WSR 14-10-003
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 14-88—Filed April 23, 2014, 4:06 p.m., effective April 23, 2014, 4:06 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-05100M; and amending WAC 220-52-051.

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

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

Reasons for this Finding: The 2014 state/tribal shrimp harvest management plans for the Strait of Juan de Fuca and Puget Sound require adoption of harvest seasons contained in this emergency rule. This emergency rule installs [a] weekly limit for nonspot shrimp in Regions 1 and 2. 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Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.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: April 23, 2014.

Philip Anderson
Director

NEW SECTION

WAC 220-52-05100N Puget Sound shrimp pot and beam trawl fishery—Season. Notwithstanding the provisions of WAC 220-52-051, effective immediately until further notice, it is unlawful to fish for shrimp for commercial purposes in Puget Sound except as provided for in this section:

(1) Shrimp pot gear:

(a) All waters of Shrimp Management Areas 1A, 1B, 1C, 2E, 2W, 3, 4, and 6 are open to the harvest of all non-spot shrimp species, effective 6:00 a.m. May 1, 2014, until further notice, except as provided for in this section:

i) In Marine Fish/Shellfish Management and Catch Reporting Area (Catch Area) 22A, all waters inside and bounded by a line projected from Blakely Marina on the northwest corner of Blakely Island to Upright Head on Lopez Island, following the shoreline southerly on Lopez Island to intersect a line projected due west from Bald Bluff on Blakely Island, are closed until 7:00 a.m. June 16, 2014.

ii) All waters of Catch Areas 23A-E, 23A-W, 23A-C and the Discovery Bay Shrimp District are closed.

iii) All waters of Shrimp Management Area 1A north of a line projected at 48°.31.5' N latitude are closed.

(b) Effective immediately, until further notice, it is unlawful for the combined total harvest of non-spot shrimp by a fisher and/or the fisher's alternate operator to exceed 1,000 pounds per week from Shrimp Management Areas 1A, 1B, 1C, 2E and 2W.

(c) The shrimp catch accounting week is Wednesday through Tuesday.

(d) It is unlawful to pull shellfish pots in more than one catch area per day.

(2) Shrimp beam trawl gear:

(a) Shrimp Management Area (SMA) 3 (outside of the Discovery Bay Shrimp District, Sequim Bay and Catch Area 23D) is open, effective immediately, until further notice. Sequim Bay includes those waters of Catch Area 25A south of a line projected west from Travis Spit on the Miller Peninsula.

(b) That portion of Catch Area 22A within SMA 1B east of a line projected 122.47°W longitude and west of a line projected 122.43°W longitude in Rosario Strait is open effective 6:00 a.m. May 1, 2014, until further notice.

(c) That portion of Catch Area 22A within SMA 1B is open effective 6:00 a.m. May 16, 2014, until further notice.

(3) All shrimp taken under this section must be sold to licensed Washington wholesale fish dealers.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-52-05100M Puget Sound shrimp pot and beam trawl fishery—Season. (14-74)

WSR 14-10-006
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 14-91—Filed April 24, 2014, 8:57 a.m., effective May 1, 2014]

Effective Date of Rule: May 1, 2014.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 232-28-620.

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

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

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

Reasons for this Finding: The department is in the process of adopting permanent rules that are necessary to implement the personal use fishing plans agreed-to with resource comanagers at the North of Falcon proceedings. These emergency rules are necessary to comply with agreed-to management plans, and are interim until permanent rules take effect.

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

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

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

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

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

Date Adopted: April 24, 2014.

Philip Anderson
Director

NEW SECTION

WAC 232-28-62000D Coastal salmon—Saltwater seasons and daily limits. Notwithstanding the provisions of WAC 232-28-620, effective immediately until further notice, it is unlawful to violate the provisions below. Unless otherwise amended, all permanent rules remain in effect:

(1) **Catch Record Card Area 1:** May 1 through May 30: Closed. May 31 through June 13: Daily limit of 2 salmon, release coho and wild Chinook. June 14 until further notice: Daily limit of 2 salmon, of which not more than one may be a Chinook salmon, release wild coho.

(2) **Catch Record Card Area 2:** May 1 through May 30: Closed. May 31 through June 13: Daily limit of 2 salmon, release coho and wild Chinook. June 14 until further notice: Daily limit of 2 salmon, of which not more than one may be a Chinook salmon, release wild coho.

(3) **Willapa Bay (Catch Record Card Area 2-1):** May 1 through May 30: Closed. May 31 through July 31: Open concurrent with Area 2 when Area 2 is open for salmon angling: Area 2 rules apply.

(4) **Grays Harbor (Catch Record Card Area 2-2 west of Buoy 13 line):** May 1 through May 30: Closed. May 31 until further notice: Open concurrent with Area 2 when Area 2 is open for salmon angling: Area 2 rules apply.

(5) **Catch Record Card Area 3:** May 1 through May 30: Closed, except open May 16, May 17, May 23, and May 24: daily limit of 2 salmon, release coho and wild Chinook. May 31 through June 13: daily limit of 2 salmon, release coho and wild Chinook. June 14 until further notice: daily limit of 2 salmon, release wild coho.

(6) **Catch Record Card Area 4:** May 1 through May 30: Closed, except open May 16, May 17, May 23, and May 24: daily limit of 2 salmon, release coho and wild Chinook. May 31 through June 13: daily limit of 2 salmon, release coho and wild Chinook. June 14 until further notice: daily limit of 2 salmon, release wild coho. Waters east of a true north-south line through Sail Rock are closed through July 31. Waters south of a line from Kydaka Point to Shipwreck Point are closed.

WSR 14-10-007

EMERGENCY RULES

DEPARTMENT OF FISH AND WILDLIFE

[Order 14-87—Filed April 24, 2014, 11:09 a.m., effective April 24, 2014, 11:09 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 232-28-621 and 220-55-220.

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

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

Reasons for this Finding: The department is in the process of adopting permanent rules that are necessary to implement the personal use fishing plans agreed-to with resource comanagers at the North of Falcon proceedings. These emergency rules are necessary to comply with agreed-to management plans, and are interim until permanent rules take effect.

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

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

Number of Sections Adopted on the Agency's Own Initiative: New 2, 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: April 24, 2014.

Philip Anderson
Director

NEW SECTION

WAC 232-28-62100B Puget Sound salmon—Saltwater seasons and daily limits. Notwithstanding the provisions of WAC 232-28-621, effective immediately until further notice, it is unlawful to violate the provisions below. Unless otherwise amended, all permanent rules remain in effect:

(1) **Catch Record Card Area 5:** July 1, 2014, until further notice: Daily limit may include an additional 2 sockeye.

(2) **Catch Record Card Area 6:** July 1, 2014, until further notice: Daily limit may include an additional 2 sockeye.

(3) **Catch Record Card Area 7:** July 1, 2014, until further notice: Daily limit may include an additional 2 sockeye.

(4) **Catch Record Card Area 8-2:** May 1 through July 31, 2014: Closed, except: Waters west of Tulalip Bay and within 2,000 feet of shore from the pilings at Old Bower's Resort to a fishing boundary marker approximately 1.4 miles northwest of Hermosa Point are open only from Friday through 11:59 a.m. the following Monday of each week, May 30 through June 20 and June 22 until further notice:

(5) **Catch Record Card Area 9:** July 16 through August 15, 2014: Daily limit of 2 salmon, of which no more than 1 Chinook may be retained. Release chum and wild Chinook. August 16 until further notice: Daily limit of 2 salmon. Release Chinook and chum.

(6) **Catch Record Card Area 10:** July 16 through August 15, 2014: Daily limit of 2 salmon, of which no more than 1 Chinook may be retained. Release chum and wild Chinook. August 16 until further notice: Daily limit of 2 salmon. Release Chinook and chum.

