46~~)) 70.68
C Low	$((~~64.46~~)) 64.33	$((~~69.38~~)) 69.25	$((~~51.62~~)) 51.49	$((~~51.62~~)) 51.49	$((~~50.93~~)) 51.15
C Med	$((~~78.74~~)) 78.61	$((~~83.66~~)) 83.53	$((~~66.27~~)) 66.14	$((~~66.27~~)) 66.14	$((~~65.58~~)) 65.80
C Med-High	$((~~97.40~~)) 97.27	$((~~102.32~~)) 102.19	$((~~83.09~~)) 82.96	$((~~83.09~~)) 82.96	$((~~81.82~~)) 82.04

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
C High	$((~~98.37~~)) 98.24	$((~~103.29~~)) 103.16	$((~~88.37~~)) 88.24	$((~~88.37~~)) 88.24	$((~~86.81~~)) 87.03
D Low	$((~~69.94~~)) 69.81	$((~~74.86~~)) 74.73	$((~~71.28~~)) 71.15	$((~~71.28~~)) 71.15	$((~~67.01~~)) 67.23
D Med	$((~~80.34~~)) 80.21	$((~~85.26~~)) 85.13	$((~~82.03~~)) 81.90	$((~~82.03~~)) 81.90	$((~~81.61~~)) 81.83
D Med-High	$((~~103.24~~)) 103.11	$((~~108.16~~)) 108.03	$((~~103.76~~)) 103.63	$((~~103.76~~)) 103.63	$((~~97.84~~)) 98.06
D High	$((~~111.85~~)) 111.72	$((~~116.77~~)) 116.64	$((~~111.85~~)) 111.72	$((~~111.85~~)) 111.72	$((~~111.16~~)) 111.38
E Med	$((~~134.64~~)) 134.51	$((~~139.56~~)) 139.43	$((~~134.64~~)) 134.51	$((~~134.64~~)) 134.51	$((~~133.95~~)) 134.17
E High	$((~~157.43~~)) 157.30	$((~~162.35~~)) 162.22	$((~~157.43~~)) 157.30	$((~~157.43~~)) 157.30	$((~~156.74~~)) 156.96

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

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

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$((~~60.07~~)) 59.94	$((~~65.31~~)) 65.18	$((~~47.19~~)) 47.06	$((~~47.19~~)) 47.06	$((~~46.39~~)) 46.61
A Med	$((~~64.46~~)) 64.33	$((~~69.70~~)) 69.57	$((~~50.36~~)) 50.23	$((~~50.36~~)) 50.23	$((~~49.52~~)) 49.74
A High	$((~~78.74~~)) 78.61	$((~~83.98~~)) 83.85	$((~~55.14~~)) 55.01	$((~~55.14~~)) 55.01	$((~~54.73~~)) 54.95
B Low	$((~~60.07~~)) 59.94	$((~~65.31~~)) 65.18	$((~~47.19~~)) 47.06	$((~~47.19~~)) 47.06	$((~~46.62~~)) 46.84
B Med	$((~~69.94~~)) 69.81	$((~~75.18~~)) 75.05	$((~~55.64~~)) 55.51	$((~~55.64~~)) 55.51	$((~~55.00~~)) 55.22
B Med-High	$((~~79.20~~)) 79.07	$((~~84.44~~)) 84.31	$((~~59.14~~)) 59.01	$((~~59.14~~)) 59.01	$((~~58.92~~)) 59.14
B High	$((~~86.42~~)) 86.29	$((~~91.66~~)) 91.53	$((~~66.84~~)) 66.71	$((~~66.84~~)) 66.71	$((~~66.64~~)) 66.86
C Low	$((~~64.46~~)) 64.33	$((~~69.70~~)) 69.57	$((~~50.36~~)) 50.23	$((~~50.36~~)) 50.23	$((~~49.52~~)) 49.74
C Med	$((~~78.74~~)) 78.61	$((~~83.98~~)) 83.85	$((~~62.65~~)) 62.52	$((~~62.65~~)) 62.52	$((~~63.07~~)) 63.29
C Med-High	$((~~97.40~~)) 97.27	$((~~102.64~~)) 102.51	$((~~79.92~~)) 79.79	$((~~79.92~~)) 79.79	$((~~78.70~~)) 78.92
C High	$((~~98.37~~)) 98.24	$((~~103.61~~)) 103.48	$((~~83.54~~)) 83.41	$((~~83.54~~)) 83.41	$((~~82.10~~)) 82.32
D Low	$((~~69.94~~)) 69.81	$((~~75.18~~)) 75.05	$((~~67.39~~)) 67.26	$((~~67.39~~)) 67.26	$((~~63.37~~)) 63.59
D Med	$((~~80.34~~)) 80.21	$((~~85.58~~)) 85.45	$((~~77.55~~)) 77.42	$((~~77.55~~)) 77.42	$((~~77.17~~)) 77.39

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
D Med-High	$((~~103.24~~)) 103.11	$((~~108.48~~)) 108.35	$((~~98.08~~)) 97.95	$((~~98.08~~)) 97.95	$((~~92.52~~)) 92.74
D High	$((~~105.73~~)) 105.60	$((~~110.97~~)) 110.84	$((~~105.73~~)) 105.60	$((~~105.73~~)) 105.60	$((~~105.10~~)) 105.32
E Med	$((~~127.27~~)) 127.14	$((~~132.51~~)) 132.38	$((~~127.27~~)) 127.14	$((~~127.27~~)) 127.14	$((~~126.64~~)) 126.86
E High	$((~~148.81~~)) 148.68	$((~~154.05~~)) 153.92	$((~~148.81~~)) 148.68	$((~~148.81~~)) 148.68	$((~~148.19~~)) 148.41

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

WSR 11-22-040
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed October 27, 2011, 9:49 a.m., effective October 29, 2011]

Effective Date of Rule: October 29, 2011.

Purpose: Chapter 7, Laws of 2011 1st sp. sess. (the act) imposes a safety net assessment (SNA) on nonexempt facilities in Washington state.

Reasons Why Rules on this Subject may be Needed and What They Might Accomplish: Effective July 1, 2011, the department implemented the new safety net assessment on Washington nursing facilities. An extension of the emergency rules is necessary to provide additional direction for implementation of this new regulation.

The CR-101 for the permanent rule was filed with the office of the code reviser September 6, 2011.

Citation of Existing Rules Affected by this Order: Amending WAC 388-96-910.

Statutory Authority for Adoption: New chapter 74.46 RCW.

Other Authority: Chapter 7, Laws of 2011 1st sp. sess.

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 year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: The CR-101 for the permanent rule was filed with the office of the code reviser September 6, 2011. The CR-102 is expected to be filed in October 2011.

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

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

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

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

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

Date Adopted: October 13, 2011.

Katherine I. Vasquez
Rules Coordinator

NEW SECTION

WAC 388-96-910 Safety net assessment. (1) Chapter 7, Laws of 2011 1st sp. sess. (the Act) imposes a safety net assessment (SNA) on nonexempt nursing facilities in Washington. Categories of facilities exempt from the SNA are described in section 17 of the Act. For state fiscal year (SFY) 2012 beginning July 1, 2011, nonexempt facilities will pay the SNA at two different levels: eleven dollars and one dollar per resident day. Facilities paying at the level of one dollar per resident day are those which reported thirty-two thousand or more medicaid resident days on their 2010 cost report, or which have more than two hundred and three licensed beds. All other nonexempt facilities pay at the level of eleven dollars per resident day. The department of social and health services (the department) may change the amount of the SNA pursuant to Sec. 16 of the Act. In such case during SFY 2012, the department will notify the Washington health care association, aging services of Washington, and each licensed nursing facility in Washington of the change at least seven calendar days before the effective date of such a change. Such notice may be delivered electronically.

(2) The status of each nursing facility under the Act will be determined based on the facility's characteristics as of July 1, 2011, but using the information on resident days from the 2010 cost report. The status of facilities will not be altered thereafter during SFY 2012. Facilities that become licensed throughout the SFY will be subject to the SNA as of the date of their licensing.

(3) The office of rates management (ORM) of the aging and disability services administration (ADSA) of the department will inform each nursing facility of its status under the Act. A facility wishing to contest its status under the Act as determined by ORM may seek review of such determination under WAC 388-96-904.

(4) Beginning July 1, 2011, an add-on to each nonexempt facility's medicaid daily rate will be paid to reimburse the facility for the SNA it owes in relation to residents whose care is provided by medicaid.

(5) The SNA is assessed and payable on a monthly basis. The SNA owed for each month must be received by the 25th day of the following month. The SNA will be reported on a form supplied by ORM. Payments of the SNA are subject to an interest penalty of one percent per month for any payment which is delinquent for any portion of a month. The department may withhold any medical assistance reimbursement payments from a facility until such time as any delinquent SNA payments, and any related penalties, are paid, or may offset such delinquent SNA payments and related penalties against the facility's medical assistance reimbursement payments.

(6) Enforcement and collection of the SNA provided by the Act is subject to successful application for a related waiver from the federal centers for medicare and medicaid services (CMS). In the review process for the waiver, it may be necessary for DSHS to modify the levels of the SNA, the standard for designating facilities that pay the SNA at the lower level, and/or the categories of fully exempt facilities described in section 17 of the Act. In that case, the obligation of each facility to pay the SNA is subject to amendment retroactive to July 1, 2011, based on the standards for the SNA contained in the waiver as eventually issued by CMS.

WSR 11-22-041
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed October 27, 2011, 9:58 a.m., effective October 30, 2011]

Effective Date of Rule: October 30, 2011.

Purpose: The department is amending WAC 388-310-1400 to expand the definition of WorkFirst community service to include a TANF/SFA recipient's self-initiated volunteer service at a childcare or preschool licensed under chapter 43.215 RCW, or at an elementary school in which the recipient's child is enrolled. This amendment is necessary to conform to ESSB 5921, section 8(6).

Citation of Existing Rules Affected by this Order: Amending WAC 388-310-1400.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.57 [74.04.057].

Other Authority: ESSB 5921, section 8(6).

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 year 2009, 2010, 2011, 2012 or 2013, 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 changes are necessary to conform to ESSB 5921, section 8(6). The department has already expanded the definition of WorkFirst community service. This amendment is already in place via an emergency adoption by WSR 11-14-081 dated July 1, 2011, which expires October 29, 2011. The department has filed a Preproposal statement of inquiry as WSR 11-15-094 on July 20, 2011, and filed a Proposed rule making notice as WSR 11-19-109 on September 21, 2011. A second emergency rule is required because the department will be unable to complete the permanent rule adoption process before the existing emergency rule expires.

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

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

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

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

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

Date Adopted: October 24, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 08-07-046, filed 3/14/08, effective 5/1/08)

WAC 388-310-1400 WorkFirst—Community service. (1) **What is community service?**

Community service is unpaid work (such as the work performed by volunteer workers) that:

(a) You perform for a charitable nonprofit organization, federal, state, local or tribal government or district, including traditional activities that perpetuate tribal culture and customs; or

(b) You self-initiate at a childcare or preschool facility licensed under chapter 43.215 RCW, or at an elementary school in which your child is enrolled.

(2) **What other activities may be approved, even though they are not considered community service, because they benefit me, my family, my community or my tribe and might be included in my individual responsibility plan?**

((~~The following types [of] activities may be approved, even though they are not considered community service, because they benefit you, your family, your community or your tribe and might be included in your individual responsibility plan:~~))

(a) Caring for a disabled family member;

(b) Caring for a child, if you are fifty-five years old or older and receiving TANF or SFA assistance for the child as a relative (instead of as the child's parent);

(c) Providing childcare for another WorkFirst participant who is doing community service;

(d) Actively participating in a drug or alcohol assessment or treatment program which is certified or contracted by the state under chapter 70.96A RCW;

(e) Participating in family violence counseling or drug or alcohol treatment that will help you become employable or keep your job (this is called "specialized services" in state law);

(f) Participating in the pregnancy to employment pathway; and/or

(g) Job preparation.

WSR 11-22-045
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Financial Services Administration)

[Filed October 27, 2011, 10:57 a.m., effective October 29, 2011]

Effective Date of Rule: October 29, 2011.

Purpose: The new section WAC 388-02-0387 is intended to implement the governor's "no wrong door" policy and allow petitions for review filed with DSHS in matters in which an applicant or recipient of medical services programs set forth in chapter 74.09 RCW seeks review of decisions made by more than one agency to go forward.

Statutory Authority for Adoption: RCW 74.09.741, 34.05.020.

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

Reasons for this Finding: The new section WAC 388-02-0387 is intended to implement the governor's "no wrong door" policy and allow petitions for review filed with DSHS in matters in which an applicant or recipient of medical services programs set forth in Title 74 RCW seeks review of decisions made by more than one agency to go forward in accordance with RCW 74.09.741.

A CR-101 for a new permanent rule was filed in WSR 11-14-097 on July 1, 2011.

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

Date Adopted: October 26, 2011.

Katherine I. Vasquez
Rules Coordinator

NEW SECTION

WAC 388-02-0387 How may you request that a hearing be consolidated or severed when multiple agencies are parties to the proceeding? The following requirements apply only to adjudicative proceedings in which an applicant or recipient of medical services programs set forth in chapter 74.09 RCW seeks review of decisions made by more than one agency.

(1) When you file a single application for an adjudicative proceeding seeking review of decisions by more than one agency, this review shall be conducted initially in one adjudicative proceeding. The administrative law judge (ALJ) may sever the proceeding into multiple proceedings on the motion of any of the parties, when:

(a) All parties consent to the severance; or

(b) Either party requests severance without another party's consent, and the ALJ finds there is good cause for severing the matter and that the proposed severance is not likely to prejudice the rights of an appellant who is a party to any of the severed proceedings.

(2) If there are multiple adjudicative proceedings involving common issues or parties where there is one appellant and both the health care authority and the department are parties, upon motion of any party or upon his or her own motion, the ALJ may consolidate the proceedings if he or she finds that the consolidation is not likely to prejudice the rights of the appellant who is a party to any of the consolidated proceedings.

(3) If the ALJ grants the motion to sever the hearing into multiple proceedings or consolidate multiple proceedings into a single proceeding, the ALJ will send out an order and a new notice of hearing to the appropriate parties in accordance with WAC 388-02-0250.

WSR 11-22-046
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-289—Filed October 27, 2011, 11:10 a.m., effective October 29, 2011]

Effective Date of Rule: October 29, 2011.

Purpose: Amend recreational fishing rules.

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

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is

necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: Large numbers of coho are staging in this area, and a night closure is needed to help maintain an orderly fishery. There is insufficient time to adopt permanent rules.

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

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

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

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

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

Date Adopted: October 27, 2011.

Sara G. LaBorde
for Philip Anderson
Director

NEW SECTION

WAC 232-28-61900H Exceptions to statewide rules—Klickitat River. Notwithstanding the provisions of WAC 232-28-619, effective October 29, 2011, through January 31, 2012, night closure is in effect in waters of the Klickitat River downstream of the Fisher Hill Bridge.

REPEALER

The following section of the Washington Administrative Code is repealed effective February 1, 2012:

WAC 232-28-61900H	Exceptions to statewide rules—Klickitat River.

WSR 11-22-047
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed October 27, 2011, 2:54 p.m., effective October 29, 2011]

Effective Date of Rule: October 29, 2011.

Purpose: Upon approval from the Centers for Medicare and Medicaid Services (CMS) of the agency's state plan amendment, the agency will implement a new alternative payment methodology for federally qualified health centers (FQHCs) and rural health clinics (RHCs) for services provided on and after July 1, 2011.

Citation of Existing Rules Affected by this Order: Amending WAC 182-548-1400 and 182-549-1400.

Statutory Authority for Adoption: RCW 41.05.021.

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 year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: The implementation of these emergency rules are necessitated by the level of appropriations made by the legislature in 2ESHB 1087, for services provided by FQHCs and RHCs as of July 1, 2011. Delaying this adoption could jeopardize the state's ability to provide mandatory medicaid services to a significant number of medicaid clients. This emergency rule is necessary to continue the current emergency rule adopted under WSR 11-14-062 while the permanent rule-making process is completed.

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 2, 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 2, Repealed 0.

Date Adopted: October 27, 2011.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-548-1400 Federally qualified health centers—Reimbursement and limitations. (1) ((~~Effective~~)) For services provided during the period beginning January 1, 2001, and ending December 31, 2008, the agency's payment methodology for federally qualified health centers (FQHC) ((~~conforms to 42 U.S.C. 1396a(bb). As set forth in 42 U.S.C. 1396a (bb)(2) and (3), all FQHCs that provide services on January 1, 2001, and through December 31, 2008, are reim-~~

~~bursed on~~)) was a prospective payment system (PPS) as authorized by 42 U.S.C. 1396a (bb)(2) and (3).

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

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

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

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

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

(a) The ((~~department~~)) agency adjusts a PPS base encounter rate to account for an increase or decrease in the scope of services provided during calendar year 2001 in accordance with WAC ((~~388-548-1500~~)) 182-548-1500.

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

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

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

(5) The ((~~department~~)) agency calculates the FQHC's APM encounter rate for services provided during the period beginning January 1, 2009, and ending April 6, 2011, as follows:

(a) ((~~Beginning January 1, 2009,~~)) The APM utilizes the FQHC base encounter rates, as described in ((~~WAC 388-548-1400~~)) subsection (4)(b) of this section.

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

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

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

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

(6) Upon approval from the federal Centers for Medicare and Medicaid Services (CMS) of the agency's state plan amendment, the agency calculates the FQHC's APM encounter rate for services provided during the period beginning April 7, 2011, and ending June 30, 2011, as described in this section. Pending state plan approval by CMS, the agency will continue to pay FQHCs at the encounter rate described in subsection (5) of this section. For all payments made for services between April 7, 2011, and the date CMS approves the state plan amendment, the agency will recoup from FQHCs any amount paid in excess of the encounter rate established in this section. The APM utilizes each FQHC's PPS rate for each calendar year and inflates it by five percent.

(7) Upon approval from CMS of the agency's state plan amendment, for services provided on and after July 1, 2011, each FQHC will have the choice of receiving either its PPS rate, as determined under the method described in subsection (3) of this section or a rate determined under a revised APM.

(a) For all payments made for services between July 1, 2011, and the date CMS approves the state plan amendment, the agency will recoup from FQHCs any amount in excess of the encounter rate established in this section.

(b) The revised APM will be as follows:

(i) For FQHCs that rebased their rate effective January 1, 2010, their allowed cost per visit during the cost report year inflated by the cumulative percentage increase in the MEI between the cost report year and 2011.

(ii) For FQHCs that did not rebase in 2010, their rate is based on their PPS base rate from 2001 (or subsequent year for FQHCs receiving their initial FQHC designation after 2002) inflated by the cumulative percentage increase in the IHS Global Insight index from the base year through calendar year 2008 and the cumulative increase in the MEI from 2008 through 2011. The rates will be inflated by MEI effective January 1, 2012, and each January 1st thereafter.

(c) When the APM methodology is in effect, the state will periodically rebase the FQHC encounter rates using the FQHC cost reports and other relevant data. Rebasing will be done only for FQHCs that are reimbursed under the APM.

(d) The agency will ensure that the payments made under the APM are at least equal to the payments that would be made under the PPS.

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

(a) The visits occur with different healthcare professionals with different specialties; or

(b) There are separate visits with unrelated diagnoses.

(((~~(7)~~))) (9) FQHC services and supplies incidental to the provider's services are included in the encounter rate payment.

(((~~(8)~~))) (10) Payments for ((~~nonFQHC~~)) non-FQHC services provided in an FQHC are made on a fee-for-service basis using the ((~~department's~~)) agency's published fee schedules. ((~~NonFQHC~~)) Non-FQHC services are subject to the coverage guidelines and limitations listed in chapters ((~~388-500 through 557~~)) 182-500 through 182-557 WAC.

(((~~(9)~~))) (11) For clients enrolled with a managed care organization (MCO), covered FQHC services are paid for by that plan.

(((~~(10)~~))) (12) Only clients enrolled in Title XIX (medicaid) or Title XXI (CHIP) are eligible for encounter or enhancement payments. The ((~~department~~)) agency does not pay the encounter rate or the enhancement rate for clients in state-only medical programs. Services provided to clients in state-only medical programs are considered fee-for-service regardless of the type of service performed.

(((~~(11)~~))) (13) For clients enrolled with ((~~a managed care organization (MCO)~~))) an MCO, the ((~~department~~)) agency pays each FQHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).

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

(b) To ensure that the appropriate amounts are paid to each FQHC, the ((~~department~~)) agency performs an annual reconciliation of the enhancement payments. For each FQHC, the ((~~department~~)) agency will compare the amount actually paid to the amount determined by the following formula: (Managed care encounters times encounter rate) less FFS equivalent of MCO services. If the ((~~center~~)) FQHC has been overpaid, the ((~~department~~)) agency will recoup the appropriate amount. If the ((~~center~~)) FQHC has been underpaid, the ((~~department~~)) agency will pay the difference.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-549-1400 Rural health clinics—Reimbursement and limitations. (1) ((~~Effective~~)) For services provided during the period beginning January 1, 2001, and ending December 31, 2008, the agency's payment methodology for rural health clinics (RHC) ((~~conforms to~~)) was a prospective payment system (PPS) as authorized by 42 U.S.C. 1396a (bb)(2) and (3). ((~~RHCs that provide services on January 1, 2001 through December 31, 2008 are reimbursed on a prospective payment system (PPS).~~

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

(((~~(2)~~))) (3) The ((~~department~~)) agency calculates the RHC's PPS encounter rate for RHC core services as follows:

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

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

(((~~(3)~~))) (4) For RHCs in existence during calendar years 1999 and 2000, the ((~~department~~)) agency sets the payment prospectively using a weighted average of one hundred percent of the ((~~clinic's~~)) RHC's total reasonable costs for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during the calendar year 2001 to establish a base encounter rate.

(a) The ((~~department~~)) agency adjusts a PPS base encounter rate to account for an increase or decrease in the scope of services provided during calendar year 2001 in accordance with WAC ((~~388-549-1500~~)) 182-549-1500.

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

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

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

(((~~(4)~~))) (5) The ((~~department~~)) agency calculates the RHC's APM encounter rate for services provided during the period beginning January 1, 2009, and ending April 6, 2011, as follows:

(a) ((~~Beginning January 1, 2009,~~)) The APM utilizes the RHC base encounter rates as described in ((~~WAC 388-549-1400 (3)(b)~~)) subsection (4)(b) of this section.

(b) The base rates are inflated by each annual percentage, from years 2002 through 2009, of the APM index.

(c) The result is the year 2009 APM rate for each RHC that chooses to be reimbursed under the APM.

(((~~(b) To ensure that the APM pays an amount that is at least equal to the PPS in accordance with 42 USC 1396a~~

~~(bb)(6), the annual inflator used to increase the APM rates is the greater of the APM index or the MEI.~~

~~(c) The department periodically rebases the APM rates. The department does not rebase rates determined under the PPS.~~

~~(d) When rebasing the APM encounter rates, the department applies a productivity standard to the number of visits performed by each practitioner group (physicians and mid-levels) to determine the number of encounters to be used in each RHC's rate calculation. The productivity standards are determined by reviewing all available RHC cost reports for the rebasing period and setting the standards at the levels necessary to allow ninety-five percent of the RHCs to meet the standards. The encounter rates of the clinics that meet the standards are calculated using each clinic's actual number of encounters. The encounter rates of the other five percent of clinics are calculated using the productivity standards. This process is applied at each rebasing, so the actual productivity standards may change each time encounter rates are rebased.~~

~~(5)~~)) (6) Upon approval from the federal Centers for Medicare and Medicaid Services (CMS) of the agency's state plan amendment, the agency calculates the RHC's APM encounter rate for services provided during the period beginning April 7, 2011, and ending June 30, 2011, as described in this section. Pending state plan approval by CMS, the agency will continue to pay RHCs at the encounter rate described in subsection (5) of this section. For all payments made for services between April 7, 2011, and the date CMS approves the state plan amendment, the agency will recoup from RHCs any amount paid in excess of the encounter rate established in this section. The APM utilizes each RHC's PPS rate for each calendar year and inflates it by five percent.

(7) Upon approval from CMS of the agency's state plan amendment, for services provided on and after July 1, 2011, each RHC will have the choice of receiving either its PPS rate, as determined under the method described in subsection (3) of this section, or a rate determined under a revised APM.

(a) For all payments made for services between July 1, 2011, and the date CMS approves the state plan amendment, the agency will recoup from RHCs any amount paid in excess of the encounter rate established in this section.

(b) The revised APM will be as follows:

(i) For RHCs that rebased their rate effective January 1, 2010, their allowed cost per visit during the cost report year inflated by the cumulative percentage increase in the MEI between the cost report year and 2011.

(ii) For RHCs that did not rebase in 2010, their rate is based on their PPS base rate from 2002 (or subsequent year for RHCs receiving their initial RHC designation after 2002) inflated by the cumulative percentage increase in the IHS Global Insight index from the base year through calendar year 2008 and the cumulative increase in the MEI from 2008 through 2011. The rate will be inflated by the MEI effective January 1, 2012, and each January 1st thereafter.

(c) When the APM methodology is in effect, the state will periodically rebase the RHC encounter rate using the RHC cost reports and other relevant data. Rebasing will be done only for RHCs that are reimbursed under the APM.

(d) The agency will ensure that the payments made under the APM are at least equal to the payments that would be made under the PPS.

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

(a) The visits occur with different healthcare professionals with different specialties; or

(b) There are separate visits with unrelated diagnoses.

(((~~6~~))) (9) RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

(((~~7~~))) (10) Payments for non-RHC services provided in an RHC are made on a fee-for-service basis using the ((~~department's~~)) agency's published fee schedules. Non-RHC services are subject to the coverage guidelines and limitations listed in chapters ((~~388-500 through 388-557~~)) 182-500 through 182-557 WAC.

(((~~8~~))) (11) For clients enrolled with a managed care organization (MCO), covered RHC services are paid for by that plan.

(((~~9~~))) (12) The ((~~department~~)) agency does not pay the encounter rate or the enhancements for clients in state-only programs. Services provided to clients in state-only programs are considered fee-for-service, regardless of the type of service performed.

(((~~10~~))) (13) For clients enrolled with ((~~a managed care organization (MCO)~~)) an MCO, the ((~~department~~)) agency pays each RHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).

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

(b) To ensure that the appropriate amounts are paid to each RHC, the ((~~department~~)) agency performs an annual reconciliation of the enhancement payments. For each RHC, the ((~~department~~)) agency will compare the amount actually paid to the amount determined by the following formula: (Managed care encounters times encounter rate) less fee-for-service equivalent of MCO services. If the ((~~clinic~~)) RHC has been overpaid, the ((~~department~~)) agency will recoup the appropriate amount. If the ((~~clinic~~)) RHC has been underpaid, the ((~~department~~)) agency will pay the difference.

WSR 11-22-048
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed October 27, 2011, 5:06 p.m., effective November 1, 2011]

Effective Date of Rule: November 1, 2011.

Purpose: Eliminating the Social Security number requirement for premium-based apple health [for] kids medical coverage is necessary to comply with federal "maintenance of effort" requirements under Patient Protection and Affordable Care Act (PPACA); adding description of lawfully present aliens to comply with Children's Health Insur-

ance Program Reauthorization Act (CHIPRA); and creating new WAC section identifying the order of Title XXI payments under the premium-based apple health for kids program.

Citation of Existing Rules Affected by this Order: Amending WAC 388-505-0210 and 388-505-0211.

Statutory Authority for Adoption: RCW 41.05.021, 74.09.500.

Other Authority: PPACA; §2102 (b)(1)(A) of the Social Security Act; and Public Law 111-3 (CHIPRA of 2009).

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: See Purpose statement above. This emergency rule is necessary to meet federal "maintenance of effort" requirements while the agency completes the permanent rule-making process. The agency has filed a CR-102 under WSR 11-20-052. A public hearing of the rule proposal is scheduled for November 8, 2011.

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 1, Amended 2, Repealed 0.

Date Adopted: October 27, 2011.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-03-001, filed 1/5/11, effective 2/5/11)

WAC 388-505-0210 Apple health for kids and other children's medical assistance programs. Funding for coverage under the apple health for kids programs may come through Title XIX (medicaid), Title XXI (CHIP), or through state-funded programs. There are no resource limits for the apple health for kids programs. Apple health for kids coverage is free to children in households with incomes of no more than two-hundred percent of the federal poverty level (FPL), and available on a premium basis to children in households with incomes of no more than three-hundred percent FPL.

(1) Newborns are eligible for federally matched categorically needy (CN) coverage through their first birthday when:

(a) The newborn is a resident of the state of Washington.

(b) The newborn's mother is eligible for medical assistance:

(i) On the date of the newborn's birth, including a retroactive eligibility determination; or

(ii) Based on meeting a medically needy (MN) spend-down liability with expenses incurred on, or prior to, the date of the newborn's birth.

(2) Children under the age of nineteen who are U.S. citizens, U.S. nationals, or lawfully present qualified or nonqualified aliens as described in WAC 388-424-0001, 388-424-0010(4), and 388-424-0006 (1), (4), and (5) are eligible for free federally matched CN coverage when they meet the following criteria:

(a) State residence as described in chapter 388-468 WAC;

(b) A Social Security number or application as described in chapter 388-476 WAC;

(c) Proof of citizenship or immigrant status and identity as required by WAC 388-490-0005(11);

(d) Family income is at or below two hundred percent of federal poverty level (FPL), as described in WAC 388-478-0075 at each application or review; or

(e) They received Supplemental Security Income (SSI) cash payments in August 1996 and would continue to be eligible for those payments except for the August 1996 passage of amendments to federal disability definitions; or

(f) They are currently eligible for SSI.

(3) Noncitizen children under the age of nineteen, who are not lawfully present qualified or nonqualified aliens as described in WAC 388-424-0001, 388-424-0010(4), and 388-424-0006 (1), (4), and (5), are eligible for free state-funded coverage when they meet the following criteria:

(a) State residence as described in chapter 388-468 WAC; and

(b) Family income is at or below two hundred percent FPL at each application or review.

(4) Children under the age of nineteen who are U.S. citizens, U.S. nationals, or lawfully present qualified or nonqualified aliens as described in WAC 388-424-0001, 388-424-0010(4), and 388-424-0006 (1), (4), and (5) are eligible for premium-based federally matched CN coverage as described in chapter 388-542 WAC when they meet the following criteria:

(a) State residence as described in chapter 388-468 WAC;

(b) ((~~A Social Security number or application as described in chapter 388-476 WAC;~~

~~(c)~~)) Proof of citizenship or immigrant status and identity as required by WAC 388-490-0005(11);

(((~~(d)~~))) (c) Family income is over two hundred percent FPL, as described in WAC 388-478-0075, but not over three hundred percent FPL at each application or review;

(((~~(e)~~))) (d) They do not have other creditable health insurance as described in WAC 388-542-0050; and

(((~~(f)~~))) (e) They pay the required monthly premiums as described in WAC 388-505-0211.

(5) Noncitizen children under the age of nineteen, who are not lawfully present qualified or nonqualified aliens as described in WAC 388-424-0001, 388-424-0010(4), and 388-424-0006 (1), (4), and (5), are eligible for premium-based state-funded CN coverage when they meet the following criteria:

(a) State residence as described in chapter 388-468 WAC;

(b) Family income is over two hundred percent FPL, as described in WAC 388-478-0075, but not over three hundred percent FPL at each application or review;

(c) They do not have other creditable health insurance as described in WAC 388-542-0050; and

(d) They pay the required monthly premium as described in WAC 388-505-0211.

(6) Children under age nineteen are eligible for the medically needy (MN) medicaid program when they meet the following criteria:

(a) Citizenship or immigrant status, state residence, and Social Security number requirements as described in subsection (2)(a), (b), and (c) of this section;

(b) Are ineligible for other federally matched CN programs;

(c) Have income that exceeds three hundred percent FPL; or

(d) Have income less than three hundred percent FPL, but do not qualify for premium-based coverage as described in subsection (4) of this section because of creditable coverage; and

(e) Meet their spenddown liability as described in WAC 388-519-0100 and 388-519-0110.

(7) Children under the age of nineteen who reside or are expected to reside in a medical institution, intermediate care facility for the mentally retarded (ICF/MR), hospice care center, nursing home, institution for mental diseases (IMD) or inpatient psychiatric facility may be eligible for apple health for kids healthcare coverage based upon institutional rules described in WAC 388-505-0260. Individuals between the age of nineteen and twenty-one may still be eligible for healthcare coverage but not under the apple health for kids programs. See WAC 388-505-0230 "Family related institutional medical" and WAC 388-513-1320 "Determining institutional status for long-term care" for more information.

(8) Children who are in foster care under the legal responsibility of the state, or a federally recognized tribe located within the state, and who meet eligibility requirements for residency, Social Security number, and citizenship as described in subsection (2)(a), (b) and (c) of this section are eligible for federally matched CN medicaid coverage through the month of their:

(a) Eighteenth birthday;

(b) Twenty-first birthday if the children's administration determines they remain eligible for continued foster care services; or

(c) Twenty-first birthday if they were in foster care on their eighteenth birthday and that birthday was on or after July 22, 2007.

(9) Children are eligible for state-funded CN coverage through the month of their eighteenth birthday if they:

(a) Are in foster care under the legal responsibility of the state or a federally recognized tribe located within the state; and

(b) Do not meet social security number and citizenship requirements in subsection (2)(b) and (c) of this section.

(10) Children who receive subsidized adoption services are eligible for federally matched CN coverage.

(11) Children under the age of nineteen not eligible for apple health for kids programs listed above may be eligible for one of the following medical assistance programs not included in apple health for kids:

(a) Family medical as described in WAC 388-505-0220;

(b) Medical extensions as described in WAC 388-523-0100;

(c) SSI-related MN if they:

(i) Meet the blind and/or disability criteria of the federal SSI program, or the condition of subsection (2)(e) of this section; and

(ii) Have countable income above the level described in WAC 388-478-0070(1).

(d) Home and community based waiver programs as described in chapter 388-515 WAC; or

(e) Alien medical as described in WAC 388-438-0110, if they:

(i) Have a documented emergency medical condition as defined in WAC 388-500-0005;

(ii) Have income more than three hundred percent FPL; or

(iii) Have income less than three hundred percent FPL, but do not qualify for premium-based coverage as described in subsection (5) of this section because of creditable coverage.

(12) Except for a child described in subsection (7) of this section, an inmate of a public institution, as defined in WAC 388-500-0005, is not eligible for any apple health for kids program.

AMENDATORY SECTION (Amending WSR 11-03-001, filed 1/5/11, effective 2/5/11)

WAC 388-505-0211 Premium requirements for premium-based healthcare coverage under programs included in apple health for kids. (1) For the purposes of this chapter, **"premium"** means an amount paid for healthcare coverage under programs included in apple health for kids as described in WAC 388-505-0210 (4) and (5).

(2) Payment of a premium is required as a condition of eligibility for premium-based coverage under programs included in apple health for kids, as described in WAC 388-505-0210 (4) and (5), unless the child is:

(a) Pregnant; or

(b) An American Indian or Alaska native.

(3) The premium requirement begins the first of the month following the determination of eligibility. There is no premium requirement for medical coverage received in a month or months before the determination of eligibility.

(4) The premium amount for the assistance unit (AU) is based on the net countable income as described in WAC 388-450-0210 and the number of children in the ((~~assistance unit~~)) AU. If the household includes more than one ((~~assistance unit~~)) AU, the premium amount billed for the ((~~assistance units~~)) AUs may be different amounts.

(5) The premium amount is limited to a monthly maximum of two premiums for households with two or more children.

(6) The premium amount for each ((~~eligible~~)) U.S. citizen or lawfully present alien child ((~~shall be~~)) described in WAC 388-505-0210(4) is:

(a) Twenty dollars per month per child for households with income above two hundred percent FPL, but not above two hundred and fifty percent FPL; or

(b) Thirty dollars per month per child for households with income above two hundred and fifty percent FPL, but not above three hundred percent FPL((~~; and~~

~~(c) Limited to a monthly maximum of two premiums for households with two or more children~~)).

(((~~(6)~~))) (7) The premium amount for each noncitizen child described in WAC 388-505-0210(5) who is not a lawfully present qualified or nonqualified alien is no greater than the average of the state-share of the per capita cost for state-funded children's health coverage. The premium amount is set every two years, based on the forecasted per capita costs for that period.

(8) All children in an ((~~assistance unit~~)) AU are ineligible for healthcare coverage when the head of household fails to pay required premium payments for three consecutive months.

(((~~(7)~~))) (9) When the ((~~department~~)) agency or the agency's designee terminates the medical coverage of a child due to nonpayment of premiums, the child's eligibility is restored only when the:

(a) Past due premiums are paid in full prior to the end of the certification period; or

(b) The child becomes eligible for coverage under a non-premium-based CN healthcare program.

(((~~(8)~~))) (10) The ((~~department~~)) agency or the agency's designee writes off past-due premiums after twelve months.

(((~~(9)~~))) (11) If all past due premiums are paid after the certification period is over:

(a) Eligibility for prior months is not restored; and

(b) Children are not eligible for premium-based coverage under apple health for kids until:

(i) The month the premiums are paid or the ((~~department~~)) agency writes off the debt; ((~~or~~)) and

(ii) The family reapplies and is found eligible.

(((~~(10)~~))) (12) A family cannot designate partial payment of the billed premium amount as payment for a specific child in the ((~~assistance unit~~)) AU. The full premium amount is the obligation of the head of household of the ((~~assistance unit~~)) AU. A family can decide to request healthcare coverage only for certain children in the ((~~assistance unit~~)) AU, if they want to reduce premium obligation.

(((~~(11)~~))) (13) A change that affects the premium amount is effective the month after the change is reported and processed.

(((~~(12)~~))) (14) A sponsor or other third party may pay the premium on behalf of the child or children in the ((~~assistance unit~~)) AU. The premium payment requirement remains the obligation of head of household of the ((~~assistance unit~~)) AU. The failure of a sponsor or other third party to pay the premium does not eliminate the obligation of the head of household to pay past due premiums.

NEW SECTION

WAC 182-505-0235 Order of payments under the premium-based apple health for kids program as funded by Title XXI of the Social Security Act. The agency administers the programs included in apple health for kids that provide premium-based coverage through a combination of state and federal funding sources. For expenditures funded by Title XXI of the Social Security Act, also known as the children's health insurance program (CHIP), federal financial participation will be sought in compliance with section 2105 of the act in the following order:

(1) For medical assistance for targeted low-income children from birth through age eighteen, as described in section 4 of the Title XXI state plan.

(2) For medical assistance for unborn children, as described in section 4.1.2.1 of the Title XXI state plan.

(3) For medical assistance for medicaid-eligible children, as described in CHIPRA, section 214.

(4) For medical assistance for medicaid-eligible children, as described in section 2105 (g)(4)(A) and (B) of the act.

(5) For allowable administrative expenditures under the ten percent cap, as defined in section 2105 (a)(1)(D) of the act in the following order:

(a) First, for reasonable expenditures necessary to administer the plan, including staffing for eligibility determinations, plan administration, quality assurance, and similar costs.

(b) Second, for a toll-free 800 telephone number providing information regarding the Washington apple health for kids program.

(c) Third, for health services initiatives, such as the funding of the Washington poison center, to the extent that state funds are appropriated by the legislature.

(d) Fourth, for translation or interpretation services in connection with the enrollment, retention, or use of services under this title by individuals for whom English is not their primary language, but only to the extent that state-matching funds are made available.

(e) Fifth, for outreach services for the Washington apple health for kids program, to the extent that appropriated state-matching funds are available.

(f) Sixth, for other CMS-approved activities to the extent that federal matching funds are available, and where such activities do not duplicate efforts conducted under this subsection.

WSR 11-22-052
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed October 31, 2011, 9:35 a.m., effective November 1, 2011]

Effective Date of Rule: November 1, 2011.

Purpose: In meeting the requirements of E2SHB [ESHB] 2082, the agency is amending, repealing, and creating new rules to: (1) Eliminate references to General assistance—Unemployable and disability lifeline cash programs; and (2) establish the incapacity-based medical care services program.

Citation of Existing Rules Affected by this Order: Repealing WAC 182-538-063, 388-418-0025, 388-505-

0110, 388-556-0500, 388-800-0020, 388-800-0025, 388-800-0030, 388-800-0035, 388-800-0048, 388-800-0110, 388-800-0115, 388-800-0130, 388-800-0135, 388-800-0140, 388-800-0145, 388-800-0150, 388-800-0155, 388-800-0160 and 388-800-0165; amending WAC 182-500-0070 and 388-505-0270; and creating WAC 182-503-0520, 182-503-0532, 182-503-0555, 182-503-0560, 182-504-0030, 182-504-0040, 182-504-0100, 182-506-0020, 182-508-0001, 182-508-0005, 182-508-0010, 182-508-0015, 182-508-0020, 182-508-0030, 182-508-0035, 182-508-0040, 182-508-0050, 182-508-0060, 182-508-0070, 182-508-0080, 182-508-0090, 182-508-0100, 182-508-0110, 182-508-0120, 182-508-0130, 182-508-0160, 182-508-0220, 182-508-0230, 182-508-0305, 182-508-0310, 182-508-0315, 182-508-0320, 182-508-0375, 182-509-0005, 182-509-0015, 182-509-0025, 182-509-0030, 182-509-0035, 182-509-0045, 182-509-0055, 182-509-0065, 182-509-0080, 182-509-0085, 182-509-0095, 182-509-0100, 182-509-0110, 182-509-0135, 182-509-0155, 182-509-0165, 182-509-0175, 182-509-0200, 182-509-0205, and 182-509-0210.

Statutory Authority for Adoption: RCW 41.05.021, 74.09.035.

Other Authority: Chapter 36, Laws of 2011 (ESSHB [ESHB] 2082).

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: See Purpose statement above.

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 53, Amended 2, Repealed 19.

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 53, Amended 2, Repealed 19.

Date Adopted: October 31, 2011.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-500-0070 Medical assistance definitions—M. "Medicaid" is the federal aid Title XIX program of the Social Security Act under which medical care is provided to eligible persons.

"Medical assistance" for the purposes of chapters 388-500 through 388-561 WAC, means the various healthcare programs administered by the agency or the agency's designee that provide federally funded and/or state-funded healthcare benefits to eligible clients.

"Medical assistance administration (MAA)" is the former organization within the department of social and health services authorized to administer the federally funded and/or state-funded healthcare programs that are now administered by the agency, formerly the medicaid purchasing administration (MPA), of the health and recovery services administration (HRSA).