(7) **Catch Record Card Area 13:** Fox Island Public Fishing Pier, effective May 1, 2014, until further notice: Daily limit of 2 salmon, of which no more than 1 Chinook may be retained. Retention of wild coho is permitted.

NEW SECTION

WAC 220-55-22000H Two-pole endorsement. Notwithstanding the provisions of WAC 220-55-220, effective immediately until further notice, it is unlawful to violate the provisions below. Unless otherwise amended, all permanent rules remain in effect:

(1) **Port Susan and Port Garner (Catch Record Card Area 8-2)**: Tulalip Terminal Area: May 30, 2014, until further notice: Anglers in possession of a valid two-pole endorsement may use up to two lines while fishing for salmon.

(2) **Seattle/Bremerton Area (Catch Record Card Area 10)**: Waters within Sinclair Inlet: July 1, 2014, until further notice: Anglers in possession of a valid two-pole endorsement may use up to two lines while fishing for salmon.

(3) **South Puget Sound (Catch Record Card Area 13)**: May 1, 2014, until further notice: Anglers in possession of a valid two-pole endorsement may use up to two lines while fishing for salmon.

WSR 14-10-010
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 14-93—Filed April 24, 2014, 1:20 p.m., effective April 24, 2014, 7:00 p.m.]

Effective Date of Rule: April 24, 2014, 7:00 p.m.

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

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

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

Other Authority: *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 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: Modifies the season structure of the spring select area commercial seasons previously adopted on January 29, except Deep River remains unchanged. Closes for a total of three periods in the Blind Slough/Knappa Channel sites, and delays implementation of the lower fall boundary in Knappa Slough until May 12. Closes for a total of three periods and reduces the open hours on two evenings in the Tongue Point/South Channel Select Area sites. The select areas' fisheries are nearing the "catch-balance" cap for upriver spring chinook assigned to these areas. By modifying the season structures in the areas that have the highest catch, upriver spring Chinook mortalities are expected to remain within the ESA and catch balance limits allowed until a runsize update is available. The fishery is consistent with the *U.S. v. Oregon* Management Agreement and the associated biological opinion. Conforms Washington state rules with Oregon state rules. Regulation is consistent with compact action of January 29 and April 23, 2014. There is insufficient time to adopt permanent rules.

Washington and Oregon jointly regulate Columbia River fisheries under the congressionally ratified Columbia River compact. Four Indian tribes have treaty fishing rights in the Columbia River. The treaties preempt state regulations that fail to allow the tribes an opportunity to take a fair share of the available fish, and the states must manage other fisheries accordingly. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or.

1969). A federal court order sets the current parameters for sharing between treaty Indians and others. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546).

Some Columbia River Basin salmon and steelhead stocks are listed as threatened or endangered under the federal ESA. On May 5, 2008, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allows for some incidental take of these species in treaty and nontreaty Columbia River fisheries governed by the 2008-2017 *U.S. v. Oregon* Management Agreement. The Washington and Oregon fish and wildlife commissions have developed policies to guide the implementation of such biological opinions in the states' regulation of nontreaty fisheries.

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

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 0, Repealed 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: April 24, 2014.

David Giglio
for Philip Anderson
Director

NEW SECTION

WAC 220-33-01000Q Columbia River seasons below Bonneville. Notwithstanding the provisions of WAC 220-33-010, WAC 220-33-020, and WAC 220-33-030, it is unlawful for a person to take or possess salmon, sturgeon, and shad for commercial purposes from Columbia River Salmon Management and Catch Reporting Areas 1A, 1B, 1C, 1D, 1E and Select Areas, except during the times and conditions listed below:

1. Deep River Select Area

a) **Dates:** Monday and Thursday nights from April 24 through June 13, 2014. Open hours are 7 PM to 7 AM

b) **Area:** From the markers at USCG navigation marker #16, upstream to the Highway 4 Bridge.

c) **Gear:** Gillnets. 9 3/4-inch maximum mesh. Nets are restricted to 100 fathoms in length with no weight restriction on leadline. Use of additional weights or anchors attached directly to the leadline is allowed.

Nets cannot be tied off to stationary structures. Nets may not fully cross navigation channel. It is unlawful to operate in any river, stream or channel any gillnet longer than three-fourths the width of the stream (WAC 220-20-015)(1). It shall be unlawful in any area to use, operate, or carry aboard a commercial fishing vessel a licensed net or combination of such nets, whether fished singly or separately, in excess of the maximum lawful size or length prescribed for a single net in that area, except as otherwise provided for in the rules and regulations of the department (WAC 220-20-010)(17).

d) **Allowable Possession:** Salmon and shad.

e) **Miscellaneous:** Transportation or possession of fish outside the fishing area (except to the sampling station) is unlawful until WDFW staff has biologically sampled individual catches. After sampling, fishers will be issued a transportation permit by WDFW staff. A sampling station will be established at WDFW's Oneida Road boat ramp, about 0.5 miles upstream of the lower Deep River area boundary (USCG navigation marker #16).

2. Tongue Point/South Channel

a) **Dates:** Monday and Thursday nights from May 1 through June 13, 2014 <u>except</u> closed Monday May 5, 2014. Open hours are 7:00 PM to 7:00 AM, <u>except</u> for on the evenings of May 1 and May 8, open hours are reduced to 7:00 PM to 1:00 AM.

b) **Area:** Tongue Point fishing area includes all waters bounded by a line extended from the upstream (southern most) pier (#1) at the Tongue Point Job Corps facility, through navigation marker #6 to Mott Island; a line from a marker at the southeast end of Mott Island, northeasterly to a marker on the northwest tip of Lois Island; and a line from a marker on the southwest end of Lois Island, westerly to a marker on the Oregon shore.

The South Channel area includes all waters bounded by a line from a marker on John Day Point through the green USCG buoy #7 to a marker on the southwest end of Lois Island, upstream to an upper boundary line from a marker on Settler Point, northwesterly to the flashing red USCG marker #10, and northwesterly to a marker on Burnside Island defining the upstream terminus of South Channel.

c) **Gear:** Gillnets. 9 3/4-inch maximum mesh. In the <u>Tongue Point fishing area</u>, gear restricted to a maximum net length of 250 fathoms, and weight not to exceed two pounds on any one fathom. <u>In the South Channel fishing area</u>, gear restricted to a maximum net length of 250 fathoms, no weight restriction on leadline, and use of additional weights or anchors attached directly to the leadline is allowed.

d) **Allowable Possession:** Salmon and shad.

e) **Miscellaneous:** Fishers are required to call 971-230-8247 and leave a message including name, catch, and where and when fish will be sold. Permanent transportation rules in effect.

f) **Observer program**: As a condition of fishing, owners or operators of commercial fishing vessels must cooperate

with department observers or observers collecting data for the department, when notified by the observer of his or her intent to board the commercial vessel for observation and sampling during an open fishery. Additionally, cooperation with department personal or observers prior to an open fishery is expected.

3. Blind Slough/Knappa Slough Select Area

a) **Dates:** Monday and Thursday nights from May 1 through June 13, 2014 except closed Monday May 5, 2014. Open hours are 7:00 PM to 7:00 AM

b) **Area:** Blind Slough and Knappa Slough areas are both open. Effective May 12: The lower boundary of the Knappa Slough fishing area is extended downstream to boundary lines defined by markers on the west end of Minaker Island to markers on Karlson Island and the Oregon Shore (fall season boundary).

c) **Gear:** Gillnets. 9 3/4-inch maximum mesh. Nets are restricted to 100 fathoms in length, with no weight restriction on leadline. Use of additional weights or anchors attached directly to the leadline is allowed.

d) **Allowable Possession:** Salmon and shad.

e) **Observer program**: As a condition of fishing, owners or operators of commercial fishing vessels must cooperate with department observers or observers collecting data for the department, when notified by the observer of his or her intent to board the commercial vessel for observation and sampling during an open fishery. Additionally, cooperation with department personal or observers prior to an open fishery is expected.

4. For all fisheries described above (Sections 1-3):

a) **24-hour** quick reporting is in effect for Washington buyers (WAC 220-69-240 (14)(d)). Permanent transportation rules in effect.

b) **Multi net rule in effect**: Nets not specifically authorized for use in these areas may be onboard a vessel if properly stored (WAC 220-33-001(2)).

c) **Lighted buoys required:** Nets that are fished at any time between official sunset and official sunrise must have lighted buoys on both ends of the net unless the net is attached to the boat. If the net is attached to the boat, then one lighted buoy on the opposite end of the net from the boat is required.

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

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 7:00 p.m. April 24, 2014:

WAC 220-33-01000P Columbia River seasons below Bonneville. (14-18)

WSR 14-10-011
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed April 25, 2014, 2:02 p.m., effective April 25, 2014, 2:02 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: In response to a court-approved settlement agreement, the agency is adopting WAC 182-531-1410, 182-531-1412, 182-531-1414, 182-531-1416, 182-531-1418, 182-531-1420, 182-531-1422, 182-531-1424, 182-531-1426, 182-531-1428, 182-531-1430, 182-531-1432, 182-531-1434 and 182-531-1436, concerning coverage for applied behavioral analysis (ABA) services for children with autism spectrum disorders. The new rules address prior authorization for services, evaluating and prescribing provider requirements, ABA provider requirements, and payment.

Statutory Authority for Adoption: RCW 41.05.021.

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 agency has been working with stakeholders and experts in autism spectrum disorders to craft rules to ensure public health and safety; however, the agency must file an emergency WAC for the short-term to remain in compliance with the January 2, 2013, deadline.

The agency is proceeding with the permanent rule adoption process initiated by the CR-101 filed under WSR 12-14-100. The agency has been working closely with stakeholders to draft the permanent rule and anticipates filing the CR-102 in 2014.

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

Date Adopted: April 25, 2014.

Kevin M. Sullivan
Rules Coordinator

NEW SECTION

WAC 182-531-1410 Applied behavior analysis (ABA)—Purpose. (1) Applied behavior analysis (ABA) assists children and their families to improve the core symptoms associated with autism spectrum disorders or other developmental disabilities for which there is evidence ABA is effective, per WAC 182-501-0165. ABA services support

learning, skill development, and assistance in any of the following areas or domains: Social, behavior, adaptive, motor, vocational, and/or cognitive.

(2) The medicaid agency pays for ABA services when the services:

(a) Are covered;

(b) Are medically necessary;

(c) Are within the scope of the eligible client's medical care program;

(d) Are provided to clients meeting program and clinical eligibility criteria, as described in WAC 182-531-1414;

(e) Are within currently accepted standards of evidence-based medical practice;

(f) Do not replicate ABA services paid for by other state agencies using medicaid funds;

(g) Are completed in stages, as described in WAC 182-531-1418, 182-531-1420, and 182-531-1422;

(h) Are provided by qualified health care professionals, as described in WAC 182-531-1424;

(i) Are authorized, as required within this section, chapters 182-501 and 182-502 WAC, and the agency's applicable, published medicaid provider guides; and

(j) Are billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's applicable, published medicaid provider guides.

NEW SECTION

WAC 182-531-1412 Applied behavior analysis (ABA)—Definitions. The following definitions and those found in chapter 182-500 WAC, medical definitions, and chapter 182-531 WAC, physician-related services, apply to the medicaid agency's applied behavior analysis (ABA) program.

ABA therapy treatment plan - An individualized, goal-directed treatment plan developed by a lead behavior analysis therapist meeting the criteria in WAC 182-531-1424 (2)(a)(i)(A), in coordination with other members of the health care team, and that is inclusive of other services being provided by team members.

Applied behavior analysis or **ABA –** Applied behavior analysis (ABA) is an empirically validated approach to improve behavior and skills related to core impairments associated with autism and a number of other developmental disabilities. ABA involves the systematic application of scientifically validated principles of human behavior to change socially significant behaviors. ABA uses scientific methods to reliably demonstrate that behavioral improvements are caused by the prescribed interventions. ABA's focus on social significance promotes a family-centered and whole-life approach to intervention. Common methods used include: Assessment of behavior, caregiver interviews, direct observation, and collection of data on targeted behaviors. A single-case design is used to demonstrate the relationship between the environment and behavior as a means to implement client-specific ABA therapy treatment plans with specific goals and promote lasting change. ABA also includes the implementation of a functional behavior assessment to identify environmental variables that maintain challenging behavior and allow for more effective interventions to be developed that reduce challenging behaviors and teach appropriate replacement behaviors.

Autism - A diagnosis on the autism spectrum disorder, as defined by the most current diagnostic and statistical manual of mental disorders (DSM) criteria, and made or confirmed by an agency-recognized center of excellence (COE).

Autism diagnostic tool - A validated tool used to establish the presence (or absence) of autism and to make a definitive diagnosis which will be the basis for treatment decisions and assist in the development of a multidisciplinary clinical treatment plan. Examples of autism diagnostic tools include:

(a) Autism Diagnosis Interview (ADI); and

(b) Autism Diagnostic Observation Schedule (ADOS).

Autism screening tool - A tool used to detect indicators or risk factors for autism and may indicate a suspicion of the condition which would then require confirmation. Examples of screening tools include, but are not limited to:

(a) Ages and Stages Questionnaire (ASQ);

(b) Communication and Symbolic Behavior Scales (CSBS);

(c) Parent's Evaluation and Developmental Status (PEDS);

(d) Modified Checklist for Autism in Toddlers (MCHAT); and

(e) Screening Tools for Autism in Toddlers and young children (STAT).

Centers of excellence or **COE -** A hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care. In this program, this term is applicable to the clinician(s) who establishes or confirms the diagnosis of an autism spectrum disorder and develops the multidisciplinary clinical treatment plan.

Comprehensive diagnostic evaluation – A medical/mental health evaluation performed by the center of excellence meeting the criteria in WAC 182-531-1418(2).

Day services program - An agency-approved, structured, nonresidential, facility-based group program designed to meet the needs of enrolled children through individualized ABA therapy plans of care. The program is comprehensive, providing a variety of health, social, therapeutic activities (occupational, speech, and physical therapy), supervision, support, and assistance with learning skills to perform activities of daily living, as needed.

Diagnostic and Statistical Manual of mental disorders (DSM) - A manual published by the American Psychiatric Association that provides a common language and standard criteria for the classification of mental disorders.

Family – Individuals who are in the role of parents, guardians, caregivers, and other primary support members to the child.

Lead behavior analysis therapist or **LBAT -** A person meeting the qualifications for lead behavior analysis therapist (LBAT) as described in WAC 182-531-1424 (2)(a).

Therapy assistant - A person meeting the qualifications for therapy assistant as described in WAC 182-531-1424 (2)(b)(ii) and having sufficient competence to perform the tasks of a therapy assistant as described in WAC 182-531-1424 (2)(b)(iii).

NEW SECTION

WAC 182-531-1414 Applied behavior analysis (ABA)—Client eligibility. To be eligible for applied behavior analysis (ABA) services, clients must meet all of the following:

(1) Program eligibility:

(a) Be twenty years of age and younger;

(b) Be covered under one of the following Washington apple health (WAH) programs:

(i) Children's health care as defined in WAC 182-505-0210;

(ii) Categorically needy program (CNP); or

(iii) Medically needy program (MNP).