"Medical care services (MCS)" means the limited scope of care medical program financed by state funds ((~~and provided to disability lifeline and alcohol and drug addiction services clients~~)) for clients who meet the incapacity criteria defined in chapter 182-508 WAC or who are eligible for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program.

"Medical consultant" means a physician employed or contracted by the agency or the agency's designee.

"Medical facility" means a medical institution or clinic that provides healthcare services.

"Medical institution" See "institution" in WAC 388-500-0050.

"Medically necessary" is a term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all.

"Medically needy (MN) or medically needy program (MNP)" is the state- and federally funded healthcare program available to specific groups of persons who would be eligible as categorically needy (CN), except their monthly income is above the CN standard. Some long-term care clients with income and/or resources above the CN standard may also qualify for MN.

"Medicare" is the federal government health insurance program for certain aged or disabled persons under Titles II and XVIII of the Social Security Act. Medicare has four parts:

(1) **"Part A" -** Covers medicare inpatient hospital services, post-hospital skilled nursing facility care, home health services, and hospice care.

(2) **"Part B" -** The supplementary medical insurance benefit (SMIB) that covers medicare doctors' services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of medicare.

(3) **"Part C" -** Covers medicare benefits for clients enrolled in a medicare advantage plan.

(4) **"Part D" -** The medicare prescription drug insurance benefit.

"Medicare assignment" means the process by which a provider agrees to provide services to a medicare beneficiary and accept medicare's payment for the services.

"Medicare cost-sharing" means out-of-pocket medical expenses related to services provided by medicare. For medical assistance clients who are enrolled in medicare, cost-sharing may include Part A and Part B premiums, co-insurance, deductibles, and copayments for medicare services. See chapter 388-517 WAC for more information.

Chapter 182-503 WAC

PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE

NEW SECTION

WAC 182-503-0520 Residency requirements for medical care services (MCS). This section applies to medical care services (MCS).

(1) A resident is a person who:

(a) Currently lives in Washington and intends to continue living here permanently or for an indefinite period of time; or

(b) Entered the state looking for a job; or

(c) Entered the state with a job commitment.

(2) A person does not need to live in the state for a specific period of time to be considered a resident.

(3) An MCS client can temporarily be out of the state for more than one month. If so, the client must provide the agency or the agency's designee with adequate information to demonstrate the intent to continue to reside in the state of Washington.

(4) A client may not receive comparable benefits from another state for the MCS program.

(5) A former resident of the state can apply for MCS while living in another state if:

(a) The person:

(i) Plans to return to this state;

(ii) Intends to maintain a residence in this state; and

(iii) Lives in the United States at the time of the application.

(b) In addition to the conditions in (a)(i), (ii), and (iii) of this subsection being met, the absence must be:

(i) Enforced and beyond the person's control; or

(ii) Essential to the person's welfare and is due to physical or social needs.

(c) See WAC 388-406-0035, 388-406-0040, and 388-406-0045 for time limits on processing applications.

(6) Residency is not a requirement for detoxification services.

(7) A person is not a resident when the person enters Washington state only for medical care. This person is not eligible for any medical program. The only exception is described in subsection (8) of this section.

(8) It is not necessary for a person moving from another state directly to a nursing facility in Washington state to establish residency before entering the facility. The person is considered a resident if they intend to remain permanently or for an indefinite period unless placed in the nursing facility by another state.

(9) A client's residence is the state:

(a) Where the parent or legal guardian, if appointed, for an institutionalized client twenty-one years of age or older, who became incapable of determining residential intent before reaching age twenty-one;

(b) Where a client is residing if the person becomes incapable of determining residential intent after reaching twenty-one years of age;

(c) Making a placement in an out-of-state institution; or

(d) For any other institutionalized individual, the state of residence is the state where the individual is living with the intent to remain there permanently or for an indefinite period.

(10) In a dispute between states as to which is a person's state of residence, the state of residence is the state in which the person is physically located.

NEW SECTION

WAC 182-503-0532 Citizenship requirements for the medical care services (MCS) and ADATSA programs. (1) To receive medical care services (MCS) benefits, an individual must be ineligible for the temporary assistance for needy families (TANF) or the Supplemental Security Income (SSI) program for a reason other than failure to cooperate with program requirements, and belong to one of the following groups as defined in WAC 388-424-0001:

(a) A U.S. citizen;

(b) A U.S. national;

(c) An American Indian born outside the U.S.;

(d) A "qualified alien" or similarly defined lawful immigrant such as victim of trafficking; or

(e) A nonqualified alien who meets the Washington state residency requirements as listed in WAC 182-503-0520.

(2) To receive ADATSA benefits, an individual must belong to one of the following groups as defined in WAC 388-424-0001:

(a) A U.S. citizen;

(b) A U.S. national;

(c) An American Indian born outside the U.S.;

(d) A "qualified alien" or similarly defined lawful immigrant such as victim of trafficking; or

(e) A nonqualified alien who meets the Washington state residency requirements as listed in WAC 182-503-0520.

NEW SECTION

WAC 182-503-0555 Age requirement for MCS and ADATSA. To be eligible for medical care services (MCS) or the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program an individual must be:

(1) Eighteen years of age or older; or

(2) For MCS only, if under eighteen years of age, a member of a married couple:

(a) Residing together; or

(b) Residing apart solely because a spouse is:

(i) On a visit of ninety days or less;

(ii) In a public or private institution;

(iii) Receiving care in a hospital, long-term care facility, or chemical dependency treatment facility; or

(iv) On active duty in the uniformed military services of the United States.

NEW SECTION

WAC 182-503-0560 Impact of fleeing felon status on eligibility for medical care services (MCS). This section applies to medical care services (MCS).

(1) An individual is considered a **fleeing felon** if the individual is fleeing to avoid prosecution, custody, or confinement for a crime or an attempt to commit a crime that is considered a felony in the place from which the individual is fleeing.

(2) If the individual is a fleeing felon, or who is violating a condition of probation or parole as determined by an administrative body or court that has the authority to make this decision, is not eligible for MCS benefits.

Chapter 182-504 WAC

CERTIFICATION PERIODS AND CHANGE OF CIRCUMSTANCES

NEW SECTION

WAC 182-504-0030 Medical certification periods for recipients of medical care services (MCS). (1) The certification period for medical care services (MCS) begins:

(a) The date the agency or the agency's designee has enough information to make an eligibility decision; or

(b) No later than the forty-fifth day from the date the agency or the agency's designee received the application unless the applicant is confined in a Washington state public institution as defined in WAC 388-406-0005 (6)(a) on the forty-fifth day, in which case MCS coverage will start on the date of release from confinement.

(2) The certification period may or may not run concurrently with the incapacity review; and

(3) MCS coverage may end before the certification period ends when the incapacity review and financial review do not run concurrently.

NEW SECTION

WAC 182-504-0040 Requirements for a midcertification review for medical care services (MCS). (1) A **midcertification review (MCR)** is a form sent by the agency or the agency's designee to gather information about the MCS recipient's current circumstances. The answers provided are used to determine if the individual remains eligible for medical coverage.

(2) A recipient of MCS must complete a midcertification review unless the review period is six months or less.

(3) The review form is sent in the fifth month of the MCS certification or review period and must be completed by the tenth day of month six.

(4) If the individual is required to complete a midcertification review, it can be completed in one of the following ways:

(a) **Complete the form and return it to the DSHS office.** The MCR will be considered complete if all of the following steps are taken:

(i) The form is completed in full and any changes in circumstances for the household are indicated;

(ii) The form is signed and dated;

(iii) Proof is provided of any changes that are reported; and

(iv) The form is returned to DSHS by mail or in person along with any required proof by the due date on the review.

(b) **Complete the midcertification review over the phone.** The MCR will be considered complete over the phone if all of the following steps are taken:

(i) DSHS is contacted at the phone number on the review form and told about any changes in the household's circumstances;

(ii) Proof is provided of any changes that are reported, and DSHS may be able to verify some information over the phone; and

(iii) Required proof is returned to DSHS by the due date on the review.

(c) **Complete the application process for another program.** If the agency or the agency's designee approves an application for another program in the month the MCR is due, the application is used to complete the review when the same individual is head of household for the application and the midcertification review.

(5) If eligibility for medical coverage ends because of the information provided in the midcertification review, the change takes effect the next month even if this does not give ten days notice before the effective date of the termination.

(6) If the required midcertification review is not completed, medical coverage under the MCS program stops at the end of the month the review was due.

(7) **Late reviews.** If the midcertification review is completed after the last day of the month the review was due, the agency or the agency's designee will process the review as described below based on when the review is received:

(a) **Midcertification reviews that are completed by the last day of the month after the month the review was due:** The agency or the agency's designee determines the MCS recipient's eligibility for ongoing medical coverage. If the individual is determined to be eligible, coverage is reinstated based on the information in the review, unless there is a wait list due to an enrollment cap under WAC 182-508-0150;

(b) **Midcertification reviews completed after the last day of the month after the month the review was due:** The agency or the agency's designee treats the review as a request to send an application. In order to determine eligibility for ongoing MCS medical coverage, the application process as described in chapter 388-406 WAC must be completed.

NEW SECTION

WAC 182-504-0100 Changes of circumstances—Changes that must be reported by a recipient of medical care services (MCS). (1) An individual who receives medical care services (MCS) coverage must report the following changes:

(a) A change in address;

(b) A change in who lives in the home with the individual;

(c) When the individual's total gross monthly income goes over the eligibility standards for MCS and ADATSA as listed in WAC 182-508-0230;

(d) When liquid resources are more than four thousand dollars;

(e) When the individual has a change in employment. The individual must notify the agency or the agency's designee if they:

(i) Get a job or change employers;

(ii) Change from part-time to full-time employment or from full-time to part-time employment;

(iii) Have a change in hourly wage rate or salary; or

(iv) Stop working.

(2) Changes listed in subsection (1) of this section must be reported to the agency or the agency's designee by the tenth day of the month following the month the change happened.

(3) When the change is a change in income, the date a change happened is the date the individual first received the income, e.g., the date of receipt of the first paycheck for a new job or the date of a paycheck showing a change in the amount of the individual's wage or salary.

(4) Changes that are reported late may result in receiving medical benefits to which the individual is not entitled.

AMENDATORY SECTION (Amending WSR 09-06-029, filed 2/24/09, effective 3/27/09)

WAC 388-505-0270 When an involuntary commitment to Eastern or Western State Hospital is covered by medicaid. (1) Individuals admitted to Eastern or Western State Hospital for inpatient psychiatric treatment may qualify for categorically needy (CN) medicaid coverage and ((~~general assistance (GA)~~)) aged, blind, disabled (ABD) cash benefits to cover their personal needs allowance (PNA).

(2) To be eligible under this program, individuals must:

(a) Be eighteen through twenty years of age or sixty-five years of age or older;

(b) Meet institutional status under WAC 388-513-1320;

(c) Be involuntarily committed to an inpatient treatment program by a court order under chapter 71.34 RCW;

(d) Meet the general eligibility requirements for the ((~~GA~~)) ABD cash program as described in WAC ((~~388-400-0025~~)) 388-400-0060;

(e) Have countable income below the payment standard described in WAC 388-478-0040; and

(f) Have countable resources below one thousand dollars. Individuals eligible under the provisions of this section may not apply excess resources towards the cost of care to become eligible. An individual with resources over the standard is not eligible for assistance under this section.

(3) ((~~GA~~)) ABD clients who receive active psychiatric treatment in Eastern or Western State Hospital at the time of their twenty-first birthday continue to be eligible for medicaid coverage until the date they are discharged from the facility or until their twenty-second birthday, whichever occurs first.

Chapter 182-506 WAC

MEDICAL FINANCIAL RESPONSIBILITY

NEW SECTION

WAC 182-506-0020 Assistance units for medical care services (MCS). (1) An adult who is incapacitated as defined in WAC 182-508-0010 can be in a medical care services assistance unit (AU).

(2) For an incapacitated adult who is married and lives with their spouse, the agency or the agency's designee decides who to include in the AU based on who is incapacitated:

(a) If both spouses are incapacitated as defined in WAC 182-508-0010, then the agency or the agency's designee includes both spouses in the AU.

(b) If only one spouse is incapacitated, then the agency or the agency's designee includes only the incapacitated spouse in the AU. Some of the income of the spouse not in the AU is counted as income to the AU as determined according to WAC 388-450-0135.

Chapter 182-508 WAC

ADULT MEDICAL AND CHEMICAL DEPENDENCY

NEW SECTION

WAC 182-508-0001 Medical assistance coverage for adults not covered under family medical programs. (1) An adult who does not meet the institutional status requirements as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for categorically needy (CN) coverage under this chapter. Individuals excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section an individual is eligible for CN coverage when the individual:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and

(b) Has CN countable income and resources that do not exceed the income and resource standards in WAC 388-478-0080; and

(c) Is sixty-five years of age or older, or meets the blind and/or disability criteria of the federal SSI program.

(2) An adult not meeting the conditions of subsection (1)(b) of this section is eligible for CN medical coverage if the individual:

(a) Is a current beneficiary of Title II of the Social Security Act (SSA) benefits who:

(i) Was a concurrent beneficiary of Title II and Supplemental Security Income (SSI) benefits;

(ii) Is ineligible for SSI benefits and/or state supplementary payments (SSP); and

(iii) Would be eligible for SSI benefits if certain cost-of-living (COLA) increases are deducted from the client's current Title II benefit amount:

(A) All Title II COLA increases under P.L. 94-566, section 503 received by the individual since their termination from SSI/SSP; and

(B) All Title II COLA increases received during the time period in (d)(iii)(A) of this subsection by the individual's spouse or other financially responsible family member living in the same household.

(b) Is an SSI beneficiary, no longer receiving a cash benefit due to employment, who meets the provisions of section 1619(b) of Title XVI of the SSA;

(c) Is a currently disabled individual receiving widow's or widower's benefits under section 202(e) or (f) of the SSA if the disabled individual:

(i) Was entitled to a monthly insurance benefit under Title II of the SSA for December 1983;

(ii) Was entitled to and received a widow's or widower's benefit based on a disability under section 202(e) or (f) of the SSA for January 1984;

(iii) Became ineligible for SSI/SSP in the first month in which the increase provided under section 134 of P.L. 98-21 was paid to the individual;

(iv) Has been continuously entitled to a widow's or widower's benefit under section 202(e) or (f) of the SSA;

(v) Would be eligible for SSI/SSP benefits if the amount of that increase, and any subsequent COLA increases provided under section 215(i) of the SSA, were disregarded;

(vi) Is fifty through fifty-nine years of age; and

(vii) Filed an application for medicaid coverage before July 1, 1988.

(d) Was receiving, as of January 1, 1991, Title II disabled widow or widower benefits under section 202(e) or (f) of the SSA if the individual:

(i) Is not eligible for the hospital insurance benefits under medicare Part A;

(ii) Received SSI/SSP payments in the month before receiving such Title II benefits;

(iii) Became ineligible for SSI/SSP due to receipt of or increase in such Title II benefits; and

(iv) Would be eligible for SSI/SSP if the amount of such Title II benefits or increase in such Title II benefits under section 202(e) or (f) of the SSA, and any subsequent COLA increases provided under section 215(i) of the act were disregarded.

(e) Is a disabled or blind individual receiving Title II Disabled Adult Childhood (DAC) benefits under section 202(d) of the SSA if the individual:

(i) Is at least eighteen years old;

(ii) Lost SSI/SSP benefits on or after July 1, 1988, due to receipt of or increase in DAC benefits; and

(iii) Would be eligible for SSI/SSP if the amount of the DAC benefits or increase under section 202(d) of the DAC and any subsequent COLA increases provided under section 215(i) of the SSA were disregarded.

(f) Is an individual who:

(i) In August 1972, received:

(A) Old age assistance (OAA);

(B) Aid to blind (AB);

(C) Aid to families with dependent children (AFDC); or

(D) Aid to the permanently and totally disabled (APTD); and

(ii) Was entitled to or received retirement, survivors, and disability insurance (RSDI) benefits; or

(iii) Is eligible for OAA, AB, AFDC, SSI, or APRD solely because of the twenty percent increase in Social Security benefits under P.L. 92-336.

(3) An adult who does not meet the institutional status requirement as defined in WAC 388-513-1320 and who does not receive waiver services as described in chapter 388-515 WAC is considered for medically needy (MN) coverage under this chapter. Individuals excluded from this section have rules applied to eligibility from chapter 388-513 WAC. Under this section an individual is eligible for MN coverage when the individual:

(a) Meets citizenship/immigrant, residency, and Social Security number requirements as described in WAC 388-503-0505; and

(b) Has MN countable income that does not exceed the income standards in WAC 388-478-0080, or meets the excess income spenddown requirements in WAC 388-519-0110; and

(c) Meets the countable resource standards in WAC 388-478-0070; and

(d) Is sixty-five years of age or older or meets the blind and/or disability criteria of the federal SSI program.

(4) MN coverage is available for an aged, blind, or disabled ineligible spouse of an SSI recipient. See WAC 388-519-0100 for additional information.

(5) An adult may be eligible for the alien emergency medical program as described in WAC 388-438-0110.

(6) An adult is eligible for the aged, blind, disabled program when the individual:

(a) Meets the requirements of the aged, blind, disabled program in WAC 388-400-0060 and 388-478-0033; or

(b) Meets the SSI-related disability standards but cannot get the SSI cash grant due to immigration status or sponsor deeming issues. Adults may be eligible for aged, blind, disabled cash benefits and CN medical coverage due to different sponsor deeming requirements.

(7) An adult is eligible for the state-funded medical care services (MCS) program when the individual:

(a) Meets the requirements under WAC 182-508-0005; or

(b) Meets the aged, blind, or disabled requirements of WAC 388-400-0060 and is a qualified alien as defined in WAC 388-424-0001 who is subject to the five-year bar as described in WAC 388-424-0006(3); or a nonqualified alien as defined in WAC 388-424-0001; or

(c) Meets the requirements of the ADATSA program as described in WAC 182-508-0320. MCS clients residing in counties designated as mandatory managed care plan counties must enroll in a plan.

NEW SECTION

WAC 182-508-0005 Eligibility for medical care services. (1) An individual is eligible for medical care services (MCS) benefits to the extent of available funds if the individual:

(a) Is incapacitated as required under WAC 182-508-0010 through 182-508-0120;

(b) Is at least eighteen years old or, if under eighteen, a member of a married couple;

(c) Is in financial need according to MCS' income and resource rules in chapter 182-509 WAC. The agency or the agency's designee determines who is in the individual's assistance unit according to WAC 182-506-0020;

(d) Meets the medical care services citizenship/alien status requirements under WAC 182-503-0532;

(e) Provides a Social Security number as required under WAC 388-476-0005;

(f) Resides in the state of Washington as required under WAC 182-503-0520;

(g) Reports changes of circumstances as required under WAC 182-504-0100; and

(h) Completes a midcertification review and provides proof of any changes as required under WAC 182-504-0040.

(2) An individual is not eligible for MCS benefits if the individual:

(a) Is eligible for temporary assistance for needy families (TANF) benefits.

(b) Refuses or fails to meet a TANF or SFA eligibility rule.

(c) Refuses to or fails to cooperate in obtaining federal aid assistance without good cause.

(d) Refuses or fails to participate in drug or alcohol treatment as required in WAC 182-508-0220.

(e) Is eligible for Supplemental Security Income (SSI) benefits.

(f) Is an ineligible spouse of an SSI recipient.

(g) Fails to follow a Social Security Administration (SSA) program rule or application requirement and SSA denied or terminated the individual's benefits.

(h) Is fleeing to avoid prosecution of, or to avoid custody or confinement for conviction of, a felony, or an attempt to commit a felony as described in WAC 182-503-0560.

(3) An individual who resides in a public institution and meets all other requirements may be eligible for MCS depending on the type of institution. A "public institution" is an institution that is supported by public funds, and a governmental unit either is responsible for it or exercises administrative control over it.

(a) An individual may be eligible for MCS if the individual is:

(i) A patient in a public medical institution; or

(ii) A patient in a public mental institution and is sixty-five years of age or older.

(b) An individual is not eligible for MCS when the individual is in the custody of or confined in a public institution such as a state penitentiary or county jail, including placement:

(i) In a work release program; or

(ii) Outside of the institution including home detention.

(4) If an enrollment cap exists under WAC 182-508-0150, a waiting list of persons may be established.

NEW SECTION

WAC 182-508-0010 Incapacity requirements for medical care services (MCS). Eligibility for the medical care services (MCS) program is based on an individual being incapacitated from working. For an individual to receive MCS program benefits, the agency or the agency's designee must determine the individual is incapacitated.

"Incapacitated" means that an individual cannot be gainfully employed as a result of a physical or mental impairment that is expected to continue for at least ninety days from the date the individual applies.

"Mental impairment" means a diagnosable mental disorder. The agency or the agency's designee excludes any diagnosis of or related to alcohol or drug abuse or addiction.

"Physical impairment" means a diagnosable physical illness.

(1) The agency or the agency's designee determines the individual is incapacitated if the individual is:

(a) Eligible for payments based on Social Security Administration (SSA) disability criteria;

(b) Eligible for services from the division of developmental disabilities (DDD);

(c) Diagnosed as having mental retardation based on a full scale score of seventy or lower on the Wechsler adult intelligence scale (WAIS);

(d) At least sixty-four years and seven months old;

(e) Eligible for long-term care services from aging and disability services administration; or

(f) Approved through the progressive evaluation process (PEP).