(2) Clinical eligibility:

(a) The client's health care record contains documentation by a clinician that may incorporate family member observations or results of diagnostic screenings, or both, establishing the presence of any of the core symptoms of an autism spectrum disorder: Functional impairment; delay in communication, behavior, and/or social interaction; or repetitive or stereotyped behavior;

(b) There is documentation by a clinician which may incorporate family member observations, that the client's behaviors are having an adverse impact on either development or communication, or both, such that:

(i) The client cannot adequately participate in home, school, or community activities because the behavior or skill deficit(s) interferes with these activities; and/or

(ii) The child exhibits challenging behavior that negatively affects the safety or health of the child or others, or impedes access to home and community activities available to other children of the same age. Examples include, but are not limited to: Self-injury, aggression towards others, destruction of property, stereotyped/repetitive behaviors, elopement, or severe disruptive behavior; and

(c) The agency's recognized center of excellence (COE) has confirmed all requirements in (a) and (b) of this subsection and all of the following:

(i) The client has a diagnosis of an autism spectrum disorder, as defined by the most current DSM version;

(ii) Either of the following:

(A) That less intrusive or less intensive behavioral interventions have been tried and have not been successful; or

(B) That no equally effective and substantially less costly alternative is available for reducing interfering behaviors, increasing prosocial skills and behaviors, or maintaining desired behaviors; and

(iii) There is a reasonable calculation the requested services will result in measurable improvement in either the client's behavior, skills, or both.

NEW SECTION

WAC 182-531-1416 Applied behavior analysis (ABA)—Program stages. The following stages must be completed:

(1) Stage one - Referral to a center of excellence (COE) for evaluation, development of a multidisciplinary clinical treatment plan that may include applied behavior analysis (ABA), and an order/prescription for ABA;

(2) Stage two – Referral to an ABA provider (see WAC 182-531-1424 for who qualifies as an ABA provider) for an ABA assessment, which includes:

(a) A functional assessment;

(b) A skill assessment using a standardized tool, if indicated;

(c) A functional behavioral analysis, if indicated; and

(d) An ABA therapy treatment plan; and

(3) Stage three - Delivery of ABA services with the medicaid agency's authorization.

NEW SECTION

WAC 182-531-1418 Applied behavior analysis (ABA)—Stage one: Referral to a COE for evaluation and order. (1) A client who meets the eligibility criteria in WAC 182-531-1414 must be referred to a center of excellence (COE) for an evaluation and multidisciplinary clinical treatment plan by:

(a) The primary care provider or other licensed health care practitioner including, but not limited to, a speech therapist or occupational therapist;

(b) A school-based health care professional as the result of an individual education plan (IEP) or an early intervention health care professional as the result of an individualized family service plan (IFSP);

(c) The client's family; or

(d) The client's managed care plan, if applicable.

(2) The COE must provide a comprehensive diagnostic evaluation and multidisciplinary clinical treatment plan that includes:

(a) Results of routine developmental screening performed by the child's primary care provider at well child visits, as available;

(b) Audiology and vision assessment results, as available, or documentation that vision and hearing were determined to be within normal limits during assessment and not a barrier to completing a valid evaluation;

(c) The name of the completed autism screening questionnaire, including date completed and significant results, as available;

(d) Documentation of how the diagnosis was made or confirmed by a COE physician or psychologist that includes:

(i) Results of formal diagnostic procedures performed by a clinician, including name of measure, dates, and results, as available; and/or

(ii) Clinical findings and observations used to confirm the diagnosis;

(e) If available, documentation of a formal cognitive and/or developmental assessment performed by the COE or another qualified clinician, including name of measure, dates, results, and standardized scores providing verbal, nonverbal, and full-scale scores. This may include school or early childhood education records. Examples of these assessment tools are:

(i) Mullen Scales of Early Learning;

(ii) Wechsler Individual Achievement Test; or

(iii) Bayley Scales of Infant and Toddler Development;

(f) If available, documentation of a formal adaptive behavior assessment performed by the COE or another qual-

ified clinician, including name of measure, dates, results, and standardized scores providing scores of each domain. Examples of these assessment tools are:

(i) Vineland Adaptive Behavior Scales; or

(ii) Adaptive Behavior Assessment System (ABAS);

(g) Expanded laboratory evaluation, if indicated;

(h) Documentation that the client's behaviors or skill deficits are having an adverse impact on development or communication, or demonstrating injurious behavior, such that:

(i) The client cannot adequately participate in home, school, or community activities because behavior or skill deficit(s) interferes with these activities; or

(ii) The client presents a safety risk to self or others;

(i) Documentation that, if applied behavior analysis (ABA) is included in the multidisciplinary clinical treatment plan:

(i) Less intrusive or less intensive behavioral interventions have been tried and were not successful; or

(ii) There is no equally effective alternative available for reducing interfering behaviors, increasing prosocial behaviors, or maintaining desired behaviors;

(j) Recommendations that consider the full range of autism treatments with ABA as a treatment component, if clinically indicated;

(k) A statement that the evaluating and prescribing provider believes that there is a reasonable calculation that the requested ABA services will result in measurable improvement in the client's behavior or skills; and

(l) An order/prescription for ABA services. If ordered/prescribed, a copy of the COE's comprehensive diagnostic evaluation and multidisciplinary clinical treatment plan must be forwarded to the family-selected ABA provider in WAC 182-531-1424(2) or provided to the family to forward to the selected ABA provider.

NEW SECTION

WAC 182-531-1420 Applied behavior analysis (ABA)—Stage two: ABA assessment and plan development. (1) If the center of excellence's (COE's) evaluating and prescribing provider orders applied behavior analysis (ABA) services, the client may begin stage two - ABA assessment, functional analysis, and ABA therapy treatment plan development.

(2) Prior to implementing the ABA therapy treatment plan, the ABA provider must receive prior authorization from the medicaid agency. The prior authorization request, including the assessment and ABA therapy treatment plan, must be received by the agency within sixty days of the family scheduling the functional assessment. The client and family select the setting in which to receive services and by which ABA provider. ABA services are rendered in one of the following settings:

(a) Day services program - This is an agency-approved, outpatient facility or clinic-based program that:

(i) Provides multidisciplinary services in a short-term day treatment program setting;

(ii) Delivers comprehensive intensive services;

(iii) Embeds early, intensive behavioral interventions in a developmentally appropriate context;

(iv) Provides a developmentally appropriate ABA therapy treatment plan for each child;

(v) Includes family support and training; and

(vi) Includes multidisciplinary team members as clinically indicated to include a lead behavior analysis therapist (LBAT), therapy assistant, occupational therapist, speech therapist, physical therapist, psychologist, medical clinician, and dietician.

(b) Home, office, clinic, and community-based program (i.e., natural setting) - This is a program that:

(i) May be used after discharge from a day services program (see (a) of this subsection);

(ii) Provides a developmentally appropriate ABA therapy treatment plan for each child;

(iii) Provides ABA services in the home (wherever the child resides), office, clinic, or community setting, as required to accomplish the goals in the ABA therapy treatment plan. Examples of community settings are: A park, restaurant, child care, early childhood education, or school and must be included in the ABA therapy treatment plan with services being provided by the medicaid-enrolled LBAT or therapy assistant approved to provide services via authorization;

(iv) Requires recertification of medical necessity through continued authorization; and

(v) Includes family education, support, and training.