(2) The agency or the agency's designee considers an individual to be incapacitated for ninety days after:

(a) The individual is released from inpatient treatment for a mental impairment if:

(i) The release from inpatient treatment was not against medical advice; and

(ii) There is no break in the individual's participation between inpatient and outpatient treatment of their mental impairment.

(b) The individual is released from a medical institution where the individual received long-term care services from the aging and disability services administration.

(c) The Social Security Administration stops the individual's Supplemental Security Income payments because the individual is not a citizen.

NEW SECTION

WAC 182-508-0015 Determining if an individual is incapacitated. When an individual applies for medical care services (MCS) program benefits, the individual must provide medical evidence to the agency or the agency's designee that shows the individual is unable to work.

If an individual is gainfully employed at the time of application for MCS, the agency or the agency's designee denies incapacity. "Gainful employment" means an individual is performing, in a regular and predictable manner, an activity usually done for pay or profit.

(1) The agency or the agency's designee doesn't consider work to be gainful employment when the individual is working:

(a) Under special conditions that go beyond the employer providing reasonable accommodation, such as in a

sheltered workshop the agency or the agency's designee has approved; or

(b) Occasionally or part-time because the individual's impairment limits the hours the individual is able to work compared to unimpaired workers in the same job as verified by the individual's employer.

(2) The agency or the agency's designee determines if the individual is incapacitated when the individual:

(a) Applies for MCS benefits;

(b) Becomes employed;

(c) Obtains work skills by completing a training program; or

(d) The agency or the agency's designee receives new information that indicates the individual may be employable.

(3) Unless the individual meets the other incapacity criteria in WAC 182-508-0010, the agency or the agency's designee decides incapacity by applying the progressive evaluation process (PEP) to the medical evidence that the individual provides that meets WAC 182-508-0030. The PEP is the sequence of seven steps described in WAC 182-508-0035 through 182-508-0110.

(4) If the individual has a physical or mental impairment and the individual is impaired by alcohol or drug addiction and does not meet the other incapacity criteria in WAC 182-508-0010, the agency or the agency's designee decides if the individual is eligible for MCS by applying the PEP described in WAC 182-508-0035 through 182-508-0110. The individual isn't eligible for aged, blind, or disabled benefits if the individual is incapacitated primarily because of alcoholism or drug addiction.

(5) In determining incapacity, the agency or the agency's designee considers only the individual's ability to perform basic work-related activities. "Basic work-related activities" are activities that anyone would be required to perform in a work setting. They consist of: Sitting, standing, walking, lifting, carrying, handling, seeing, hearing, communicating, and understanding and following instructions.

NEW SECTION

WAC 182-508-0020 Acceptable medical evidence. The agency or the agency's designee accepts medical evidence from these sources:

(1) For a physical impairment, a health professional licensed in Washington state or where the examination was performed:

(a) A physician, which for medical care services (MCS) program purposes, includes:

(i) Medical doctor (M.D.);

(ii) Doctor of osteopathy (D.O.);

(iii) Doctor of optometry (O.D.) to evaluate visual acuity impairments;

(iv) Doctor of podiatry (D.P.) for foot disorders; and

(v) Doctor of dental surgery (D.D.S.) or doctor of medical dentistry (D.M.D.) for tooth abscesses or temporomandibular joint (TMJ) disorders.

(b) An advanced registered nurse practitioner (ARNP) for physical impairments that are within the ARNP's area of certification to treat;

(c) The chief of medical administration of the Veterans' Administration, or their designee, as authorized in federal law; or

(d) A physician assistant when the report is cosigned by the supervising physician.

(2) For a mental impairment, professionals licensed in Washington state or where the examination was performed:

(a) A psychiatrist;

(b) A psychologist;

(c) An advanced registered nurse practitioner certified in psychiatric nursing; or

(d) At the agency's or the agency's designee's discretion:

(i) A person identified as a mental health professional within the regional support network mental health treatment system provided the person's training and qualifications at a minimum include having a master's degree and two years of mental health treatment experience; or

(ii) The physician who is currently treating the individual for a mental impairment.

(3) **"Supplemental medical evidence"** means information from a health professional not listed in subsection (1) or (2) of this section and who can provide supporting medical evidence for impairments identified by any of the professionals listed in subsection (1) or (2) of this section. The agency includes as supplemental medical evidence sources:

(a) A health professional who has conducted tests on or provides ongoing treatment to the individual, such as a physical therapist, chiropractor, nurse, physician assistant;

(b) Workers at state institutions and agencies who are not health professionals and are providing or have provided medical or health-related services to the individual; or

(c) Chemical dependency professionals (CDPs) when requesting information on the effects of alcohol or drug abuse.

NEW SECTION

WAC 182-508-0030 Required medical evidence. An individual must provide medical evidence that clearly shows if that individual has an impairment and how that impairment prevents the individual from being capable of gainful employment. Medical evidence must be in writing and be clear, objective and complete.

(1) Objective evidence for physical impairments means:

(a) Laboratory test results;

(b) Pathology reports;

(c) Radiology findings including results of X rays and computer imaging scans;

(d) Clinical finding including, but not limited to, ranges of joint motion, blood pressure, temperature or pulse; and documentation of a physical examination; or

(e) Hospital history and physical reports and admission and discharge summaries; or

(f) Other medical history and physical reports related to the individual's current impairments.

(2) Objective evidence for mental impairments means:

(a) Clinical interview observations, including objective mental status exam results and interpretation.

(b) Explanation of how examination findings meet the clinical and diagnostic criteria of the most recent edition of

the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

(c) Hospital, outpatient and other treatment records related to the individual's current impairments.

(d) Testing results, if any, including:

(i) Description and interpretation of tests of memory, concentration, cognition or intelligence; or

(ii) Interpretation of medical tests to identify or exclude a connection between the mental impairment and physical illness.

(3) Medical evidence sufficient for an incapacity determination must be from a medical professional described in WAC 182-508-0020 and must include:

(a) A diagnosis for the impairment, or impairments, based on an examination performed within twelve months of application;

(b) A clear description of how the impairment relates to the individual's ability to perform the work-related activities listed in WAC 182-508-0015(5);

(c) Documentation of how the impairment, or impairments, is currently limiting the individual's ability to work based on an examination performed within the ninety days of the date of application or the forty-five days before the month of incapacity review; and

(d) Facts in addition to objective evidence to support the medical provider's opinion that the individual is unable to be gainfully employed, such as proof of hospitalization.

(4) When making an incapacity decision, the agency or the agency's designee does not use the individual's report of symptoms as evidence unless objective evidence shows there is an impairment that could reasonably be expected to produce those symptoms.

(5) The agency or the agency's designee doesn't use symptoms related to substance abuse or a diagnosis of addiction or chemical dependency when determining incapacity.

(6) The agency or the agency's designee considers diagnoses that are independent of addiction or chemical dependency when determining incapacity.

(7) The agency or the agency's designee determines the individual has a diagnosis that is independent of addiction or chemical dependency if the impairment will persist at least ninety days after the individual stops using drugs or alcohol.

(8) If the individual can't obtain medical evidence of an impairment that prevents the individual from working without cost to the individual and the individual meets the eligibility conditions other than incapacity in WAC 182-508-0005, the agency pays the costs to obtain objective evidence based on the agency's published payment limits and fee schedules.

(9) The agency or the agency's designee decides incapacity based solely on the objective information it receives. The agency or the agency's designee is not obligated to accept a decision that the individual is incapacitated or unemployable made by another agency or person.

(10) The agency or the agency's designee can't use a statement from a medical professional to determine that the individual is incapacitated unless the statement is supported by objective medical evidence.

NEW SECTION

WAC 182-508-0035 How severity ratings of impairment are assigned. (1) **"Severity rating"** means a rating of the extent of the individual's incapacity, and how severely it impacts the individual's ability to perform the basic work activities. Severity ratings are assigned in Steps II through IV of the PEP. The following chart provides a description of levels of limitations on work activities and the severity ratings that would be assigned to each.

Effect on Work Activities		Degree of Impairment	Numerical Value
(a)	There is no effect on performance of basic work-related activities.	None	1
(b)	There is no significant effect on performance of basic work-related activities.	Mild	2
(c)	There are significant limits on performance of at least one basic work-related activity.	Moderate	3
(d)	There are very significant limits on performance of at least one basic work-related activity.	Marked	4
(e)	The individual is unable to perform at least one basic work-related activity.	Severe	5

(2) The agency or the agency's designee uses the description of how the individual's condition impairs their ability to perform work activities given by the medical evidence provider to establish severity ratings when the impairments are supported by, and consistent with, the objective medical evidence.

(3) A contracted doctor reviews the individual's medical evidence and the ratings assigned to the individual's impairment when:

(a) The medical evidence provider describes functional limitations consistent with at least a moderate physical or mental health impairment;

(b) The individual's impairment has lasted, or is expected to last, twelve months or more; and

(c) The individual was not previously determined to meet aged, blind, or disabled under WAC 388-400-0060.

(4) The contracted doctor reviews the individual's medical evidence, severity ratings, and functional assessment to determine whether:

(a) The medical evidence is objective and sufficient to support the findings of the provider;

(b) Description of impairments is supported by the medical evidence; and

(c) Severity rating and assessment of functional limitations assigned by the agency or the agency's designee are consistent with the medical evidence.

(5) If the medical evidence provider's description of the individual's impairments is not consistent with other objective evidence the agency or the agency's designee has obtained, the agency or the agency's designee takes the following action:

(a) If the individual's limitations are more severe than the impairments described, the agency or the agency's designee assigns a higher severity rating; or

(b) If the individual's limitations are less severe than the impairments described, the agency or the agency's designee assigns a lower severity rating; and

(c) The agency or the agency's designee gives clear and convincing reasons for rejecting the medical evidence provider's opinion.

NEW SECTION

WAC 182-508-0040 PEP Step I—Review of medical evidence required for eligibility determination. When the agency or the agency's designee receives the individual's medical evidence, the agency or the agency's designee reviews it to see if it is sufficient to decide whether the individual's circumstances meet incapacity requirements.

(1) The agency or the agency's designee requires a written medical report to determine incapacity. The report must:

(a) Contain sufficient information as described under WAC 182-508-0030;

(b) Be written by an authorized medical professional described in WAC 182-508-0020;

(c) Document the existence of a potentially incapacitating condition; and

(d) Indicate an impairment is expected to last ninety days or more from the application date.

(2) If the information received isn't clear, the agency or the agency's designee may require more information before the agency or the agency's designee decides the individual's ability to be gainfully employed. As examples, the agency or the agency's designee may require the individual to get more medical tests or be examined by a medical specialist.

(3) The agency or the agency's designee denies incapacity if:

(a) There is only one impairment and the severity rating is less than three;

(b) A reported impairment isn't expected to last ninety days (twelve weeks) or more from the date of application;

(c) The only impairment supported by objective medical evidence is drug or alcohol addiction; or

(d) The agency or the agency's designee doesn't have clear and objective medical evidence to approve incapacity.

NEW SECTION

WAC 182-508-0050 PEP Step II—Determining the severity of mental impairments. If the individual is diagnosed with a mental impairment by a professional described in WAC 182-508-0020, the agency or the agency's designee uses information from the provider to determine how the impairment limits work-related activities.

(1) The agency or the agency's designee reviews the following psychological evidence to determine the severity of the individual's mental impairment:

(a) Psychosocial and treatment history records;

(b) Clinical findings of specific abnormalities of behavior, mood, thought, orientation, or perception;

(c) Results of psychological tests; and

(d) Symptoms observed by the examining practitioner that show how the individual's impairment affects their ability to perform basic work-related activities.

(2) The agency or the agency's designee excludes diagnosis and related symptoms of alcohol or substance abuse or addiction.

(3) If the individual is diagnosed with mental retardation, the diagnosis must be based on the Wechsler adult intelligence scale (WAIS). The following test results determine the severity rating:

Intelligence Quotient (IQ) Score	Severity Rating
85 or above	1
71 to 84	3
70 or lower	5

(4) If the individual is diagnosed with a mental impairment with physical causes, the agency or the agency's designee assigns a severity rating based on the most severe of the following four areas of impairment:

(a) Short term memory impairment;

(b) Perceptual or thinking disturbances;

(c) Disorientation to time and place; or

(d) Labile, shallow, or coarse affect.

(5) The agency or the agency's designee bases the severity of an impairment diagnosed as a mood, thought, memory, or cognitive disorder on a clinical assessment of the intensity and frequency of symptoms that:

(a) Affect the individual's ability to perform basic work-related activities; and

(b) Are consistent with a diagnosis of a mental impairment as listed in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV).

(6) The agency or the agency's designee bases the severity rating for a functional mental impairment on accumulated severity ratings for the symptoms in subsection (5)(a) of this section as follows:

Symptom Ratings or Condition		Severity Rating
(a)	The individual is diagnosed with a functional disorder with psychotic features;	Moderate (3)
(b)	The individual has had two or more hospitalizations for psychiatric reasons in the past two years;	

Symptom Ratings or Condition		Severity Rating
(c)	The individual has had more than six months of continuous psychiatric inpatient or residential treatment in the past two years;	
(d)	The objective evidence and global assessment of functional score are consistent with a significant limitation on performing work activities.	
(e)	The objective evidence and global assessment of functioning score are consistent with very significant limitations on ability to perform work activities.	Marked (4)
(f)	The objective evidence and global assessment of functioning score are consistent with the absence of ability to perform work activities.	Severe (5)

(7) If the individual is diagnosed with any combination of mental retardation, mental impairment with physical causes, or functional mental impairment, the agency or the agency's designee assigns a severity rating as follows:

Condition		Severity Rating
(a)	Two or more disorders with moderate severity (3) ratings; or	Marked (4)
(b)	One or more disorders rated moderate severity (3), and one rated marked severity (4).	
(c)	Two or more disorders rated marked severity (4).	Severe (5)

(8) We deny incapacity when the individual hasn't been diagnosed with a significant physical impairment and the individual's overall mental severity rating is one or two;

(9) The agency or the agency's designee approves incapacity when the individual has an overall mental severity rating of severe (5).

NEW SECTION

WAC 182-508-0060 PEP Step III—Determining the severity of physical impairments. The agency or the agency's designee must decide if the individual's physical impairment is serious enough to limit the individual's ability to be gainfully employed. "Severity of a physical impairment" means the degree that an impairment restricts the individual from performing basic work-related activities (see WAC 182-508-0015). Severity ratings range from one to five, with five being the most severe. The agency or the agency's designee will assign severity ratings according to the table in WAC 182-508-0035.

(1) The agency or the agency's designee assigns to each physical impairment a severity rating that is supported by medical evidence.

(2) If the individual's physical impairment is rated two, and there is no mental impairment or a mental impairment that is rated one, the agency or the agency's designee denies incapacity.

(3) If the individual's physical impairment is consistent with a severity rating of five, the agency or the agency's designee approves incapacity.

NEW SECTION

WAC 182-508-0070 PEP Step IV—Determining the severity of multiple impairments. (1) If an individual has more than one impairment, the agency or the agency's designee decides the overall severity rating by deciding if the individual's impairments have a combined effect on their ability to be gainfully employed. Each diagnosis is grouped by affected organ or function into one of thirteen "body systems." The thirteen body systems consist of:

(a) Musculo-skeletal;
(b) Special senses and speech;
(c) Respiratory;
(d) Cardiovascular;
(e) Digestive;
(f) Genito-urinary;
(g) Hemic and lymphatic;
(h) Skin;
(i) Endocrine and obesity;
(j) Neurological;
(k) Mental disorders;
(l) Neoplastic; and
(m) Immune systems.

(2) The agency or the agency's designee follows these rules when there are multiple impairments:

(a) The agency or the agency's designee groups each diagnosis by body system.

(b) When an individual has two or more diagnosed impairments that limit work activities, the agency or the agency's designee assigns an overall severity rating as follows:

Client Condition		Severity Rating
(i)	All impairments are in the same body system, are rated two and there is no cumulative effect on basic work activities.	2
(ii)	All impairments are in the same body system, are rated two and there is a cumulative effect on basic work activities.	3

Client Condition		Severity Rating
(iii)	All impairments are in different body systems, are rated two and there is a cumulative effect on basic work activities.	
(iv)	Two or more impairments are in different body systems and are rated three.	4
(v)	Two or more impairments are in different body systems; one is rated three and one is rated four.	
(vi)	Two or more impairments in different body systems are rated four.	5

(c) The agency or the agency's designee denies incapacity when the overall severity rating is two.

(d) The agency or the agency's designee approves incapacity when the overall severity rating is five.

NEW SECTION

WAC 182-508-0080 PEP Step V—Determining level of function of mentally impaired individuals in a work environment. If an individual has a mental impairment, the agency or the agency's designee evaluates the individual's cognitive and social functioning in a work setting. "Functioning" means an individual's ability to perform typical tasks that would be required in a routine job setting and the individual's ability to interact effectively while working.

(1) The agency or the agency's designee evaluates cognitive and social functioning by assessing the individual's ability to:

(a) Understand, remember, and persist in tasks by following simple instructions of one or two steps.

(b) Understand, remember, and persist in tasks by following complex instructions of three or more steps.

(c) Learn new tasks.

(d) Perform routine tasks without undue supervision.

(e) Be aware of normal hazards and take appropriate precautions.

(f) Communicate and perform effectively in a work setting with public contact.

(g) Communicate and perform effectively in a work setting with limited public contact.

(h) Maintain appropriate behavior in a work setting.

(2) The agency or the agency's designee approves incapacity when it has objective medical evidence, including a mental status exam (MSE) per WAC 182-508-0050, that demonstrates the individual is:

(a) At least moderately impaired in their ability to understand, remember, and persist in tasks following simple instructions, and at least moderately limited in their ability to:

(i) Learn new tasks;

(ii) Be aware of normal hazards and take appropriate precautions; and

(iii) Perform routine tasks without undue supervision; or

(b) At least moderately impaired in the ability to understand, remember, and persist in task following complex instructions; and

(c) Markedly impaired in the ability to learn new tasks, be aware of normal hazards and take appropriate precautions, and perform routine tasks without undue supervision.

(3) The agency or the agency's designee approves incapacity when the individual is moderately (rated three) impaired in their ability to:

(a) Communicate and perform effectively in a work setting with public contact;

(b) Communicate and perform effectively in a work setting with limited public contact; and

(c) Markedly (rated four) impaired in their ability to maintain appropriate behavior in a work setting.

NEW SECTION

WAC 182-508-0090 PEP Step VI—Determining level of function of physically impaired individuals in a work environment. In Step VI of the PEP, the agency or the agency's designee reviews the medical evidence provided and determines how an individual's physical impairment prevents that individual from working. This determination is then used in Steps VII and VIII of the PEP to determine the individual's ability to perform either work they have done in the past or other work.

(1) **"Exertion level"** means having strength, flexibility, and mobility to lift, carry, stand or walk as needed to fulfill job duties in the following work levels. For this section, "occasionally" means less than one third of the time and "frequently" means one third to two thirds of the time.

The following table is used to determine an individual's exertion level. Included in this table is a strength factor, which is an individual's ability to perform physical activities, as defined in Appendix C of the *Dictionary of Occupational Titles* (DOT), Revised Edition, published by the U.S. Department of Labor as posted on the Occupational Information Network (O.*NET).

If a client is able to:		Then the client is assigned this exertion level
(a)	Lift no more than two pounds or unable to stand or walk.	Severely limited
(b)	Lift ten pounds maximum and frequently lift or carry lightweight articles. Walking or standing only for brief periods.	Sedentary
(c)	Lift twenty pounds maximum and frequently lift or carry objects weighing up to ten pounds. Walk six out of eight hours per day or stand during a significant portion of the workday. Sitting and using pushing or pulling arm or leg movements most of the day.	Light

If a client is able to:		Then the client is assigned this exertion level
(d)	Lift fifty pounds maximum and frequently lift or carry up to twenty-five pounds.	Medium
(e)	Lift one hundred pounds maximum and frequently lift or carry up to fifty pounds.	Heavy

(2) **"Exertionally related limitation"** means a restriction in mobility, agility or flexibility in the following twelve activities: Balancing, bending, climbing, crawling, crouching, handling, kneeling, pulling, pushing, reaching, sitting, and stooping. If an individual has exertionally related limitations, then the agency or the agency's designee considers them in determining their ability to work.

(3) **"Functional physical capacity"** means the degree of strength, agility, flexibility, and mobility an individual can apply to work-related activities. The agency or the agency's designee considers the effect of the physical impairment on the ability to perform work-related activities when the physical impairment is assigned an overall severity rating of three or four. The agency or the agency's designee determines functional physical capacity based on the individual's exertional, exertionally related and nonexertional limitations. All limitations must be substantiated by the medical evidence and directly related to the diagnosed impairment(s).

(4) **"Nonexertional physical limitation"** means a restriction on work activities that does not affect strength, mobility, agility, or flexibility. Examples are:

(a) Environmental restrictions which could include, among other things, an individual's inability to work in an area where they would be exposed to chemicals; and

(b) Workplace restrictions, such as impaired hearing or speech, which would limit the types of work environments an individual could work in.

NEW SECTION

WAC 182-508-0100 PEP Step VII—Evaluating a client's capacity to perform relevant past work. If the individual's overall severity rating is moderate (three) or marked (four) at this stage of the PEP and the agency or the agency's designee has not approved or denied the individual's application, then the agency or the agency's designee will decide if the individual can do the same or similar work as they have done in the past. The agency or the agency's designee looks at the individual's current physical and/or mental limitations from cognitive, social, and vocational factors to make this decision. Vocational factors are education, relevant work history, and age.

(1) The agency or the agency's designee evaluates education in terms of formal schooling or other training that would enable the individual to meet job requirements. Education is classified as:

If the client:		Then the client's education level is
(a)	Can't read or write a simple communication, such as two sentences or a list of items.	Illiterate
(b)	Has no formal schooling or vocational training beyond the eleventh grade; or	Limited education
(c)	Has participated in special education in basic academic classes of reading, writing, or mathematics in high school.	
(d)	Has received a high school diploma or general equivalency degree (GED); or	High school and above level of education
(e)	Has received skills training and was awarded a certificate, degree or license.	

(2) The agency or the agency's designee evaluates the individual's work experience to determine if they have relevant past work. "Relevant past work" means work that:

(a) Is defined as gainful employment per WAC 182-508-0015;

(b) Has been performed in the past five years; and

(c) The individual performed long enough to acquire the knowledge and skills to continue performing the job. The individual must meet the specific vocational preparation level as defined in Appendix C of the *Dictionary of Occupational Titles*.

(3) For each relevant past work situation that the individual had, the agency or the agency's designee determines:

(a) The exertion or skill requirements of the job; and

(b) Current cognitive, social, or nonexertion factors that significantly limit the individual's ability to perform past work.

(4) After considering vocational factors, the agency or the agency's designee approves or denies incapacity when the individual has:

(a) The physical and mental ability to perform past work, and there is no significant cognitive, social or exertion limitation that would prevent the individual from performing past work; or

(b) Recently acquired specific work skills through completion of schooling or training, for jobs within the individual's current physical or mental capacities.

(5) The agency or the agency's designee approves incapacity when the individual is fifty-five years of age or older and doesn't have the physical or mental ability to perform past work.

NEW SECTION

WAC 182-508-0110 PEP Step VIII—Evaluating a client's capacity to perform other work. If the individual decides they cannot do work that they've done before, then the agency or the agency's designee decides if the individual can do any other work.

(1) The agency or the agency's designee approves incapacity if the individual has a physical impairment and meets the vocational factors below:

Highest Work Level Assigned by the Practitioner	Age	Education Level	Other Vocational Factors
Sedentary	Any age	Any level	Does not apply
Light	50 and older	Any level	Does not apply
Light	35 and older	Illiterate or LEP	Does not apply
Light	18 and older	Limited Education	Does not have any past work
Medium	50 and older	Limited Education	Does not have any past work

(2) The agency or the agency's designee approves incapacity when the individual has a moderate (three) or marked (four) mental health impairment and the agency or the agency's designee has objective medical evidence, including a mental status exam (MSE) per WAC 182-508-0050, that demonstrates social or cognitive factors described in WAC 182-508-0080, interfere with working as follows:

Social Limitation	Age
(a) Moderately impaired (rated three) in the individual's ability to: (i) Communicate and perform effectively in a work setting with limited public contact; and (ii) Maintain appropriate behavior in a work setting.	50 years and older
(b) The individual has a severe (five) impairment in their ability to: (i) Communicate and perform effectively in a work setting with public contact; or (ii) Communicate and perform effectively in a work setting with limited public contact.	Any age
(c) A mental disorder of marked severity (rated four): (i) One or more severe (rated five) mental impairment symptoms; and (ii) Moderately impaired (rated three) in the ability to communicate and perform effectively in a work setting with public or limited public contact.	Any age

(3) The agency or the agency's designee approves incapacity when the individual has both mental and physical impairments and the agency or the agency's designee has objective medical evidence, including a mental status exam (MSE) per WAC 182-508-0050, that demonstrate social or cognitive factors, as described in WAC 182-508-0080 interfere with working as follows:

Age	Education	Other Restrictions
Any age	Any level	(a) The individual is moderately impaired in their ability to communicate and perform effectively in a work setting with limited public contact; and (b) The individual is markedly impaired in their ability to communicate and perform effectively in a work setting with public contact.
50 or older	Limited education	(c) Restricted to medium work level or less.
Any age	Limited education	(d) Restricted to light work level.

(4) The agency or the agency's designee denies incapacity if the agency or the agency's designee decides the individual doesn't meet the criteria listed above.

NEW SECTION

WAC 182-508-0120 Deciding how long a client is incapacitated. The agency or the agency's designee decides how long an individual is incapacitated, up to the maximum period set by WAC 182-508-0160, using medical evidence on the expected length of time needed to heal or recover from the incapacitating disorder(s).

NEW SECTION

WAC 182-508-0130 Medical care services—Limited coverage. (1) The agency covers only the medically necessary services within the applicable program limitations listed in WAC 182-501-0060.

(2) The agency does not cover medical services received outside the state of Washington unless the medical services are provided in a border city listed in WAC 182-501-0175.

NEW SECTION

WAC 182-508-0160 When medical care services benefits end. (1) The maximum period of eligibility for medical care services (MCS) is twelve months before the agency or the agency's designee must review incapacity. The agency or the agency's designee uses current medical evidence and the

expected length of time before the individual will be capable of gainful employment to decide when MCS benefits will end.

(2) The individual's benefits stop at the end of the individual's incapacity period unless the individual provides additional medical evidence that demonstrates during the current incapacity period that there was no material improvement in the individual's impairment. No material improvement means that the individual's impairment continues to meet the progressive evaluation process criteria in WAC 182-508-0015 through 182-508-0110, excluding the requirement that the individual's impairment(s) prevent employment for ninety days.

(3) The medical evidence must meet all of the criteria defined in WAC 182-508-0030.

(4) The agency or the agency's designee uses medical evidence received after the individual's incapacity period had ended when:

(a) The delay was not due to the individual's failure to cooperate; and

(b) The agency or the agency's designee receives the evidence within thirty days of the end of the individual's incapacity period; and

(c) The evidence meets the progressive evaluation process criteria in WAC 182-508-0015 through 182-508-0110.

(5) Even if the individual's condition has not improved, the individual isn't eligible for MCS when:

(a) The agency or the agency's designee receives current medical evidence that doesn't meet the progressive evaluation process criteria in WAC 182-508-0035 through 182-508-0110; and

(b) The agency's or the agency designee's prior decision that the individual's incapacity met the requirements was incorrect because:

(i) The information the agency or the agency's designee had was incorrect or not enough to show incapacity; or

(ii) The agency or the agency's designee didn't apply the rules correctly to the information it had at that time.

NEW SECTION

WAC 182-508-0220 How alcohol or drug dependence affects an individual's eligibility for medical care services (MCS). (1) An individual who gets medical care services (MCS) must complete a chemical dependency assessment when the agency or the agency's designee has information that indicates the individual may be chemically dependent.

(2) An individual must accept an assessment referral and participate in drug or alcohol treatment if a certified chemical dependency counselor indicates a need for treatment, unless the individual meets one of the following good cause reasons:

(a) The agency or the agency's designee determines that the individual's physical or mental health impairment prevents them from participating in treatment.

(b) The outpatient chemical dependency treatment the individual needs isn't available in the county they live in.

(c) The individual needs inpatient chemical dependency treatment at a location that they can't reasonably access.

(3) If an individual refuses or fails to complete an assessment or treatment without good cause, the individual's MCS coverage will end following advance notification rules under WAC 388-458-0030.

NEW SECTION

WAC 182-508-0230 Eligibility standards for medical care services and ADATSA. Effective November 1, 2011, the eligibility standards for medical care services (MCS) and Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Eligibility Standard
1	$339
2	$428

The eligibility standards for MCS and ADATSA assistance units with shelter provided at no cost are:

Assistance Unit Size	Eligibility Standard
1	$206
2	$261

NEW SECTION

WAC 182-508-0305 Detoxification—Covered services. (1) The agency or the agency's designee only pays for services that are:

(a) Provided to eligible individuals as described in subsection (5) of this section;

(b) Directly related to detoxification; and

(c) Performed by a certified detoxification center or by a general hospital that has a contract with the department of social and health services to provide detoxification services.

(2) The agency limits on paying for detoxification services are:

(a) Three days for an acute alcoholic condition; or

(b) Five days for acute drug addiction.

(3) The agency only pays for detoxification services when notified within ten working days of the date detoxification began and all eligibility factors are met.

(4) To apply for detoxification services, an individual must complete an application for benefits. An interview is not required when applying for medical assistance. However, additional documentation may be needed to prove or confirm the information provided in the application form.

(5) An individual is eligible for detoxification services if the individual receives benefits under one of the following programs:

(a) Temporary assistance for needy families (TANF);

(b) Aged, blind, disabled cash assistance program (ABD);

(c) Supplemental Security Income (SSI);

(d) Medical care services program (MCS);

(e) Alcohol and Drug Addiction Treatment and Support Act (ADATSA); or

(f) A medical assistance program.

(6) An individual who is not eligible for one of the programs listed in subsection (5) of this section is eligible for the detoxification program if they meet the following criteria:

(a) Nonexempt countable income does not exceed the eligibility standards for MCS and ADATSA as described in WAC 182-508-0230; and

(b) Nonexempt countable resources do not exceed one thousand dollars.

(7) The following expenses are deducted from income when determining countable income:

(a) Mandatory expenses of employment;

(b) Support payments paid under a court order; and

(c) Payments to a wage earner specified by a court in bankruptcy proceedings, or previously contracted major household repairs, when failure to make such payments will result in garnishment of wages or loss of employment.

(8) The following resources are not counted when determining countable resources:

(a) A home;

(b) Household furnishings and personal clothing essential for daily living;

(c) Other personal property used to reduce need for assistance or for rehabilitation;

(d) A used and useful automobile; and

(e) All income and resources of a noninstitutionalized SSI beneficiary.

(9) The following resources are counted when determining countable resources:

(a) Cash and other liquid assets;

(b) Marketable securities; and

(c) Any other resource not specifically exempted that can be converted to cash.

(10) If an individual receives detoxification services, the individual will not incur a deductible as a factor of eligibility for the covered period of detoxification.

(11) Once an individual has been determined eligible for detoxification services, the individual is eligible from the date detoxification begins through the end of the month in which the detoxification is completed.

NEW SECTION

WAC 182-508-0310 ADATSA—Purpose. (1) The Alcohol and Drug Addiction Treatment and Support Act (ADATSA) is a legislative enactment providing state-funded treatment and support to chemically dependent indigent individuals.

(2) ADATSA provides eligible individuals with treatment if they are chemically dependent and would benefit from it.

NEW SECTION

WAC 182-508-0315 ADATSA—Covered services. If an individual qualifies for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) they may be eligible for:

(1) Alcohol/drug treatment services and support based on an individual assessment of alcohol/drug involvement and treatment needs in accordance with RCW 70.96A.100.

(2) Medical care services (MCS) as described under WAC 182-508-0005, 182-501-0060, and 182-501-0065.

NEW SECTION

WAC 182-508-0320 ADATSA—Eligible individuals. (1) To be eligible for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) services, an individual must:

(a) Be eighteen years of age or older;

(b) Be a resident of Washington as defined in WAC 182-503-0520;

(c) Meet citizenship requirements as described in WAC 182-503-0532;

(d) Provide their Social Security number; and

(e) Meet the same income and resource criteria for the medical care services (MCS) program (unless subsection (2) of this section applies), or receive federal assistance under Supplemental Security Income (SSI) or temporary assistance for needy families (TANF).

(2) An individual with nonexcluded countable income higher than the MCS eligibility standard described in WAC 182-508-0230 may qualify for inpatient only residential treatment if total countable income is below the projected monthly cost of care in the treatment center based on the state daily reimbursement rate.

NEW SECTION

WAC 182-508-0375 ADATSA—Eligibility for state-funded medical care services (MCS). To be eligible for state-funded medical care services (MCS), one of the following situations must exist:

(1) The individual meets the requirements in WAC 182-508-0320 and be waiting to receive the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) services;

(2) The individual is participating in ADATSA residential or outpatient treatment; or

(3) The individual has chosen opiate dependency (methadone maintenance) chemical dependency treatment services instead of other ADATSA treatment, but only if these treatment services are from a state-approved, publicly funded opiate dependency/methadone maintenance program.

Chapter 182-509 WAC

INCOME AND RESOURCES

NEW SECTION

WAC 182-509-0005 MCS income—Ownership and availability. This section applies to medical care services (MCS) program.

(1) The agency or the agency's designee counts all available income owned or held by persons in the assistance unit under WAC 182-506-0020 to decide if the individual is eligible for benefits when:

(a) The individual gets or expects to get income in the month.

(b) The agency or the agency's designee must count the income based on rules under this chapter.

(c) The individual owns the income. The agency or the agency's designee uses state and federal laws about who owns property to decide if the individual actually owns the income. If the individual is married, the agency or the agency's designee decides if the income is separate or community income according to chapter 26.16 RCW.

(d) The individual has control over the income, which means the income is actually available to the individual. If the individual has a representative payee, protective payee, or other person who manages the individual's income, the agency or the agency's designee considers this as the individual having control over this income.

(e) The individual can use the income to meet their current needs. The agency or the agency's designee counts the gross amount of available income in the month the individual's assistance unit gets it. If the individual normally gets the income:

(i) On a specific day, the agency or the agency's designee counts it as available on that date.

(ii) Monthly or twice monthly and the pay date changes due to a reason beyond the individual's control, such as a weekend or holiday, the agency or the agency's designee counts it in the month the individual would normally get it.

(iii) Weekly or every other week and the pay date changes due to a reason beyond the individual's control, the agency or the agency's designee counts it in the month the individual would normally get it.

(2) If income is legally the individual's designee, the agency or the agency's designee considers the income as available to the individual even if it is paid to someone else for the individual.

(3) The agency or the agency's designee:

(a) May count the income of certain people who live in the individual's home, even if they are not getting or applying for benefits. Their income counts as part of the individual's income.

(b) Counts the income of ineligible, disqualified, or financially responsible people as defined in WAC 182-509-0100.

(4) If the individual has a joint bank account with someone who is not in the individual's assistance unit (AU), the agency or the agency's designee counts any money deposited into that account as the individual's income unless:

(a) The individual can show that all or part of the funds belong **only** to the other account holder and are held or used **only** for the benefit of that holder; or

(b) Social Security Administration (SSA) used that money to determine the other account holder's eligibility for SSI benefits.

(5) Potential income is income the individual may be able to get that can be used to lower their need for assistance. If the agency or the agency's designee determines that the individual has a potential source of income, the individual must make a reasonable effort to make the income available in order to get MCS. The agency or the agency's designee does not count that income until the individual actually gets it.

(6) If the individual's AU includes a sponsored immigrant, the agency or the agency's designee considers the income of the immigrant's sponsor as available to the immigrant under the rules of this chapter. The agency or the agency's designee uses this income when deciding if the individual's AU is eligible for benefits and to calculate the individual's monthly benefits.

(7) The individual may give the agency or the agency's designee proof about a type of income at anytime, including when the agency or the agency's designee asks for it or if the individual disagrees with a decision the agency or the agency's designee made, about:

(a) Who owns the income;

(b) Who has legal control of the income;

(c) The amount of the income; or

(d) If the income is available.

NEW SECTION

WAC 182-509-0015 MCS income—Excluded income types. There are some types of income that do not count when determining if an individual is eligible for medical care services (MCS) coverage. Examples of income that do not count are:

(1) Bona fide loans as defined in WAC 388-470-0045, except certain student loans as specified under WAC 182-509-0035;

(2) Federal earned income tax refunds and earned income tax credit (EITC) payments for up to twelve months from the date of receipt;

(3) Federal economic stimulus payments that are excluded for federal and federally assisted state programs;

(4) Federal twenty-five dollar supplemental weekly unemployment compensation payment authorized by the American Recovery and Reinvestment Act of 2009;

(5) Title IV-E and state foster care maintenance payments if the individual chooses not to include the foster child in the assistance unit;

(6) Energy assistance payments;

(7) Educational assistance that is not counted under WAC 182-509-0035;

(8) Native American benefits and payments that are not counted under WAC 388-450-0040;

(9) Income from employment and training programs that is not counted under WAC 182-509-0045;

(10) Money withheld from a benefit to repay an overpayment from the same income source;

(11) One-time payments issued under the Department of State or Department of Justice Reception and Replacement Programs, such as voluntary agency (VOLAG) payments;

(12) Payments we are directly told to exclude as income under state or federal law; and

(13) Payments made to someone outside of the household for the benefits of the assistance unit using funds that are not owed to the household.

NEW SECTION

WAC 182-509-0025 MCS income—Unearned income. This section applies to medical care services (MCS).

(1) Unearned income is income an individual gets from a source other than employment or self-employment. Some examples of unearned income are:

(a) Railroad retirement;

(b) Unemployment compensation;

(c) Social Security benefits (including retirement benefits, disability benefits, and benefits for survivors);

(d) Time loss benefits as described in WAC 388-450-0010, such as benefits from the department of labor and industries (L&I); or

(e) Veteran Administration benefits.

(2) The agency or the agency's designee counts unearned income before any taxes are taken out.

NEW SECTION

WAC 182-509-0030 MCS income—Earned income. This section applies to medical care services (MCS).

(1) Earned income money received from working. This includes:

(a) Wages;

(b) Tips;

(c) Commissions;

(d) Profits from self-employment activities as described in WAC 182-509-0080; and

(e) One-time payments for work performed over a period of time.

(2) Income received for work performed for something other than money, such as rent, is considered earned income. The amount that is counted when determining the individual's eligibility for MCS is the amount received before any taxes are taken out (gross income).

NEW SECTION

WAC 182-509-0035 MCS income—Educational benefits. This section applies to medical care services (MCS).

(1) Educational benefits that do not count are:

(a) Educational assistance in the form of grants, loans or work study, issued from Title IV of the Higher Education Amendments (Title IV - HEA) and Bureau of Indian Affairs (BIA) education assistance programs. Examples of Title IV - HEA and BIA educational assistance include, but are not limited to:

(i) College work study (federal and state);

(ii) Pell grants; and

(iii) BIA higher education grants.

(b) Educational assistance in the form of grants, loans or work study made available under any program administered by the Department of Education (DOE) to an undergraduate student. Examples of programs administered by DOE include, but are not limited to:

(i) Christa McAuliffe Fellowship Program;

(ii) Jacob K. Javits Fellowship Program; and

(iii) Library Career Training Program.

(2) For assistance in the form of grants, loans or work study under the Carl D. Perkins Vocational and Applied Technology Education Act, P.L. 101-391:

(a) If the individual is attending school half time or more, the following expenses are subtracted:

(i) Tuition;

(ii) Fees;

(iii) Costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study;

(iv) Books;

(v) Supplies;

(vi) Transportation;

(vii) Dependent care; and

(viii) Miscellaneous personal expenses.

(b) If the individual is attending school less than half time, the following expenses are subtracted:

(i) Tuition;

(ii) Fees; and

(iii) Costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study.

(c) The MCS eligibility standard based on one person is also subtracted.

(d) Any remaining income is unearned income and budgeted using the appropriate budgeting method for the assistance unit.

(3) If the individual is participating in a work study that is not excluded in subsection (1) of this section, that work study income is counted as earned income under the following conditions:

(a) The individual is allowed the earned income work incentive deduction described in WAC 182-509-0175; and

(b) The remaining income is budgeted using the appropriate budgeting method for the assistance unit.

(4) If the individual receives Veteran's Administration Educational Assistance:

(a) All applicable attendance costs are subtracted; and

(b) The remaining unearned income is budgeted using the appropriate budgeting method for the assistance unit.

NEW SECTION

WAC 182-509-0045 MCS income—Employment and training programs. This section applies to medical care services (MCS).

(1) All payments issued under the Workforce Investment Act (WIA) are excluded.

(2) All payments issued under the National and Community Service Trust Act of 1993 are excluded. This includes payments made through the AmeriCorps program.

(3) All payments issued under Title I of the Domestic Volunteer Act of 1973, such as VISTA, AmeriCorps Vista, university year for action, and urban crime prevention program are excluded.

(4) All payments issued under Title II of the Domestic Volunteer Act of 1973 are excluded. These include:

(a) Retired senior volunteer program (RSVP);

(b) Foster grandparents program; and

(c) Senior companion program.

(5) Training allowances from vocational and rehabilitative programs are counted as earned income when:

(a) The program is recognized by federal, state, or local governments; and

(b) The allowance is not a reimbursement.

(6) When an MCS client receives training allowances, the following is allowed:

(a) The earned income incentive and work expense deduction specified under WAC 182-509-0175, when applicable; and

(b) The actual cost of uniforms or special clothing required for the course as a deduction, if enrolled in a remedial education or vocational training course.

NEW SECTION

WAC 182-509-0055 MCS income—Needs-based assistance from other agencies or organizations. (1) Needs-based assistance given to the individual by other agencies or organizations is not counted if the assistance is given for reasons other than ongoing living expenses which do not duplicate the purpose of DSHS cash assistance programs. Ongoing living expenses include the following items:

(a) Clothing;

(b) Food;

(c) Household supplies;

(d) Medical supplies (nonprescription);

(e) Personal care items;

(f) Shelter;

(g) Transportation; and

(h) Utilities (e.g., lights, cooking fuel, the cost of heating or heating fuel).