(3) An assessment, as described in WAC 182-531-1416(2), must be conducted and an ABA therapy treatment plan developed by an LBAT in the chosen setting. The ABA therapy treatment plan must follow the agency's ABA therapy treatment plan report template and:

(a) Be signed by the LBAT responsible for the plan development and oversight;

(b) Be time-limited (e.g., three or six months) and based on the COE's comprehensive diagnostic evaluation (see WAC 182-531-1418(2)) that took place no more than twelve months before the ABA assessment;

(c) Address the behaviors, skill deficit(s), and symptoms that prevent the client from adequately participating in home, school, community activities, or present a safety risk to self or others;

(d) Be specific and individualized to the client;

(e) Be client-centered, family-focused, community-based, culturally competent, and minimally intrusive;

(f) Take into account all school or other community resources available to the client, assure that the requested services are not redundant, but are in coordination with, other services already being provided or otherwise available, and coordinate services (e.g., from school and special education or from early intervention programs and early intervention providers) with other interventions and treatments (e.g., speech therapy, occupational therapy, physical therapy, family counseling, and medication management);

(g) Focus on family engagement and training;

(h) Identify and describe in detail the targeted behaviors and symptoms;

(i) Include objective, baseline measurement levels for each target behavior/symptom in terms of frequency, inten-

sity, and duration, including use of curriculum-based measures, single-case studies, or other generally accepted assessment tools;

(j) Include a comprehensive description of treatment interventions, or type of treatment interventions, and techniques specific to each of the targeted behaviors/symptoms, (e.g., discrete trial training, reinforcement, picture exchange, communication systems, etc.) including documentation of the number of service hours, in terms of frequency and duration, for each intervention;

(k) Establish treatment goals and objective measures of progress for each intervention specified to be accomplished in the three- to six-month treatment period;

(l) Incorporate strategies for generalized learning skills;

(m) Integrate family education, goals, training, support services, and modeling and coaching family/child interaction;

(n) Incorporate strategies for coordinating treatment with school-based special education programs and community-based early intervention programs, and plan for transition through a continuum of treatments, services, and settings; and

(o) Include measurable discharge criteria and a discharge plan.

NEW SECTION

WAC 182-531-1422 Applied behavior analysis (ABA)—Stage three: Delivery of ABA services. (1) The medicaid agency requires prior authorization (PA) of applied behavior analysis (ABA) services prior to delivery. Documents that support the PA and that must be submitted to the agency for consideration, as described in WAC 182-501-0163, are:

(a) The comprehensive diagnostic evaluation and multidisciplinary clinical treatment plan completed by the center of excellence (COE) described in WAC 182-531-1418(2);

(b) The ABA assessment and ABA therapy treatment plan described in WAC 182-531-1420(3); and

(c) Other documents required as described in the agency's medicaid provider guides.

(2) After the services are prior authorized, the ABA therapy treatment plan is implemented by the lead behavior analysis therapist (LBAT) or a therapy assistant in conjunction with other care team members. The LBAT is responsible for communicating and collaborating with other care team members to assure consistency in approaches to achieve treatment goals. If services are rendered by a therapy assistant, the therapy assistant must:

(a) Assess the client's response to techniques and report that response to the LBAT;

(b) Provide direct on-site services in the client's natural setting found in the home, office, clinic, or community, or in the day services program;

(c) Be directly supervised by an LBAT for a minimum of five percent of total direct care per week (e.g., one hour per twenty hours of care);

(d) Consult with the LBAT when considering modification to technique, when barriers and challenges occur that prohibit implementation of plan, and as otherwise clinically indicated (see WAC 182-531-1426 for appropriate procedures and physical interventions and WAC 182-531-1428 for prohibited procedures and physical interventions);

(e) Assure family involvement through modeling, coaching, and training to support generalization and maintenance of achieved behaviors;

(f) Keep documentation of each visit with the client and family to include targeted behavior, interventions, response, modifications in techniques, and a plan for the next visit, along with behavior tracking sheets that record and graph data collected for each visit; and

(g) Maintain documentation of family's confirmation that the visit occurred, recording signature, and date.

NEW SECTION

WAC 182-531-1424 Applied behavior analysis (ABA)—Provider requirements. (1) **Stage one.** The center of excellence's (COE's) evaluating and prescribing providers must function as a multidisciplinary team whether facility-based or practitioner-based.

(a) The qualifications for a COE are:

(i) The entity or individual employs:

(A) A person or persons licensed under Title 18 RCW who is experienced in the diagnosis and treatment of autism spectrum disorders and has a specialty in one of the following:

(I) Neurology;

(II) Pediatric neurology;

(III) Developmental pediatrics;

(IV) Psychology;

(V) Pediatric psychiatry; or

(VI) Psychiatry; and

(B) A licensed midlevel practitioner (i.e., advanced registered nurse practitioner (ARNP) or physician assistant (PA)) who has been trained by and works under the tutelage of one of the specialists in (a)(i)(A) of this subsection and meets the qualifications in (a)(ii) of this subsection; or

(C) Another qualified medical provider who, within the discretion of the medicaid agency, meets qualifications in (a)(ii) of this subsection.

(ii) The entity or individual has been prequalified by the medicaid agency as meeting or employing persons meeting the following criteria:

(A) For physicians or psychologists only, have sufficient expertise to diagnose an autism spectrum disorder using a validated diagnostic tool or to confirm the diagnosis through observing the client's behavior, reviewing the documentation available from the client's primary care provider, reviewing the child's individualized education plan (IEP) or individualized family service plan (IFSP), and interviewing family members;

(B) Have sufficient experience in or knowledge of the medically necessary use of applied behavior analysis (ABA); and

(C) Are sufficiently qualified to conduct and document a comprehensive diagnostic evaluation, and to develop a multidisciplinary clinical treatment plan as described in WAC 182-531-1418(2); and

(iii) The entity or individual has a core provider agreement (CPA) with the agency or is a performing provider on an approved CPA with the agency, unless the client is covered under a managed care organization or has other third-party insurance.

(b) Examples of providers who can qualify and be paid for these services as a designated COE are:

(i) Multidisciplinary clinics;

(ii) Individual qualified provider offices; and

(iii) Neurodevelopmental centers.

(2) **Stages two and three.** Regardless of the service delivery option, ABA providers must meet the specified minimum qualifications and comply with applicable state laws.

(a) Lead behavior analysis therapist (LBAT).

(i) Requirements.

(A) The LBAT must be:

(I) Able to practice independently by being licensed by the department of health (DOH) as a physician, psychologist, or licensed mental health practitioner under Title 18 RCW in good standing with no license restrictions; or

(II) Employed by or contracted with an agency that is enrolled as a participating provider and licensed by DOH as a hospital, a residential treatment facility, or an in-home services agency with a home health service category to provide ABA services, and be able to practice independently by being licensed by DOH as a physician, psychologist, licensed mental health practitioner, or credentialed as a counselor under Title 18 RCW in good standing with no license restrictions; or

(III) Employed or contracted with an agency that is enrolled as a participating provider and licensed by the department of social and health services' division of behavioral health and recovery (DBHR) with certification to provide ABA services, and be able to meet the staff requirements specified in chapter 388-877A WAC.

(B) The LBAT must:

(I) Enroll as a performing/servicing provider and be authorized to supervise ancillary providers; and

(II) Be a board-certified behavior analyst (BCBA) with proof of board certification through the Behavior Analysis Certification Board; or

(III) Either have two hundred forty hours of course work related to behavior analysis and seven hundred fifty hours of supervision under a BCBA, or have two years of practical experience in designing and implementing comprehensive ABA therapy treatment plans.

(ii) Role. The LBAT must:

(A) Develop and maintain an ABA therapy treatment plan that is comprehensive, incorporating treatment being provided by other health care professionals, and that states how all treatment will be coordinated, as applicable; and

(B) Supervise a minimum of five percent of the total direct care provided by the therapy assistant per week (e.g., one hour per twenty hours of care).

(b) Therapy assistant. Requirements.