(2) **"Needs-based"** means eligibility is based on an asset test of income and resources relative to the federal poverty level (FPL). This definition excludes such incomes as retirement benefits or unemployment compensation which are not needs-based.

(3) If the needs-based assistance is countable, it is treated as unearned income under WAC 182-509-0025.

NEW SECTION

WAC 182-509-0065 MCS income—Gifts—Cash and noncash. This section applies to medical care services. A gift is an item furnished to an individual without work or cost on the individual's part.

(1) A cash gift is a gift that is furnished as money, cash, checks or any other readily negotiable form. Cash gifts totaling no more than thirty dollars per calendar quarter for each assistance unit member are disregarded as income.

(2) A noncash gift is treated as a resource.

(a) If the gift is a countable resource, its value is added to the value of the individual's existing countable resources and a determination is made on the impact to continue the individual's eligibility for MCS, per WAC 182-509-0005.

(b) If the gift is an excluded or noncountable resource, it does not affect the individual's eligibility or benefit level.

NEW SECTION

WAC 182-509-0080 MCS income—Self-employment income. This section applies to medical care services (MCS).

(1) Self-employment income is income that is earned by an individual from running a business, performing a service, selling items that are made by the individual or by reselling items to make a profit.

(2) An individual is self-employed if the individual earns income without having an employer/employee relationship with the person who pays for the goods or services. This includes, but is not limited to, when:

(a) The individual has primary control of the way they do their work; or

(b) Income is reported by the individual using IRS Schedule C, Schedule C-EZ, Schedule K-1, or Schedule SE.

(3) An individual usually is considered to have an employer/employee relationship when:

(a) The person the individual provides services for has primary control of how the individual does their work; or

(b) The individual gets an IRS form W-2 to report their income.

(4) Self-employment does not have to be a licensed business for the individual's business or activity to qualify as self-employment. Some examples of self-employment include:

(a) Childcare that requires a license under chapter 74.15 RCW;

(b) Driving a taxi cab;

(c) Farming/fishing;

(d) Odd jobs such as mowing lawns, house painting, gutter cleaning, or car care;

(e) Running a lodging for roomers and/or boarders. Roomer income includes money paid to the individual for shelter costs by someone not in your assistance unit who lives with the individual when:

(i) The individual owns or is buying their own residence; or

(ii) The individual rents all or a part of their residence and the total rent charges to all others living in the home is more than the individual's total rent.

(f) Running an adult family home;

(g) Providing services such as a massage therapist or a professional escort;

(h) Retainer fees to reserve a bed for a foster child;

(i) Selling items that are home-made or items that are supplied to the individual;

(j) Selling or donating biological products such as providing blood or reproductive material for profit;

(k) Working as an independent contractor; and

(l) Running a business or trade either as a sole proprietorship or in a partnership.

(5) If the individual is an employee of a company or person who does the activities listed in subsection (2) of this section as a part of their job, the agency or the agency's designee does not count the work that is performed by the individual as self-employment.

(6) Self-employment income is counted as earned income as described in WAC 182-509-0030 except as described in subsection (7) of this section.

(7) There are special rules about renting or leasing out property or real estate that is owned by the individual. If the individual does not spend at least twenty hours per week managing the property, the income is counted as unearned income.

NEW SECTION

WAC 182-509-0085 MCS income—Self-employment income—Calculation of countable income. This section applies to medical care services (MCS). The agency or the agency's designee decides how much of an individual's self-employment income to count by:

(1) Counting actual income in the month of application. This is done by:

(a) Adding together the individual's gross self-employment income and any profit the individual made from selling their business property or equipment;

(b) Subtracting the individual's business expenses as described in subsection (2) of this section; and

(c) Dividing the remaining amount of self-employment income by the number of months over which the income will be averaged.

(2) Subtracting one hundred dollars as a business expense even if the individual's costs are less than this. If the individual's costs are more than one hundred dollars, the agency or the agency's designee may subtract the individual's actual costs if the individual provides proof of their expenses. The following expenses are never allowed:

(a) Federal, state, and local income taxes;

(b) Money set aside for retirement purposes;

(c) Personal work-related expenses (such as travel to and from work);

(d) Net losses from previous periods;

(e) Depreciation; or

(f) Any amount that is more than the payment the individual gets from a boarder for lodging and meals.

(3) If the individual has worked at their business for less than a year, figuring the individual's gross self-employment income by averaging:

(a) The income over the period of time the business has been in operation; and

(b) The monthly amount is estimated to be the amount the individual will get for the coming year.

(4) If the individual's self-employment expenses are more than their self-employment income, not using this "loss" to reduce income from other self-employment businesses or other sources of income to the assistance unit.

NEW SECTION

WAC 182-509-0095 MCS income—Allocating income—General. This section applies to medical care services (MCS).

(1) Allocation is the process of determining how much of a financially responsible person's income is considered available to meet the needs of legal dependents within or outside of an assistance unit (AU).

(2) **"In-bound allocation"** means income possessed by a financially responsible person outside the AU which is considered available to meet the needs of legal dependents in the AU.

(3) **"Out-bound allocation"** means income possessed by a financially responsible AU member which is set aside to meet the needs of a legal dependent outside the AU.

NEW SECTION

WAC 182-509-0100 MCS income—Allocating income—Definitions. The following definitions apply to the allocation rules for medical care services (MCS):

(1) **"Dependent"** means a person who:

(a) Is or could be claimed for federal income tax purposes by the financially responsible person; or

(b) The financially responsible person is legally obligated to support.

(2) **"Financially responsible person"** means a parent, stepparent, adoptive parent, spouse or caretaker relative.

(3) **"Ineligible assistance unit member"** means a person who is:

(a) Ineligible for MCS due to the citizenship/alien status requirements in WAC 182-503-0532;

(b) Ineligible to receive MCS under WAC 182-503-0560 for fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime; or

(c) Ineligible to receive MCS under WAC 182-503-0560 for violating a condition of probation or parole which was imposed under federal or state law as determined by an administrative body or court of competent jurisdiction.

NEW SECTION

WAC 182-509-0110 MCS income—Allocating income to legal dependents. This section applies to medical care services (MCS).

(1) The income of an individual is reduced by the following:

(a) The MCS earned income work incentive deduction as specified in WAC 182-509-0175; and

(b) An amount not to exceed the ordered amount paid for court or administratively ordered current or back support for legal dependents living outside the home.

(2) When an individual resides in a medical institution, alcohol or drug treatment center, boarding home, or adult family home and has income, the individual retains an amount equal to:

(a) The eligibility standard amount for the nonapplying spouse living in the home; and

(b) The standard of assistance or personal needs allowance the individual is eligible for based upon their living arrangement.

(3) An individual with countable income remaining after the allocation in subsection (2)(a) and (b) of this section is not eligible for medical care services (MCS).

NEW SECTION

WAC 182-509-0135 MCS income—Allocating income of an ineligible spouse to a medical care services (MCS) client. This section applies to medical care services (MCS). When an individual is married and lives with the nonapplying spouse, the following income is available to the individual:

(1) The remainder of the individual's wages, retirement benefits or separate property after reducing the income by:

(a) The MCS earned income work incentive deduction as specified in WAC 182-509-0175; and

(b) An amount not to exceed the ordered amount paid for court or administratively ordered current or back support for legal dependents living outside the home.

(2) The remainder of the nonapplying spouse's wages, retirement benefits and separate property after reducing the income by:

(a) An amount not to exceed the ordered amount paid for court or administratively ordered current or back support for

legal dependents living outside the home, when the order is a separate order from the applying individual's order; and

(b) The one-person eligibility standard amount as specified under WAC 182-508-0230 which includes ineligible assistance unit members.

(3) One-half of all other community income, as provided in WAC 182-509-0005.

NEW SECTION

WAC 182-509-0155 MCS income—Exemption from sponsor deeming for medical care services (MCS). This section applies to medical care services (MCS).

(1) An individual who meets any of the following conditions is permanently exempt from deeming and none of a sponsor's income or resources are counted when determining eligibility for MCS:

(a) The Immigration and Nationality Act (INA) does not require the individual to have a sponsor. Immigrants who are not required to have a sponsor include those with the following status with United States Citizenship and Immigration Services (USCIS):

(i) Refugee;

(ii) Parolee;

(iii) Asylee;

(iv) Cuban/Haitian entrant; or

(v) Special immigrant from Iraq or Afghanistan.

(b) The sponsor is an organization or group as opposed to an individual;

(c) The individual does not meet the alien status requirements to be eligible for benefits under WAC 182-503-0532;

(d) The individual has worked or can get credit for forty qualifying quarters of work under Title II of the Social Security Act. If the individual worked during a quarter in which they received TANF, Basic Food, SSI, CHIP, or nonemergency medicaid benefits, a quarter of work is not counted towards the forty quarters. A quarter of work by the following people is also counted toward the forty qualifying quarters:

(i) The individual;

(ii) The individual's parents for the time they worked before the individual turned eighteen years old (including the time they worked before the individual was born); and

(iii) The individual's spouse if still married or if the spouse is deceased.

(e) The individual becomes a United States (U.S.) citizen;

(f) The individual's sponsor is dead; or

(g) If USCIS or a court decides that the individual, their child, or their parent was a victim of domestic violence from the sponsor and:

(i) The individual no longer lives with the sponsor; and

(ii) Leaving the sponsor caused the need for benefits.

(2) While the individual is in the same assistance unit (AU) as their sponsor, they are exempt from the deeming process. An individual is also exempt from the deeming process if:

(a) The sponsor signed the affidavit of support more than five years ago;

(b) The sponsor becomes permanently incapacitated; or

(c) The individual is a qualified alien according to WAC 388-424-0001 and:

(i) Is on active duty with the U.S. armed forces or the individual is the spouse or unmarried dependent child of someone on active duty;

(ii) Is an honorably discharged veteran of the U.S. armed forces or the individual is the spouse or unmarried dependent child of an honorably discharged veteran;

(iii) Was employed by an agency of the U.S. government or served in the armed forces of an allied country during a military conflict between the U.S. and a military opponent; or

(iv) Is a victim of domestic violence and the individual has petitioned for legal status under the Violence Against Women Act.

(3) If the individual, their child, or their parent was a victim of domestic violence, the individual is exempt from the deeming process for twelve months if:

(a) The individual no longer lives with the person who committed the violence; and

(b) Leaving this person caused the need for benefits.

(4) If the AU has income at or below one hundred thirty percent of the federal poverty level (FPL), the individual is exempt from the deeming process for twelve months. This is called the "indigence exemption." For this rule, the following is counted as income to the AU:

(a) Earned and unearned income the AU receives from any source; and

(b) Any noncash items of value such as free rent, commodities, goods, or services that are received from an individual or organization.

(5) If the individual chooses to use the indigence exemption, and is eligible for a state program, this information is not reported to the United States Attorney General.

(6) If the individual chooses not to use the indigence exemption:

(a) The individual could be found ineligible for benefits for not verifying the income and resources of the sponsor; or

(b) The individual will be subject to regular deeming rules under this section.

NEW SECTION

WAC 182-509-0165 MCS income—Income calculation. This section applies to medical care services (MCS).

(1) Countable income is all income that is available to the assistance unit (AU) after the following is subtracted:

(a) Excluded or disregarded income under WAC 182-509-0015;

(b) The earned income work incentive deduction under WAC 182-509-0175;

(c) Income that is allocated to someone outside of the AU under WAC 182-509-0110 through 182-509-0135.

(2) Countable income includes all income that must be counted because it is deemed or allocated from financially responsible persons who are not members of the AU under WAC 182-509-0110 through 182-509-0165.

(3) Countable income is compared to the eligibility standards under WAC 182-508-0230.

(4) If countable income available to the AU is equal to or greater than the eligibility standard, the individual is not eligible for medical care services (MCS).

NEW SECTION

WAC 182-509-0175 MCS income—Earned income work incentive deduction. This section applies to medical care services (MCS).

(1) When determining eligibility for MCS, the agency or the agency's designee allows an earned income work incentive deduction of fifty percent of an individual's gross earned income.

(2) This deduction is used to reduce countable income before comparing the income to the eligibility standard for the program.

NEW SECTION

WAC 182-509-0200 MCS resources—How resources affect eligibility for medical care services (MCS). This section applies to medical care services (MCS).

(1) The following definitions apply to this chapter:

(a) **"Equity value"** means the fair market value (FMV) minus any amount you owe on the resource.

(b) **"Community property"** means a resource in the name of the husband, wife, or both.

(c) **"Separate property"** means a resource of a married person that one of the spouses:

(i) Had possession of and paid for before they were married;

(ii) Acquired and paid for entirely out of income from separate property; or

(iii) Received as a gift or inheritance.

(2) A resource is counted towards the resource limit described in subsection (6) of this section when:

(a) It is a resource that must be counted under WAC 182-509-0205;

(b) The individual owns the resource. Ownership means:

(i) The individual's name is on the title to the property; or

(ii) The individual has property that doesn't have a title; and

(c) The individual has control over the resource, which means the resource is actually available to the individual; and

(d) The individual could legally sell the resource or convert it into cash within twenty days.

(3) The individual must try to make their resources available even if it will take more than twenty days to do so, unless:

(a) There is a legal barrier; or

(b) A court must be petitioned to release part or all of a resource.

(4) Resources are counted as of the date of application for MCS coverage.

(5) If total countable resources are over the resource limit in subsection (6) of this section, the individual is not eligible for MCS.

(6) Countable resources must be below the standards listed below based on the equity value of all countable resources.

(a) Applicants can have countable resources up to one thousand dollars.

(b) Recipients can have an additional three thousand dollars in a savings account.

(7) If the individual owns a countable resource with someone who is not included in the assistance unit (AU), only the portion of the resource that is owned by the individual is counted. If ownership of the funds cannot be determined, an equal portion of the resource is presumed to be owned by the individual and all other joint owners.

(8) It is assumed an individual has control of community property and is legally able to sell the property or convert it to cash unless evidence is provided to show the individual does not have control of the property.

(9) An item may not be considered separate property if the individual used both separate and community funds to buy or improve it.

(10) The resources of victims of family violence are not counted when:

(a) The resource is owned jointly with member of the former household;

(b) Availability of the resource depends on an agreement of the joint owner; or

(c) Making the resource available would place the individual at risk of harm.

(11) An individual may provide proof about a resource anytime, including when asked for proof by the agency or the agency's designee, or if the individual disagrees with a decision made about:

(a) Who owns a resource;

(b) Who has legal control of the resource;

(c) The value of a resource;

(d) The availability of a resource; or

(e) The portion of a property owned by the individual or another person(s).

(12) Resources of certain people who live in the home with the individual are countable, even if they are not getting assistance. Resources that count toward the resource limit in subsection (6) of this section include the resources of ineligible or financially responsible people as defined in WAC 182-509-0100.

NEW SECTION

WAC 182-509-0205 MCS resources—How resources count toward the resource limits for medical care services (MCS). This section applies to medical care services (MCS).

(1) The following resources count toward the resource limit described in WAC 182-509-0200:

(a) Liquid resources not specifically excluded in subsection (2) of this section. These are resources that are easily changed into cash. Some examples of liquid resources are:

(i) Cash on hand;

(ii) Money in checking or savings accounts;

(iii) Money market accounts or certificates of deposit (CDs) less any withdrawal penalty;

(iv) Available retirement funds or pension benefits, less any withdrawal penalty;

(v) Stocks, bonds, annuities, or mutual funds less any early withdrawal penalty;

(vi) Available trusts or trust accounts;

(vii) Lump sum payments as described in chapter 388-455 WAC; or

(viii) Any funds retained beyond the month of receipt from conversion of federally protected rights or extraction of exempt resources by members of a federally recognized tribe that are in the form of countable resources.

(b) The cash surrender value (CSV) of whole life insurance policies.

(c) The CSV over fifteen hundred dollars of revocable burial insurance policies or funeral agreements.

(d) Funds withdrawn from an individual development account (IDA) if they were removed for a purpose other than those specified in RCW 74.08A.220.

(e) Any real property like a home, land, or buildings not specifically excluded in subsection (3) of this section.

(f) The equity value of vehicles as described in WAC 182-509-0210.

(g) Personal property that is not:

(i) A household good;

(ii) Needed for self-employment; or

(iii) Of "great sentimental value," due to personal attachment or hobby interest.

(h) Resources of a sponsor as described in WAC 388-470-0060.

(i) Sales contracts.

(2) The following types of liquid resources are not counted toward the resource limit described in WAC 182-509-0200 when determining eligibility for MCS:

(a) Bona fide loans, including student loans;

(b) Basic food benefits;

(c) Income tax refunds for twelve months from the date of receipt;

(d) Earned income tax credit (EITC) in the month received and for up to twelve months;

(e) Advance earned income tax credit payments;

(f) Federal economic stimulus payments that are excluded for federal and federally assisted state programs;

(g) Individual development accounts (IDAs) established under RCW 74.08A.220;

(h) Retroactive cash benefits or TANF/SFA benefits resulting from a court order modifying a decision of the department;

(i) Underpayments received under chapter 388-410 WAC;

(j) Educational benefits that are excluded as income under WAC 182-509-0035;

(k) The income and resources of an SSI recipient;

(l) A bank account jointly owned with an SSI recipient if SSA already counted the money for SSI purposes;

(m) Foster care payments provided under Title IV-E and/or state foster care maintenance payments;

(n) Adoption support payments;

(o) Self-employment accounts receivable that the individual has billed to the customer but has been unable to collect;

(p) Resources specifically excluded by federal law; and

(q) Receipts from exercising federally protected rights or extracted exempt resources (fishing, shell fishing, timber sales, etc.) during the month of receipt for a member of a federally recognized tribe.

(3) The following types of real property are not counted when determining eligibility for MCS coverage:

(a) A home where the individual, their spouse, or their dependents live, including the surrounding property;

(b) A house the individual does not live in but plans to return to, and the individual is out of the home because of:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Natural disaster or casualty.

(c) Property that:

(i) The individual is making a good faith effort to sell;

(ii) The individual intends to build a home on, if they do not already own a home;

(iii) Produces income consistent with its fair market value (FMV), even if used only on a seasonal basis; or

(iv) A household member needs for employment or self-employment. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing.

(d) Indian lands held jointly with the tribe, or land that can be sold only with the approval of the Bureau of Indian Affairs.

(4) If the individual deposits excluded liquid resources into a bank account with countable liquid resources, the excluded liquid resources are not counted for six months from the date of deposit.

(5) If the individual sells their home, the individual has ninety days to reinvest the proceeds from the sale of a home into an exempt resource.

(a) If the individual does not reinvest within ninety days, the agency or the agency's designee will determine whether there is good cause to allow more time. Some examples of good cause are:

(i) Closing on a new home is taking longer than anticipated;

(ii) The individual is unable to find a new home that is affordable;

(iii) Someone in the household is receiving emergent medical care; or

(iv) The individual has children or dependents that are in school and moving would require them to change schools.

(b) If good cause is determined, more time will be allowed based on the individual's circumstances.

(c) If good cause is not determined, the money received from the sale of the home is considered a countable resource.

NEW SECTION

WAC 182-509-0210 MCS resources—How vehicles count toward the resource limit for medical care services (MCS). This rule applies to medical care services (MCS).

(1) A vehicle is any device for carrying persons and objects by land, water, or air.

(2) The entire value of a licensed vehicle needed to transport a physically disabled assistance unit (AU) member is excluded.

(3) The equity value of one vehicle up to five thousand dollars is excluded when the vehicle is used by the AU or household as a means of transportation.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-418-0025	Effect of changes on medical program eligibility.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-800-0020	What detoxification services will the department pay for?
WAC 388-800-0025	What information does the department use to decide if I am eligible for the detoxification program?
WAC 388-800-0030	Who is eligible for detoxification services?
WAC 388-800-0035	How long am I eligible to receive detoxification services?
WAC 388-800-0048	Who is eligible for ADATSA?
WAC 388-800-0110	What cash benefits am I eligible for through ADATSA if I am in residential treatment?
WAC 388-800-0115	What cash benefits can I receive through ADATSA if I am in outpatient treatment?
WAC 388-800-0130	What are ADATSA shelter services?
WAC 388-800-0135	When am I eligible for ADATSA shelter services?
WAC 388-800-0140	What incapacity criteria must I meet to be eligible for ADATSA shelter services?
WAC 388-800-0145	How does the department review my eligibility for ADATSA shelter services?
WAC 388-800-0150	Who is my protective payee?
WAC 388-800-0155	What are the responsibilities of my protective payee?
WAC 388-800-0160	What are the responsibilities of an intensive protective payee?
WAC 388-800-0165	What happens if my relationship with my protective payee ends?

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-505-0110	Medical assistance coverage for adults not covered under family medical programs.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-538-063	GAU clients residing in a designated mandatory managed care plan county.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-556-0500	Medical care services under state-administered cash programs.

WSR 11-22-053
EMERGENCY RULES
DEPARTMENT OF TRANSPORTATION

[Filed October 31, 2011, 9:38 a.m., effective October 31, 2011, 9:38 a.m.]

Effective Date of Rule: Immediately.

Purpose: The purpose of the WAC rule amendment is to adjust the form of financial data submitted by contractors seeking prequalification to bid on the New Keller Ferry Contract No. 00-8194. The amendment will help maximize competition for the contract without compromising the department's ability to assess the financial data. The amendments will also benefit the prequalification process for all future contracts that are governed by such rules.

Citation of Existing Rules Affected by this Order: Amending WAC 468-310-020 and 468-310-050.

Statutory Authority for Adoption: RCW 47.60.680 through 47.60.760.

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 existing WAC rules limit the maximum capacity rating to $10 million for contractors not submitting audited financial statements for purposes of prequalification. WSDOT ferries division (WSF) has issued an invitation for bids (IFB) to build a new Keller Ferry for the department's eastern region. The contract work consists of the fabrication, transport and on-site assembly of one new auto ferry to replace the M.V. Martha S which the WSDOT eastern region operates on Lake Roosevelt at the Keller Ferry crossing for State Route 21. The need for a replacement of this vessel, which is at the end of its sixty year service life and significantly under-capacity for traffic on the route, has been well documented. On August 15 and September 15, 2011, WSDOT held prebid site inspections at the south Keller Ferry landing for all interested contractors. Six interested prime contractors and one subcontractor attended the site inspections. Bids are due October 25, 2011. In the last month, several interested contractors advised that the existing WAC rules restrict their ability to submit a bid for the New Keller Ferry Contract because their companies use reviewed rather than audited financial documents. This unforeseen and unexpected development could substantially limit public competition by otherwise qualified bidders for the project.

The new ferry must be delivered to WSDOT eastern region anytime between May 1 and May 27, 2013. The short delivery window is dictated by seasonal and environmental conditions, and failure to meet this window will substantially delay the launch of the new vessel until May the following year. The time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest since the new Keller Ferry construction, transport and assembly/launching at Lake Roosevelt is complex, multi-year project that should commence in late 2011 if the 2013 replacement date is to be met. The general welfare is best served when the department can maximize competition for its contracts without compromising the scope of a project, as with this [these] proposed WAC rule amendments.

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 2, Repealed 0.

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

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

Date Adopted: October 31, 2011.

Stephen T. Reinmuth

Chief of Staff

AMENDATORY SECTION (Amending WSR 08-19-004, filed 9/4/08, effective 10/5/08)

WAC 468-310-020 Contents of standard prequalification questionnaire and financial statement. The standard prequalification questionnaire and financial statement shall be transmitted to ((~~the director of~~)) Washington state ferries. The contractor shall provide the following information:

(1) The name, address, phone number, contractor registration number and type of organization (corporation, copartnership, individual, etc.) of the contractor seeking prequalification.

(2) The contract size in dollars and the class or classes of work for which the contractor seeks prequalification (such as vessel dry-docking and hull repairs, vessel electrical repairs, etc.) as enumerated in WAC 468-310-050(6).

(3) Ownership of the contractor and if a corporation, the name of the parent corporation (if any) and any affiliated companies or subsidiaries.

(4) An accurate and complete record of the fifteen largest contracts in excess of ten thousand dollars performed by the contractor in whole or in part within the preceding three years both in Washington and elsewhere, including subcontracts, giving the contract amount, the date completed, the class of work, the name, address and phone number of the owner/agency representative, and any liquidated damages assessed against the contractor by an owner arising out of the performance of the contract.

(5) The principal officers and key employees showing the number of years each engaged in the class or classes of work for which the contractor seeks prequalification. The department may require resumes of such personnel as deemed proper for making its determination.

(6) Except as otherwise provided in this section or WAC 468-310-050(8), a contractor requesting prequalification certification to perform work in excess of ten million dollars shall submit copies of its audited or reviewed annual financial statements for the previous three years as ((~~audited~~)) prepared by an independent certified public accountant which shall include comparative balance sheets and income statements, a statement of retained earnings, supporting schedules and notes attached thereto, and the opinion of the independent auditor. ((~~The financial statement shall not be more than twelve months old when submitted.~~)) Any wholly owned subsidiary corporation may file the latest consolidated financial statement of its parent corporation in lieu of a financial statement prepared solely for such subsidiary providing the financial statement otherwise meets the requirements of the preceding two sentences. If a consolidated financial statement is filed on behalf of a subsidiary corporation, a bid of the subsidiary corporation will be considered only if there is on file with the department a letter from the parent corporation guaranteeing performance by the subsidiary corporation of its contract with the department of transportation in an amount at least equal to the amount of the bid. A letter of guarantee by a parent corporation may cover a specific contract bid by its subsidiary or all contracts bid by its subsidiary within a stated period of time.

(7) A list of all major items of equipment to be used in those classes of work for which prequalification certification is requested including the original cost, age, location and

condition of such equipment. The schedule shall show whether the equipment is owned, leased or rented. All major items of useful equipment should be listed even though fully depreciated but no obsolete or useless equipment should be included. In the event the contractor seeks prequalification certification to perform work on ferry vessels, the schedule shall also describe plant facilities of the contractor including shipyards, dry docks, repair facilities and other plant facilities.

(8) Such other information as may be required by the prequalification questionnaire.

(9) Notwithstanding the provisions of this section, a contractor who wishes to prequalify for the department's procurement of new auto ferries for the Port Townsend/Keystone ferry route, pursuant to the department's 2008 invitation for bids, shall submit a reviewed financial statement for at least one year in the previous three years, plus annual financial statements for two additional years in the previous three years. The reviewed financial statement shall be prepared by an independent certified public accountant which shall include comparative balance sheets and income statements, a statement of retained earnings, supporting schedules and notes attached thereto, and the opinion of the independent auditor. The form and quantity of financial statements shall be specified in the department's invitation for bids and is subject to modification by addendum during the bid process. This subsection applies in lieu of the form and quantity of audited financial statements specified in subsection (6) of this section for the Port Townsend/Keystone vessel procurement only. It does not replace or modify any other provisions in this chapter or governing prequalification statutes that authorize the department to evaluate a contractor's financial ability to perform the contract.

AMENDATORY SECTION (Amending WSR 08-19-004, filed 9/4/08, effective 10/5/08)

WAC 468-310-050 Classification and capacity rating. (1) Except as otherwise specified in this section, each contractor seeking prequalification under these rules will be classified for one or more of the classes of work listed in subsection (6)(a) of this section and will be given a maximum capacity rating in accordance with its financial ability, the adequacy of its equipment and plant facilities to perform the class or classes of work for which it has sought prequalification, the extent of the contractor's experience in performing contracts of the class or classes for which prequalification is sought, and the adequacy of the experience and capability of the contractor's officers and key employees in performing contracts of the class or classes for which prequalification is sought. The maximum capacity rating will limit the quantity of uncompleted work which the contractor shall have under contract at any one time either as a prime contractor or a subcontractor.

(2) Except as provided in subsections (7) through (9) of this section, the maximum capacity rating for a contractor applying for a rating in excess of fifty thousand dollars will be ten times the contractor's net worth as set forth in the standard prequalification questionnaire and financial statement. A properly executed letter of credit from an acceptable financial institution may be considered as an asset increasing the contractor's maximum capacity rating by the amount of the credit, but without the use of a multiplier. The maximum capacity rating for a contractor not submitting ((~~an~~)) audited or reviewed financial statements as provided in WAC 468-310-020(6) will be ten million dollars: Provided, That in all cases the contractor's maximum capacity rating may be reduced to an amount considered by the department to be within the contractor's actual capacity based upon its organization, personnel, equipment and plant, and experience.

(3) Consideration will be given to raising, by an amount not to exceed fifty percent, the maximum capacity rating of a contractor who qualifies with respect to actual capacity based upon organization, personnel, equipment and plant facilities, and experience, upon receipt of evidence of a current bonding capacity of such additional amount with a corporate surety. Such evidence shall be in the form of a letter of commitment executed by an officer of the surety who is authorized to bind the surety. Notwithstanding the provisions of this subsection, the maximum capacity rating for a contractor not submitting ((~~an~~)) audited or reviewed financial statements as provided in WAC 468-310-020(6) will be ten million dollars.

(4) The certificate of prequalification issued by the department will establish a contractor's maximum capacity rating which will be subject to reduction by the total value of its current uncompleted work ((~~regardless of its location and with whom it may be contracted~~)) to determine the contractor's bidding capacity at the particular time.

(5) Notwithstanding the provisions of this section, a contractor will be allowed to submit a bid for an amount up to $50,000 on a class or classes of work for which it is prequalified without regard to any financial maximum capacity rating or financial current capacity rating: Provided, That the contractor's current capacity may be reduced to an amount considered by the department to be within the contractor's actual capacity based upon its organization, personnel, equipment and plant facilities, and experience.

(6)(a) Construction, repair and maintenance work on ferry vessels for which prequalification certification under these rules may be granted are classified as follows:

Class 81	Vessel construction and renovation;
Class 82	Dry-docking and hull repairs;
Class 83	Vessel metal fabrication repairs;
Class 84	Vessel electrical repairs;
Class 85	Vessel miscellaneous repairs;

(b) A contractor currently prequalified under RCW 47.28.070 to perform those classes of work required in the construction, improvement and repair of ferry terminal facilities will initially be deemed prequalified under these rules to perform such classes of work with the same capacity rating as approved by the department for highway related work.

(7) Notwithstanding the provisions of this section, proposers who wish to prequalify for the department's construction of new 130-auto ferries, pursuant to the department's 2003 request for proposals, must submit evidence of their ability, if awarded the contract, to obtain contract security in the amount of thirteen million dollars. The department estimates such amount to be adequate to protect one hundred percent of the department's estimated exposure to loss on the

vessel construction contract, as calculated by the department prior to issuance of the request for proposals. Such amount shall be specified in the project request for proposals and is subject to modification by addendum during the request for proposals process. The actual contract security amount for the project construction contract will be a percentage of the successful proposer's total bid price. Such percentage shall be specified in the construction contract within the request for proposals. For the new 130-auto ferries contract, this provision applies in lieu of the maximum capacity rating formula specified in subsection (2) of this section.

(8) Notwithstanding the provisions of this section or WAC 468-310-020, proposers who wish to prequalify for the department's construction of new 130-auto ferries, pursuant to the department's 2003 request for proposals, shall, in addition to the evidence of contract security required in subsection (7) of this section, submit an audited financial statement for at least one year in the previous three years, plus annual financial statements for two additional years in the previous three years. The audited financial statement shall be performed by an independent certified public accountant which shall include comparative balance sheets and income statements, a statement of retained earnings, supporting schedules and notes attached thereto, and the opinion of the independent auditor. The form and quantity of financial statements shall be specified in the project request for proposals and is subject to modification by addendum during the request for proposals process. For the new 130-auto ferries contract, this provision applies in lieu of the quantity of audited financial statements specified in WAC 468-310-020.

(9) This subsection shall apply to the Port Townsend/Keystone vessel procurement only and shall be used in lieu of the requirements of subsections (1) through (5) of this section. It does not replace or modify any other provisions in this chapter or governing prequalification statutes. The department may prequalify a contractor under a Class 81 classification to bid on the Port Townsend/Keystone vessel procurement pursuant to this section based on the department's evaluation of the following criteria:

(a) Whether the contractor has adequate equipment and plant facilities available to accomplish the work;

(b) Whether the contractor has trained personnel available to perform the work;

(c) Whether the contractor has demonstrated experience in the type of work;

(d) Whether the contractor has an organization and technical staff with the size, training, experience and capability to accomplish the work;

(e) Whether the contractor has adequate financial resources to perform the type and size of work, or the ability to timely secure such resources. In evaluating such financial resources, the department may consider the contractor's overall financial condition including, but not limited to:

(i) Level of capitalization;

(ii) Cash flow;

(iii) Level of business activity;

(iv) Credit history;

(v) Debts;

(vi) Assets; and

(vii) Ability to obtain financing, including but not limited to, irrevocable lines of credit, and parent company guarantees.

A contractor does not have adequate financial resources when, based upon the totality of the circumstances, it lacks the financial resources reasonably expected of a contractor capable of performing the work on time and without interruption.

WSR 11-22-067
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-290—Filed October 31, 2011, 3:19 p.m., effective November 1, 2011]

Effective Date of Rule: November 1, 2011.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 220-47-311.

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: There is not enough harvestable share remaining at the current agreed-to run size to allow a day of purse seine fishing. 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 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: October 31, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-47-31100N Purse seines—Open periods. Notwithstanding the provisions of WAC 220-47-311, effective November 1, 2011, it is unlawful to take, fish for, or possess salmon taken for commercial purposes with purse seine

gear in waters of Puget Sound Management and Catch Reporting Areas 12, 12B and 12C.

WSR 11-22-072
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed November 1, 2011, 9:15 a.m., effective November 1, 2011, 9:15 a.m.]

Effective Date of Rule: Immediately.

Purpose: This emergency WAC filing replaces and supersedes WSR 11-17-145 filed August 24, 2011. 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). Effective January 1, 2011, the excess home equity limits is $506,000. The standard utility allowance (SUA) reference has changed effective October 1, 2011, this emergency adoption corrects the reference.

Eliminating reference to general assistance and/or disability lifeline and referencing to the correct aged, blind or disabled (ABD) cash program or medical care services (MCS) program. This emergency adoption is coordinated with community services division's (CSD) emergency adoption in eliminating disability lifeline, this is to ensure that expenditures do not exceed funds appropriated under the 2011-2013 operating budget (2ESHB 1087) signed by Governor Gregoire on June 15, 2011.

Citation of Existing Rules Affected by this Order: Amending WAC 388-513-1305, 388-513-1315, 388-513-1350, 388-513-1380, 388-515-1505, 388-515-1506, 388-515-1507, 388-515-1509, 388-515-1512, and 388-515-1514.

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

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

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 CPIU. This CR-103E continues emergency rules filed under WSR 11-10-038 while the department completes the process for permanent adoption. The initial public notice (CR-101) was filed December 29, 2010, under WSR 11-02-032. The SUA changed effective October 1, 2011. The department is coordinating with the health care authority (HCA) regarding current recodifying and emergency WACs HCA and CSD has filed which affect WAC references in chapters 388-513 and 388-515 WAC regarding changes to aged, blind or disabled cash, and medical care services.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 10, 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 10, Repealed 0.

Date Adopted: October 27, 2011.

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 11-23 issue of the Register.

WSR 11-22-073
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed November 1, 2011, 9:15 a.m., effective December 15, 2011]

Effective Date of Rule: December 15, 2011.

Purpose: The department is amending chapter 388-106 WAC, Long-term care services, to revise the assessment process for allocating personal care hours to disabled children as a result of the Washington state supreme court decision regarding the *Samantha A. v. Department of Social and Health Services*.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-106-0126 and 388-106-0213; and amending WAC 388-106-0075 and 388-106-0130.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

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: The department must revise its assessment process as soon as possible in order to allocate personal care services for children on a more individualized basis. The emergency rule is necessary in order to implement as soon as possible the state supreme court decision in *Samantha A. v. DSHS*. The department will discontinue children's annual reassessments immediately except when there has been a significant change in the child's condition or there is a new request for personal care hours. The department will assess a new request for personal care for children using the current comprehensive assessment reporting evaluation

(CARE) assessment through December 14, 2011. Effective December 15, 2011, the department will release a revised version of the children's CARE assessment that complies with the supreme court's ruling. The department is taking all reasonable steps necessary to implement the supreme court's decision as quickly as possible. The department is proceeding with the permanent adoption by filing a CR-101.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 3, Repealed 2; 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 3, Repealed 2.

Date Adopted: October 27, 2011.

Katherine I. Vasquez
Rules Coordinator

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

WAC 388-106-0075 How is my need for personal care services assessed in CARE? ((~~To assess your need for personal care services,~~)) The department gathers information from you, your caregivers, family members((~~,~~)) and other sources to assess your abilities to perform personal care tasks. The department will also consider developmental milestones for children as defined in WAC 388-106-0130 when individually assessing your abilities and needs for assistance. The department will assess your ability to perform:

(1) Activities of daily living (ADL) using self performance((~~,~~)) support provided, status and assistance available, as defined in WAC 388-106-0010. Also, the department determines your need for "assistance with body care" and "assistance with medication management," as defined in WAC 388-106-0010; and

(2) Instrumental activities of daily living (IADL) using self performance((~~,~~)) difficulty, status and assistance available, as defined in WAC 388-106-0010.

AMENDATORY SECTION (Amending WSR 11-11-024, filed 5/10/11, effective 6/10/11)

WAC 388-106-0130 How does the department determine the number of hours I may receive for in-home care? (1) The department assigns a base number of hours to each classification group as described in WAC 388-106-0125.

(2) The department will ((~~deduct from the~~)) adjust base hours to account for informal supports, shared benefit, and age appropriate functioning (as those terms are defined in WAC 388-106-0010), ((~~or~~)) and other paid services that meet some of an individual's need for personal care services, including adult day health, as follows:

(a) The CARE tool determines the adjustment for informal supports ((~~by determining~~)), shared benefit, and age appropriate functioning; determines the amount of assistance available ((~~to meet your needs,~~)); assigns ((~~it~~)) a numeric ((~~percentage,~~)) value to those assessed indicators; and ((~~reduces~~)) adjusts the base hours assigned to the classification group by the numeric ((~~percentage~~)) value. The department has assigned the following numeric values for the amount of assistance available for each ADL and IADL:

Meds	**Self Performance**	**Status**	**Assistance Available**	**Value ((~~Percentage~~))**
Self administration of medications	Rules for all codes apply except independent is not counted	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Age appropriate functioning	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3
Unscheduled ADLs	**Self Performance**	**Status**	**Assistance Available**	**Value ((~~Percentage~~))**
Bed mobility, transfer, walk in room, eating, toilet use	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client declined and independent are not counted.	Unmet	N/A	1

		Met	N/A	0
		Decline	N/A	0
		Age appropriate functioning	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3
Scheduled ADLs	**Self Performance**	**Status**	**Assistance Available**	**Value ((~~Percentage~~))**
Dressing, personal hygiene, bathing	Rules apply for all codes except: Did not occur/client not able and Did not occur/no provider = 1; Did not occur/client declined and independent are not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Age appropriate functioning	N/A	0
		Partially met	<1/4 time	.75
			1/4 to 1/2 time	.55
			1/2 to 3/4 time	.35
			>3/4 time	.15
IADLs	**Self Performance**	**Status**	**Assistance Available**	**Value ((~~Percentage~~))**
Meal preparation, Ordinary housework, Essential shopping	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Age appropriate functioning	N/A	0
		Partially met or shared benefit	<1/4 time	.3
			1/4 to 1/2 time	.2
			1/2 to 3/4 time	.1
			>3/4 time	.05
IADLs	**Self Performance**	**Status**	**Assistance Available**	**Value ((~~Percentage~~))**
Travel to medical	Rules for all codes apply except independent is not counted.	Unmet	N/A	1
		Met	N/A	0
		Decline	N/A	0
		Age appropriate functioning	N/A	0
		Partially met	<1/4 time	.9
			1/4 to 1/2 time	.7
			1/2 to 3/4 time	.5
			>3/4 time	.3
Key: > means greater than < means less than				

(b) To determine the amount of ((~~reduction~~)) adjustments for informal support, shared benefit and/or age appropriate functioning, the ((~~value percentages~~)) numeric values are totaled and divided by the number of qualifying ADLs and IADLs needs. The result is value A. Value A is then subtracted from one. This is value B. Value B is divided by three. This is value C. Value A and Value C are summed. This is value D. Value D is multiplied by the "base hours" assigned to your classification group and the result is the number of adjusted in-home hours ((~~reduced for informal supports~~)).

(3) ((~~Also, the department will adjust in-home base hours when:~~

~~(a) There is more than one client receiving ADSA-paid personal care services living in the same household, the status under subsection (2)(a) of this section must be met or partially met for the following IADLs:~~

~~(i) Meal preparation;~~

~~(ii) Housekeeping;~~

~~(iii) Shopping; and~~

~~(iv) Wood supply.~~

~~(b) You are under the age of eighteen, your assessment will be coded according to age guidelines codified in WAC 388-106-0213.~~

~~(4)~~)) After ((~~deductions~~)) adjustments are made to your base hours, as described in ((~~subsections (2) and (3)~~)) subsection (2), the department may add on hours based on your living environment:

Condition	Status	Assistance Available	Add On Hours
Offsite laundry facilities, which means the client does not have facilities in own home and the caregiver is not available to perform any other personal or household tasks while laundry is done.	N/A	N/A	8
Client is >45 minutes from essential services (which means he/she lives more than 45 minutes one-way from a full-service market).	Unmet	N/A	5
	Met	N/A	0
	Age appropriate	N/A	0
	Partially met or shared benefit	<1/4 time	5
		between 1/4 to 1/2 time	4
		between 1/2 to 3/4 time	2
		>3/4 time	2
Wood supply used as sole source of heat.	Unmet	N/A	8
	Met	N/A	0
	Declines	N/A	0
	Age appropriate	N/A	0
	Partially met or shared benefit	<1/4 time	8
		between 1/4 to 1/2 time	6
		between 1/2 to 3/4 time	4
		>3/4 time	2

((~~(5)~~)) (4) In the case of New Freedom consumer directed services (NFCDS), the department determines hours as described in WAC 388-106-1445.

((~~(6)~~)) (5) The result of actions under subsections (2), (3), and (4) is the maximum number of hours that can be used to develop your plan of care. The department must take into account cost effectiveness, client health and safety, and program limits in determining how hours can be used to ((~~meet~~)) address your identified needs. In the case of New Freedom consumer directed services (NFCDS), a New Freedom spending plan (NFSP) is developed in place of a plan of care.