(i) Therapy assistants must be:

(A) Able to practice independently by being licensed by DOH as a licensed mental health practitioner or credentialed as a counselor under Title 18 RCW in good standing with no license restrictions; or

(B) Employed by or contracted with an agency that is enrolled as a participating provider and licensed by DOH as a hospital, a residential treatment facility, or an in-home services agency with a home health service category to provide ABA services, and be able to practice independently by being licensed by DOH as a licensed mental health practitioner or credentialed as a counselor under Title 18 RCW in good standing with no license restrictions; or

(C) Employed by or contracted with an agency that is enrolled as a participating provider and licensed by DBHR as a community mental health agency with certification to provide ABA services, and be able to meet the staff requirements specified in chapter 388-877A WAC;

(ii) The therapy assistant must:

(A) Have sixty hours of ABA training that includes applicable ABA principles and techniques, services, and caring for a child with core symptoms of autism; and

(B) Have a written letter of attestation signed by the lead LBAT that the therapy assistant has demonstrated competency in implementing ABA therapy treatment plans and delivering ABA services prior to providing services without supervision to covered clients; and

(C) Enroll as a performing/servicing provider.

(iii) Role. The therapy assistant must:

(A) Deliver services according to the ABA therapy treatment plan; and

(B) Be supervised by an LBAT who meets the requirements in (a)(i) of this subsection; and

(C) Review the ABA therapy treatment plan and the client's progress with the LBAT at least every two weeks for documentation of supervision, and make changes as indicated by the child's response.

(c) Licensure for facility-based day program setting. This applies to the model described in WAC 182-531-1420 (2)(a). Outpatient hospital facilities providing these services must meet the applicable DOH licensure requirements. Clinics and nonhospital-based facilities providing these services must be licensed as a community mental health agency by DBHR, as described in chapter 388-877A WAC. Providers rendering direct ABA services must meet the qualifications and applicable licensure or certification requirements as described in this subsection, as applicable. Other providers serving as members of the multidisciplinary care team must be licensed or certified under Title 18 RCW, as required.

NEW SECTION

WAC 182-531-1426 Applied behavior analysis (ABA)—Protective restrictive procedures and physical interventions. In the course of receiving applied behavior analysis (ABA) services, when a client's behavior presents a threat of injury to self or others or significant damage to property, steps must be taken to protect the client and others from harm, or to prevent significant property damage.

(1) Protective restrictive procedures include, but are not limited to:

(a) Requiring a client to leave an area with physical force (i.e., physically holding and moving the client) for protection of the client, others, or property;

(b) Physical restraint to prevent the free movement of part or all of the client's body when the client's behavior poses an immediate risk to physical safety. Restraint in a prone or supine position (i.e., with the client lying on the stomach or back, respectively) is prohibited; and

(c) Mechanical restraint that limits the client's free movement or prevents self-injurious behavior (e.g., a helmet for head-banging, hand mittens or arm splints for biting, etc.). Mechanical restraint in a prone position (lying on the stomach) is prohibited.

(2) Protective physical interventions include, but are not limited to:

(a) Hand, arm, and leg holds;

(b) Standing holds;

(c) Physically holding and moving a client who is resisting; and

(d) Head holds. Physical control of the head is permitted only to interrupt biting or self-injury such as head banging.

NEW SECTION

WAC 182-531-1428 Applied behavior analysis (ABA)—Prohibited procedures and physical restrictions. The medicaid agency prohibits the use of the following procedures and physical restrictions for clients receiving applied behavior analysis (ABA) services:

(1) Procedures that are prohibited include:

(a) Corporal/physical punishment;

(b) The application of any electric shock or stimulus to a client's body;

(c) Forced compliance, including exercise, when it is not for protection;

(d) Locking a client alone in a room;

(e) Overcorrection;

(f) Physical or mechanical restraint in a prone position where the client is lying on his/her stomach;

(g) Physical restraint in a supine position where the client is lying on his/her back;

(h) Removing, withholding, or taking away money, tokens, points, or activities that a client has previously earned;

(i) Requiring a client to re-earn money or items purchased previously;

(j) Withholding or modifying food as a consequence for behavior (e.g., withholding dessert because the client was aggressive);

(k) Restraint chairs; and

(l) Restraint boards.

(2) Physical interventions using any of the following are not permitted under any circumstances:

(a) Any intervention that causes pain to the client and/or uses pressure points (whether for brief or extended periods);

(b) Obstruction of the client's airway and/or excessive pressure on the chest, lungs, sternum, and diaphragm;

(c) Hyperextension (pushing or pulling limbs, joints, fingers, thumbs or neck beyond normal limits in any direction) or putting the client in significant risk of hyperextension;

(d) Joint or skin torsion (twisting/turning in opposite directions);

(e) Direct physical contact covering the face;

(f) Straddling or sitting on the torso;

(g) Any of the following specific physical techniques:

(i) Arm or other joint locks (e.g., holding one or both arms behind back and applying pressure, pulling or lifting);

(ii) A "sleeper hold" or any maneuver that puts weight or pressure on any artery, or otherwise obstructs or restricts circulation;

(iii) Wrestling holds, body throws, or other martial arts techniques;

(iv) Prone restraint (client lying on the stomach);

(v) Supine restraint (client lying on the back);

(vi) A head hold where the client's head is used as a lever to control movement of other body parts;

(vii) Any maneuver that forces the client to the floor on his/her knees or hands and knees;

(viii) Any technique that keeps the client off balance (e.g., shoving, tripping, pushing on the backs of the knees, pulling on the client's legs or arms, swinging or spinning the client around, etc.); and

(ix) Any technique that restrains a client face-first vertically against a wall or post.

(h) Excessive force (i.e., using more force than is necessary; beyond resisting with like force);

(i) Any maneuver that involves punching, hitting, slapping, poking, pinching or shoving the client;

(j) Use of bed side rails for staff convenience or to purposely restrain a client unnecessarily.

NEW SECTION

WAC 182-531-1430 Applied behavior analysis (ABA)—Covered services. (1) The medicaid agency covers only the following ABA services delivered in settings described in stage two, as noted in WAC 182-531-1420 (1) and (2), for eligible clients:

(a) The ABA assessments to determine the relationship between environmental events and behaviors;

(b) The direct provision of ABA services by the therapy assistant or lead behavior analysis therapist (LBAT);

(c) Initial ABA assessment and development of a written, initial ABA therapy treatment plan, limited to one per year;

(d) Additional ABA assessments and revisions of the initial ABA therapy treatment plan to meet client's needs, limited to four per year;

(e) Supervision of the therapy assistant;

(f) Training of family members to carry out the approved ABA therapy treatment plans;

(g) Observation of the family (or other plan implementer) and the individual's behavior to assure correct implementation of the approved ABA therapy treatment plan;

(h) Observation of the client's behavior to determine the effectiveness of the approved ABA therapy treatment plan; and

(i) On-site assistance in a difficult or crisis situation.

(2) The agency covers the following services, which may be provided in conjunction with ABA services under other agency programs and be consistent with the program rules:

(a) Speech and language therapy;

(b) Occupational therapy;

(c) Physical therapy;
(d) Counseling;
(e) Interpreter services;
(f) Dietician services; and
(g) Transportation services.

(3) The agency does not authorize payment of ABA services if the services are duplicative of services being rendered in another setting.

(4) Limits in amount or frequency of the covered services described in this section are subject to the provisions in WAC 182-501-0169, limitation extension.

NEW SECTION

WAC 182-531-1432 Applied behavior analysis (ABA)—Noncovered services. The medicaid agency does not cover the following services including, but not limited to:
(1) Autism camps;
(2) Dolphin therapy;
(3) Equine therapy/hippo therapy;
(4) Language development training;
(5) Primarily educational services;
(6) Recreational therapy;
(7) Respite care;
(8) Safety monitoring services;
(9) School-based health care services or early intervention program-based services, unless prior authorized and as described in WAC 182-531-1420 (2)(b)(iii);
(10) Vocational rehabilitation;
(11) Life coaching; and
(12) Treatment that is unproven or investigational (e.g., holding therapy, Higashi (day life therapy), auditory integration therapy, etc.).

NEW SECTION

WAC 182-531-1434 Applied behavior analysis (ABA)—Prior authorization and recertification of ABA services. (1) The medicaid agency requires prior authorization (PA) and recertification of the medical necessity of applied behavior analysis (ABA) services.