((~~(7)~~)) (6) You and your case manager will work to determine what services you choose to receive if you are eligible. The hours may be used to authorize:

(a) Personal care services from a home care agency provider and/or an individual provider.

(b) Home delivered meals (i.e. a half hour from the available hours for each meal authorized).

(c) Adult day care (i.e. a half hour from the available hours for each hour of day care authorized).

(d) A home health aide if you are eligible per WAC 388-106-0300 or 388-106-0500.

(e) A private duty nurse (PDN) if you are eligible per WAC 388-71-0910 and 388-71-0915 or WAC 388-551-3000 (i.e. one hour from the available hours for each hour of PDN authorized).

(f) The purchase of New Freedom consumer directed services (NFCDS).

(7) If you are a child applying for personal care services:

(a) The department will complete a CARE assessment and use the developmental milestones table below when assessing your ability to perform personal care tasks.

(b) Your status will be coded as age appropriate when your self performance is at a level expected for persons in your assessed age range, as indicated by the developmental milestones table, unless the circumstances in subpart (c) apply.

(c) The department may code status as other than age appropriate for an ADL or IADL, despite your self performance falling within the expected developmental milestones for your age, if the department determines during your assessment that your level of functioning is not primarily due to your age.

Developmental Milestones for Activities of Daily Living (ADLS)		
ADL	**Self-Performance**	**Assessed Age Range**
Medication Management	Independent Self-Directed Assistance Required Must Be Administered	Birth through the 17th year
Locomotion in Room	Independent Supervision Limited Extensive	Birth through the 3rd year
	Total	Birth through the 1st year
Locomotion Outside Room	Independent Supervision	Birth through the 5th year
	Limited Extensive	Birth through the 3rd year
	Total	Birth through the 1st year
Walk in Room	Independent Supervision Limited Extensive	Birth through the 3rd year
	Total	Birth through the 1st year
Bed Mobility	Independent Supervision Limited Extensive	Birth through the 2nd year
	Total	Birth through the 1st year
Transfers	Independent Supervision Limited Extensive Total	Birth through the 2nd year
Toilet Use	Independent Supervision Limited Extensive	Birth through the 7th year
	Total	Birth through the 3rd year
Eating	Independent Supervision Limited Extensive Total	Birth through the 2nd year
Bathing	Independent Supervision	Birth through the 11th year
	Physical help/Transfer only Physical help/part of bathing	Birth through the 7th year
	Total	Birth through the 4th year
Dressing	Independent Supervision	Birth through the 11th year
	Limited Extensive	Birth through the 7th year
	Total	Birth through the 4th year

Personal Hygiene	Independent Supervision	Birth through the 11th year
	Limited or extensive	Birth through the 7th year
	Total	Birth through the 4th year

Developmental Milestones for Instrumental Activities of Daily Living		
IADL	**Self Performance**	**Assessed Age**
Telephone Transportation Essential Shopping Wood Supply Housework Finances Meal Preparation	Independent Supervision Limited Extensive Total	Birth through the 17th year

Additional Developmental Milestones coding		
CARE panel	**Selection**	**Assessed Age**
Speech/Hearing: Comprehension	By others client is = Age Appropriate	Birth through the 2nd year
Psych Social: MMSE	Can MMSE be administereed? = No	Birth through the 17th year
Psych Social: Memory/Short Term	Recent memory = Age appropriate	Birth through the 11th year
Psych Social: Memory/Long Term	Long Term memory = Age appropriate	Birth through the 11th year
Psych Social: Depression	Interview = unable to obtain	Birth through the 11th year
Psych Social: Decision Making	Rate how client makes decision = Age appropriate	Birth through the 11th year
Bladder/Bowel:	Bladder/Bowel Control: Continent Usually Continent Occasionally Incontinent Frequently Incontinent	Birth through the 11th year
Bladder/Bowel:	Bladder/Bowel Control: Incontinent all or most of the time	Birth through the 5th year
Bladder/Bowel:	Appliance and programs = Potty Training	Birth through the 3rd year
Bladder/Bowel:	Individual management = Age appropriate	Birth through the 5th year

(8) If you are a child applying for personal care services and your self performance is not age appropriate as determined under subsection (7), the department will assess for any informal supports or shared benefit available to assist you with each ADL and IADL.

(a) When you are living with your legally responsible parent(s), the department will take into account their legal obligation to care for you when determining the availability of informal supports. Legally responsible parents include natural parents, step-parents, and adoptive parents. Legally responsible parents generally do not include other relative caregivers or foster parents. A legally responsible parent will not be considered unavailable to meet your needs due to other obligations such as work or additional children because such obligations do not decrease the parent's legal responsibility to care for you regardless of your disabilities.

(b) Informal supports for school-age children include supports actually available through a school district, regardless of whether you take advantage of those available supports.

(c) The department will presume that you have informal supports available to assist you with your ADLs and IADLs over three-fourths but not all of the time. The department will code your informal support as greater or less than the

presumed amount if your assessment shows that your need for assistance with personal care tasks is fully met by informal supports o shared benefit, or if you provide specific information during your assessment to indicate why you do not have support available three-fourths or more of the time to assist you with a particular ADL or IADL.

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.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-106-0126	If I am under age twenty-one, how does CARE use criteria to place me in a classification group for in-home care?
WAC 388-106-0213	How are my needs assessed if I am a child applying for MPC services?

WSR 11-22-075
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed November 1, 2011, 9:15 a.m., effective December 15, 2011]

Effective Date of Rule: December 15, 2011.

Purpose: The department is amending chapter 388-106 WAC, Long-term care services, to revise the assessment process for allocating personal care hours to disabled children as a result of the Washington state supreme court decision regarding *Samantha A. v. Department of Social and Health Services*.

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

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

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: The department must revise its assessment process as soon as possible in order to allocate personal care services for children on a more individualized basis. The emergency rule is necessary in order to implement as soon as possible the state supreme court decision in *Samantha A. v. DSHS*. The department will discontinue children's annual reassessments immediately except when there has been a significant change in the child's condition or there is a new request for personal care hours. The department will assess a new request for personal care for children using the current comprehensive assessment reporting evaluation (CARE) assessment through December 14, 2011. Effective December 15, 2011, the department will release a revised version of the children's CARE assessment that complies with the supreme court's ruling. The department is taking all reasonable steps necessary to implement the supreme court's decision as quickly as possible. The department is proceeding with the permanent adoption by filing a CR-101. This filing replaces and supersedes WSR 11-17-133 filed August 24, 2011.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 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: October 27, 2011.

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. Each classification group is assigned a number of base hours as described below based upon the level of funding provided by the legislature for personal care services, and based upon the related level of functional disability of persons in each classification group as compared to persons in other classification groups.

(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.

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.

WSR 11-22-076
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed November 1, 2011, 9:15 a.m., effective November 1, 2011, 9:15 a.m.]

Effective Date of Rule: Immediately.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: The amendments are necessary to comply with:

- ESSB 5921, section 4, directing the department to establish income eligibility criteria for TANF benefits for a child, other than a foster child, who lives with a caregiver other than his or her parents.
- ESHB 2082, Laws of 2011, terminating all components of the disability lifeline (DL) program effective October 31, 2011, and establishes the aged, blind, or disabled (ABD) assistance and the pregnant women assistance (PWA) programs effective November 1, 2011.

When effective, this emergency filing will supersede emergency rules filed August 16, 2011, as WSR 11-17-075.

Purpose: The department is amending WAC 388-418-0005 How will I know what changes to report? and 388-450-0162 How does the department count my income to determine if my assistance unit is eligible and calculate the amount of my cash and Basic Food benefits?

The department is amending the above rules to:

- Establish income eligibility criteria for TANF benefits for a child, other than a foster child, who lives with a caregiver other than his or her parents.
- Eliminate reference to general assistance as the DL is terminated effective October 31, 2011, and establish new standards for ABD assistance and PWA programs effective November 1, 2011.

Citation of Existing Rules Affected by this Order: Amending WAC 388-418-0005 and 388-450-0162.

Statutory Authority for Adoption: RCW 74.04.050, 74.08.090, chapter 74.12 RCW.

Other Authority: ESSB 5921, chapter 42, and ESHB 2082, chapter 36, Laws of 2011.

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: These changes are necessary to update existing regulations to establish income eligibility for nonparental child-only TANF grants required by ESSB 5921 that go into effect November 1, 2011; and to eliminate reference to DL October 31, 2011, and create new standards for ABD and PWA November 1, 2011, as required by ESHB 2082.

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 2, 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 2, Repealed 0.

Date Adopted: October 27, 2011.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-02-071, filed 1/5/11, effective 2/5/11)

WAC 388-418-0005 How will I know what changes to report? You must report changes to the department based on the kinds of assistance you receive. We inform you of your reporting requirements on letters we send you about your benefits. Follow the steps below to determine the types of changes you must report:

(1) If you receive assistance from any of the programs listed in subsection (1), you must report changes for people in your assistance unit under chapter 388-408 WAC, based on the **first** program you receive benefits from.

(a) If you receive **long term care** benefits such as a home and community based waiver (Basic, Basic Plus, CORE, Community Protection, COPES, New Freedom, Medically Needy), care in a medical institution (nursing home, hospice care center, state veterans home, ICF/MR, RHC) or hospice, you must tell us if you have a change of:

(i) Residence;

(ii) Marital status;

(iii) Living arrangement;

(iv) Income;

(v) Resources;

(vi) Medical expenses; and

(vii) If we allow you expenses for your spouse or dependents, you must report changes in their income or shelter cost.

(b) If you receive **medical benefits based on age, blindness, disability (SSI-related medical), or ADATSA** benefits, you need to tell us if:

(i) You move;

(ii) A family member moves into or out of your home;

(iii) Your resources change; or

(iv) Your income changes. This includes the income of you, your spouse or your child living with you.

(c) If you receive **cash** benefits, you need to tell us if:

(i) You move;

(ii) Someone moves out of your home;

(iii) Your total gross monthly income goes over the:

(A) Payment standard under WAC ((~~388-478-0030~~)) 388-478-0033 if you receive ((~~general assistance~~)) ABD cash; or

(B) Earned income limit under WAC 388-478-0035 and 388-450-0165 for all other programs;

(iv) You have liquid resources more than four thousand dollars; or

(v) You have a change in employment. Tell us if you:

(A) Get a job or change employers;

(B) Change from part-time to full-time or full-time to part-time;

(C) Have a change in your hourly wage rate or salary; ((~~or~~))

(D) Stop working; or

(E) See WAC 182-504-0100 for medical care services reporting requirements.

(d) If you are a relative or nonrelative caregiver and receive cash benefits on behalf of a child in your care but not for yourself or other adults in your household, you need to tell us if:

(i) You move;

(ii) The child you are caring for moves out of the home;

(iii) ((~~The child's parent moves into your home;~~

~~(iv) The~~)) Anyone related to you or to the child you are caring for moves into or out of the home;

(iv) There is a change in the earned or unearned income of anyone in your child-only means-testing assistance unit, as defined in WAC 388-450-0162 (3)(b). You do not need to report changes in earned income for your dependent children who are in school full-time (see WAC 388-450-0070).

(v) There is a change in the recipient child's earned or unearned income ((~~changes~~)) (see WAC 388-450-0070 for how we count the earned income of a child);

(((~~(v)~~))) (vi) The recipient child has liquid resources more than four thousand dollars;

(vii) A recipient child in the home becomes a foster child; or

(viii) You legally adopt the recipient child.

(e) If you receive **family medical** benefits, you need to tell us if:

(i) You move;

(ii) A family member moves out of your home; or

(iii) If your income goes up or down by one hundred dollars or more a month and you expect this income change will continue for at least two months.

(2) If you do not receive assistance from any of the programs listed in subsection (1), but you do receive benefits from any of the programs listed in subsection (2), you must report changes for the people in your assistance unit under chapter 388-408 WAC, based on all the benefits you receive.

(a) If you receive **Basic Food** benefits, you need to tell us if:

(i) If your household is a categorically eligible household as defined under WAC 388-414-0001, tell us if your total gross monthly income is more than two hundred percent of the federal poverty level; or

(ii) For all other households tell us if your total monthly income is more than the maximum gross monthly income as described in WAC 388-478-0060; or

(iii) Anyone who receives food benefits in your assistance unit and who must meet work requirements under WAC 388-444-0030 ((~~and~~)) has their hours at work go below twenty hours per week.

(b) If you receive **children's medical** benefits, you need to tell us if:

(i) You move; or

(ii) A family member moves out of the house.

(c) If you receive **pregnancy medical** benefits, you need to tell us if:

(i) You move; or

(ii) You are no longer pregnant.

(d) If you receive **other medical** benefits, you need to tell us if:

(i) You move; or

(ii) A family member moves out of the home.

AMENDATORY SECTION (Amending WSR 09-07-054, filed 3/11/09, effective 4/11/09)

WAC 388-450-0162 How does the department count my income to determine if my assistance unit is eligible and how does the department calculate the amount of my cash and Basic Food benefits? (1) Countable income is all income your assistance unit (AU) or your child-only means-testing AU has after we subtract the following:

(a) Excluded or disregarded income under WAC 388-450-0015;

(b) For **cash assistance,** earned income incentives and deductions allowed for specific programs under WAC 388-450-0170 and 388-450-0175;

(c) For **Basic Food,** deductions allowed under WAC 388-450-0185; and

(d) Income we allocate to someone outside of the assistance unit under WAC 388-450-0095 through 388-450-0160.

(2) Countable income includes all income that we must deem or allocate from financially responsible persons who are not members of your AU under WAC 388-450-0095 through 388-450-0160.

(3) Starting November 1, 2011, we may apply child-only means-testing to determine eligibility and your payment standard amount.

(a) Child-only means-testing applies when you are a nonparental relative or unrelated caregiver applying for or receiving a nonneedy TANF/SFA grant for a child or children only, unless at least one child was placed by a state or tribal child welfare agency and it is an open child welfare case.

(b) For the purposes of child-only means-testing only, we include yourself, your spouse, your dependents, and other persons who are financially responsible for yourself or the child as defined in WAC 388-450-0100 in your assistance unit (AU). We call this your child-only means-testing AU.

(c) As shown in the chart below, we compare your child-only means-testing AU's total countable income to the current federal poverty level (FPL) for your household size to determine your child-only means-testing payment standard. Your child-only means-tested payment standard is a percentage of the payment standards in WAC 388-478-0020.

If your countable child-only means-testing AU income is:	Your child-only means-tested payment standard is equal to the following percentage of the payment standards in WAC 388-478-0020:
200% FPL or less	100%
Between 201% and 225% of FPL	80%
Between 226% and 250% of FPL	60%
Between 251% and 275% of FPL	40%
Between 276% and 300% of FPL	20%
Over 300% of the FPL	The children in your care are not eligible for a TANF/SFA grant.

(d) If the children in your care qualify for a TANF/SFA grant once the child-only means-test is applied, the child's income is budgeted against the child-only means-tested payment standard amount.

(e) If the children in your care do not qualify for a TANF/SFA grant once the child-only means-test is applied, they may still qualify for medical assistance as described in WAC 388-408-0055 and WAC 388-505-0210.

(4) For **cash assistance:**

(a) We compare your countable income to the payment standard in WAC 388-478-0020 and ((~~388-478-0030~~)) 388-478-0033 or, for child-only means-tested cases, to the payment standard amount in subsection (3) of this section.

(b) You are not eligible for benefits when your AU's countable income is equal to or greater than the payment standard plus any authorized additional requirements.

(c) Your benefit level is the payment standard and authorized additional requirements minus your AU's countable income.

((~~(4)~~)) (5) For **Basic Food,** if you meet all other eligibility requirements for the program under WAC 388-400-0040, we determine if you meet the income requirements for benefits and calculate your AU's monthly benefits as specified under Title 7 Part 273 of code of federal regulations for the supplemental nutrition assistance program (SNAP). The process is described in brief below:

(a) How we determine if your AU is income eligible for Basic Food:

(i) We compare your AU's total monthly income to the gross monthly income standard under WAC 388-478-0060. We don't use income that isn't counted under WAC 388-450-0015 as a part of your gross monthly income.

(ii) We then compare your AU's countable monthly income to the net income standard under WAC 388-478-0060.

(A) If your AU is categorically eligible for Basic Food under WAC 388-414-0001, your AU can have income over the gross or net income standard and still be eligible for benefits.

(B) If your AU includes a person who is sixty years of age or older or has a disability, your AU can have income over the gross income standard, but must have income under the net income standard to be eligible for benefits.

(C) **All other AUs** must have income at or below the gross and net income standards as required under WAC 388-478-0060 to be eligible for Basic Food.

(b) How we calculate your AU's monthly Basic Food benefits:

(i) We start with the maximum allotment for your AU under WAC 388-478-0060.

(ii) We then subtract thirty percent of your AU's countable income from the maximum allotment and round the benefit down to the next whole dollar to determine your monthly benefit.

(iii) If your AU is eligible for benefits and has one or two persons, your AU will receive at least the minimum allotment as described under WAC 388-412-0015, even if the monthly benefit we calculate is lower than the minimum allotment.

WSR 11-22-093
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 11-291—Filed November 1, 2011, 4:19 p.m., effective November 2, 2011, 6:00 a.m.]

Effective Date of Rule: November 2, 2011, 6:00 a.m.

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

Citation of Existing Rules Affected by this Order: Repealing WAC 220-32-05700F; and amending WAC 220-32-057.

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

Other Authority: *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546); *Northwest Gillnetters Ass'n v. Sandison*, 95 Wn.2d 638, 628 P.2d 800 (1981); Washington fish and wildlife commission policies concerning Columbia River fisheries; 40 Stat. 515 (Columbia River compact).

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

Reasons for this Finding: Reopens the sturgeon set-line commercial treaty fishery in SMCRA 1G (The Dalles Pool). Harvestable fish remain under the pool-specific guideline. Only allows sales of sturgeon, including those caught with traditional platform and hook and line gear. Conforms state rules to tribal rules. Consistent with compact action of November 1, 2011. There is insufficient time to promulgate permanent rules.

The Yakama, Warm Springs, Umatilla, and Nez Perce Indian tribes have treaty fishing rights in the Columbia River and inherent sovereign authority to regulate their fisheries. Washington and Oregon also have some authority to regulate fishing by treaty Indians in the Columbia River, authority that the states exercise jointly under the congressionally ratified Columbia River compact. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969).

The tribes and the states adopt parallel regulations for treaty Indian fisheries under the supervision of the federal courts. A court order sets the current parameters. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546). Some salmon and steelhead stocks in the Columbia River are listed as threatened or endangered under the federal ESA. On May 5, 2008, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allow for some incidental take of these species in the fisheries as described in the 2008-2017 *U.S. v. Oregon* Management Agreement. Columbia River fisheries are monitored very closely to ensure consistency with court orders and ESA guidelines. Because conditions change rapidly, the fisheries are managed almost exclusively by emergency rule. As required by court order, the Washington (WDFW) and Oregon (ODFW) departments of fish and wildlife convene public hearings and invite tribal participation when considering proposals for new emergency rules affecting treaty fishing rights. *Sohappy*, 302 F. Supp. at 912. WDFW and ODFW then adopt regulations reflecting agreements reached.

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 0, Repealed 1; Federal Rules or Standards: New 1, Amended 0, Repealed 1; or Recently Enacted State Statutes: New 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: November 1, 2011.

Philip Anderson
Director

NEW SECTION

WAC 220-32-05700F Columbia River sturgeon seasons above Bonneville Dam. Notwithstanding the provisions of WAC 220-32-057, effective immediately, it is unlawful to take, fish for or possess sturgeon for commercial purposes in Columbia River Salmon Management and Catch Reporting Areas 1F, 1G, and 1H, except that those individu-

als possessing treaty fishing rights under the Yakama, Warm Springs, Umatilla, and Nez Perce treaties may fish for sturgeon with set-line gear under the following provisions:

1. **Open period:** 6:00 a.m. November 2 through 6:00 p.m. December 2, 2011.

2. **Area:** SMCRA 1G

3. **Gear:** Set-lines. Fishers are encouraged to use circle hooks and avoid J-hooks. It is unlawful to use setline gear with more than 100 hooks per set-line, with hooks less than the minimum size of 9/0, with treble hooks, without visible buoys attached, and with buoys that do not specify operator and tribal identification.

Traditional platform and hook and line gear is also allowed, which includes hoop nets, dip bag nets, and rod and reel with hook and line gear.

4. **Allowable Sales:** Sturgeon between 43 and 54 inches in fork length. Sturgeon within the size limits stated above, and caught in this platform and hook and line fishery, may be sold if caught during the open periods and open area of the set-line fishery.

5. **Sanctuaries:** Standard sanctuaries applicable to these gear types.

6. **Additional Regulations:** 24-hour quick reporting required for Washington wholesale dealers, pursuant to WAC 220-69-240.

7. **Miscellaneous:** It is unlawful to sell, barter, or attempt to sell or barter sturgeon eggs that have been removed from the body cavity of a sturgeon prior to sale of the sturgeon to a wholesale dealer licensed under chapter 77.65 RCW, or to sell or barter sturgeon eggs at retail. It is unlawful to deliver to a wholesale dealer licensed under chapter 77.65 RCW any sturgeon that are not in the round with the head and tail intact.

Reviser's note: The unnecessary underscoring 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 6:01 p.m. December 2, 2011:

WAC 220-32-05700F	Columbia River sturgeon seasons above Bonneville.