(2) Requirements for PA requests are described in WAC 182-531-1422(1).

(3) The agency may reduce or deny services requested based on medical necessity (refer to subsection (5) of this section) when completing PA or recertification responsibilities.

(4) The following are requirements for recertification of ABA services:

(a) Continued ABA services require the agency's authorization. Authorization is granted in three-month increments, or longer at the agency's discretion;

(b) The lead behavior analysis therapist (LBAT) must request authorization for continuing services three weeks prior to the expiration date of the current authorization. A reevaluation and revised ABA therapy treatment plan documenting the client's progress and showing measurable changes in the frequency, intensity, and duration of the targeted behavior/symptoms addressed in the previously authorized ABA therapy treatment plan must be submitted with this request. Documentation must include:

(i) Projection of eventual outcome;
(ii) Assessment instruments;
(iii) Developmental markers of readiness; and
(iv) Evidence of coordination with providers; and

(c) In deciding whether to authorize continued ABA services, the agency may obtain the evaluating and prescribing center of excellence (COE) provider's review and recommendation. This COE provider must review the ABA therapy treatment plan, conduct a face-to-face visit with the child, facilitate a multidisciplinary record review of the client's progress, hold a family conference, or request a second opinion before recommending continued ABA services. Services will continue pending recertification.

(5) Basis for denial and/or reduction of services includes, but is not limited to, the following:

(a) Lack of medical necessity, for example:

(i) Failure to respond to ABA services, even after trying different ABA techniques and approaches, if applicable; or

(ii) Absence of meaningful, measurable, functional improvement changes or progress has plateaued without documentation of significant interfering events (e.g., serious physical illness, major family disruption, change of residence, etc.), if applicable. For changes to be meaningful they must be:

(A) Confirmed through data;
(B) Documented in charts and graphs;
(C) Durable over time beyond the end of the actual treatment session; and
(D) Generalizable outside of the treatment setting to the client's residence and the larger community within which the client resides; or

(b) Noncompliance as demonstrated by a pattern of failure of the family to:
(i) Keep appointments;
(ii) Attend treatment sessions;
(iii) Attend scheduled family training sessions;
(iv) Complete homework assignments; and
(v) Apply training as directed by the therapy assistant or LBAT. Absences that are reasonably justified (e.g., illness) are not considered part of the pattern.

NEW SECTION

WAC 182-531-1436 Applied behavior analysis (ABA)—Services provided via telemedicine. (1) Telemedicine is when a health care practitioner uses HIPAA compliant, interactive, real-time audio and video telecommunications (including web-based applications) to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located. Using telemedicine enables the health care practitioner and the client to interact in real-time communication as if they were having a face-to-face session. Telemedicine allows medicaid agency clients, particularly those in medically underserved areas of the state, improved access to essential health care services that may not otherwise be available without traveling long distances.

(2) Telemedicine may be used to provide the following authorized services:

(a) Program supervision when the client is present; and

(b) Family training, which does not require the client's presence.

(3) The lead behavior analysis therapist (LBAT):

(a) May use telemedicine to supervise the therapy assistant's delivery of ABA services to the client and/or family; and

(b) Is responsible for determining that telemedicine can be performed without compromising the outcome of the ABA therapy treatment plan.

(4) The agency does not cover the following services as telemedicine:

(a) E-mail, telephone, and facsimile transmissions;

(b) Installation or maintenance of any telecommunication devices or systems; or

(c) Purchase, rental, or repair of telemedicine equipment.

(5) **Originating site.** An originating site is the physical location of the eligible agency client at the time the professional service is provided by the LBAT through telemedicine. The originating site is eligible to be paid a facility fee per completed transmission. Approved originating sites are:

(a) Clinic;

(b) Community setting;

(c) Home;

(d) Office; and

(e) Outpatient facility.

(6) **Distance site.** A distant site is the physical location where the LBAT provides the services listed in subsection (2) of this section to an eligible agency client through telemedicine.

(7) To be paid for providing ABA services via telemedicine, providers must bill the agency using the agency's current published *Applied Behavior Analysis (ABA) Medicaid Provider Guide*.

(8) If the LBAT or therapy assistant performs a separately identifiable service for the client on the same day as the telemedicine service, documentation for both services must be clearly and separately identified in the client's medical record.

WSR 14-10-012
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 14-89—Filed April 25, 2014, 3:22 p.m., effective May 1, 2014]

Effective Date of Rule: May 1, 2014.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-03000P; and amending WAC 220-52-030.

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

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

Reasons for this Finding: Based on historical catches and on-site inspection, there should be adequate razor clams to support an eight week commercial season. Biotoxin levels currently fall below the regulatory threshold. 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: April 25, 2014.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-52-03000P Commercial razor clams. Notwithstanding the provisions of WAC 220-52-030, effective 12:01 a.m. May 1, 2014, through 11:59 p.m. July 2, 2014, a person may dig for and possess razor clams for commercial purposes only in those waters and detached beaches of Razor Clam Area 2 lying south of the Willapa Bay Ship Channel, west of Ellen Sands, and north of the tip of Leadbetter Point.

REPEALER

The following section of the Washington Administrative Code is repealed effective 12:01 a.m. July 3, 2014:

WAC 220-52-03000P Commercial razor clams.

WSR 14-10-013
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 14-90—Filed April 25, 2014, 3:23 p.m., effective April 27, 2014, 12:01 a.m.]

Effective Date of Rule: April 27, 2014, 12:01 a.m.

Purpose: Amend recreational fishing rules.

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

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

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

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

Reasons for this Finding: Survey results show that adequate razor clams are available for recreational harvest in Razor Clam Areas 1, 3, and 5. Washington department of health has certified clams from these beaches are 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: April 25, 2014.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-56-36000L 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, 3, 4, or 5, except as provided in this section:

(1) Effective 12:01 a.m. April 27, 2014 through 11:59 a.m. May 4, 2014, razor clam digging is allowed in Razor Clam Area 1. Digging is allowed from 12:01 a.m. to 11:59 a.m. each day only.

(2) Effective 12:01 a.m. April 27, 2014 through 11:59 a.m. May 4, 2014, razor clam digging is allowed in Razor Clam Area 3. Digging is allowed from 12:01 a.m. to 11:59 a.m. each day only.

(3) Effective 12:01 a.m. May 2, 2014 through 11:59 a.m. May 4, 2014, razor clam digging is allowed in Razor Clam Area 5. Digging is allowed from 12:01 a.m. to 11:59 a.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 as defined in WAC 220-56-372.

REPEALER

The following section of the Washington Administrative Code is repealed effective 12:01 p.m. May 4, 2014:

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

WSR 14-10-014
EMERGENCY RULES
DEPARTMENT OF AGRICULTURE

[Filed April 25, 2014, 3:25 p.m., effective April 25, 2014, 3:25 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: This rule-making order amends WAC 16-324-409 by repealing the requirement to post-harvest test all generation 1 (G-1) seed potato lots and seed potato lots sold for recertification for potato virus Y (PVY) by enzyme-linked immunosorbant assay. This will temporarily suspend the laboratory component of post-harvest testing.

Citation of Existing Rules Affected by this Order: Amending WAC 16-324-409.

Statutory Authority for Adoption: RCW 15.14.015.

Other Authority: Chapter 34.05 RCW.

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

Reasons for this Finding: In 2013, the department adopted changes to the seed potato certification rule in response to disease pressures. One of these changes was adding an additional laboratory test for PVY for all seed potato lots entered for post-harvest testing. Since then it has become apparent that there are challenges related to sampling and testing for PVY. As a result of this change, seed potato growers will have very few lots to plant this spring and may not be able to sustain their seed operations. This emergency repeal will allow seed potato growers to plant their 2014 crop and allow time to find a permanent solution to challenges related to sampling and laboratory testing.

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

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 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: April 25, 2014.

Don R. Hover
Director

Chapter 16-324 WAC

CERTIFICATION OF SEED POTATOES

AMENDATORY SECTION (Amending WSR 13-12-014, filed 5/24/13, effective 6/24/13)

WAC 16-324-409 Post-harvest test requirements. (1) Post-harvest testing is required for the following lots:

(a) All Generation 1 lots except lots that are less than 0.25 acre and planted back on the same seed potato farm;

(b) Seed lots sold for recertification; and

(c) Lots for which a post-harvest test is required by WAC 16-324-399.

(2) ((~~Seed lots submitted for post-harvest testing in subsection (1)(a) and (b) of this section must also be ELISA tested for PVY.~~

~~(3)~~)) A minimum of four hundred tubers must be submitted for each seed lot entered for post-harvest testing. Seed lots less than 0.25 acre in size must submit a minimum of four tubers per total hundred weight with a minimum of fifty tubers.

((~~(4)~~)) (3) The applicant is responsible for the cost of post-harvest testing.

((~~(5)~~)) (4) Seed lots in the post-harvest test which fail to comply with the disease tolerance requirements set forth in WAC 16-324-420 are not eligible for recertification.

(a) The applicant must notify in writing all receivers of any seed lot that failed to comply with post-harvest tolerances set forth in WAC 16-324-420.

(b) Acceptance of a seed lot that fails to comply with the tolerances set forth in WAC 16-324-420 must be based on a written buyer/seller agreement. The grower must provide the department with a copy of the written agreement within thirty days of receiving the post-harvest results.

WSR 14-10-015
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 14-94—Filed April 25, 2014, 3:26 p.m., effective April 29, 2014]

Effective Date of Rule: April 29, 2014.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-07100D; and amending WAC 220-52-071.

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

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

Reasons for this Finding: Harvestable amounts of sea cucumbers are available in sea cucumber districts listed. 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: April 25, 2014.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-52-07100E Sea cucumbers Notwithstanding the provisions of WAC 220-52-071, effective April 29, 2014 until further notice, it is unlawful to take or possess sea cucumbers taken for commercial purposes except as provided for in this section:

(1) Sea cucumber harvest using shellfish diver gear is allowed in Sea Cucumber District 5 on Monday through Friday of each week.

(2) The maximum cumulative landing of sea cucumbers for each weekly fishery opening period is 1,800 pounds per valid designated sea cucumber harvest license. It is permissible for all or any fraction of the maximum 1,800 pound total to be harvested during any legal harvest date within any legal harvest area so long as the cumulative total for the fishery week does not exceed the maximum.

REPEALER

The following section of the Washington Administrative Code is repealed effective April 29, 2014:

WAC 220-52-07100D Sea cucumbers (14-34)

WSR 14-10-016
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 14-96—Filed April 25, 2014, 3:35 p.m., effective April 25, 2014, 3:35 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: Amend commercial fishing rules.

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

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

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

Reasons for this Finding: Mandatory meat pick-out rate allowance for coastal crab will be achieved by the opening dates contained herein. The special management areas are listed in accordance with state/tribal management agreements. The stepped opening periods/areas will also provide for fair start provisions. There is insufficient time to adopt permanent rules.

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

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

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

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

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

Date Adopted: April 25, 2014.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

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

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

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

(3) Klipsan Beach and the U.S./Canada Border, including Grays Harbor: Open.

(4) The Quinault Secondary Special Management Area (SSMA) is closed to fishing for Dungeness crab starting at 8:00 A.M., May 1, 2014, from the area shoreward of a line approximating the 27-fathom depth curve between the mouth of the Copalis River (47º08.00) and Split Rock (47º24.50). This area will be closed until further notice. This SSMA is described by the following coordinates:

• Northeast Corner (Split Rock):	47°24.50 N. Lat.	124°20.00 W. Lon.
• Northwest Corner:	47°24.50 N. Lat.	124°32.40 W. Lon.
• Southwest Corner:	47°08.00 N. Lat.	124°25.50 W. Lon.
• Southeast Corner (Copalis River):	47°08.00 N. Lat.	124°11.20 W. Lon.

(5) It is unlawful for a vessel to use more than 200 pots in the area between Split Rock (47º24.50) and Raft River (47º28.00) shoreward of a line approximating the 27-fathom depth curve from 8:00 a.m. May 1, 2014, until 8:00 a.m. May 31, 2014. Fishers must pre-register with the Department of Fish and Wildlife 24 hours prior to deploying gear in this area by one of the three following methods:

• Fax transmission to Carol Henry at 360-249-1229;
• E-mail to: Carol Henry at Carol.Henry@dfw.wa.gov; or
• Telephone call to Carol Henry at 360-249-1296.

(6) The Quileute Special Management Area (SMA) will open to fishing for Dungeness crab at 8:00 a.m. on May 1, 2014. The SMA includes the area shoreward of a line approximating the 30-fathom depth curve between Destruction Island and Cape Johnson according to the following points:

• Northeast Corner (Cape Johnson)	47°58.00' N. Lat.	124°40.40' W. Lon.
• Northwest Corner:	47°58.00' N. Lat.	124°49.00' W. Lon.
• Southwest Corner:	47°40.50' N. Lat.	124°40.00' W. Lon.
• Southeast Corner (Destruction Island):	47°40.50' N. Lat.	124°24.43' W. Lon.

(7) It is unlawful for a vessel to use more than 100 pots in the Quileute SMA from 8:00 a.m. May 1, 2014, until 8:00 a.m. May 31, 2014. Fishers must pre-register with the Department of Fish and Wildlife 24 hours prior to deploying gear in this area by one of the three following methods:

• Fax transmission to Carol Henry at 360-249-1229;
• E-mail to Carol Henry at Carol.Henry@dfw.wa.gov; or
• Telephone call to Carol Henry at 360-249-1296.

(8) All non-conflicting provisions of the permanent rule remain in effect.

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 sections of the Washington Administrative Code are repealed:

WAC 220-52-04000G	Commercial crab fishery. Lawful and unlawful gear, methods and other unlawful acts. (14-21)
WAC 220-52-04600W	Coastal crab seasons (14-21)

WSR 14-10-018

EMERGENCY RULES

DEPARTMENT OF FISH AND WILDLIFE

[Order 14-92—Filed April 25, 2014, 4:49 p.m., effective April 25, 2014, 4:49 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Amending WAC 220-310-190.

Statutory Authority for Adoption: RCW 77.12.047, 77.12.045, 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 department is in the process of adopting permanent rules that are necessary to implement the personal use fishing plans agreed-to with resource comanagers at the North of Falcon proceedings. These emergency rules are necessary to comply with agreed-to management plans, and are interim until permanent rules take effect.

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

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

Number of Sections Adopted on the Agency's Own Initiative: New 1, Amended 0, Repealed 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: April 25, 2014.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-310-19000B Freshwater exceptions to statewide rules—Puget Sound. Notwithstanding the provisions of WAC 220-310-190, effective immediately until further notice, it is unlawful to violate the following provisions, provided that unless otherwise amended, all permanent rules remain in effect:

1. Baker Lake (Whatcom County):

Salmon: Open July 10 until further notice: Daily limit 3; minimum length 18 inches: Each angler aboard a vessel may deploy salmon angling gear until the limit for all licensed and juvenile anglers aboard is reached. It is permissible to fish with two poles so long as the angler possesses a two-pole endorsement.

2. Nisqually River (Pierce County):

From the mouth to Military Tank Crossing: July 1 until further notice: Vessel closure dates are rescinded; anti-snagging rule and night closure in effect; barbed hooks are permitted.

3. Skagit River (Skagit/Whatcom counties):

(a) From the mouth to Memorial Highway Bridge (Highway 536 at Mt. Vernon): May 1 until further notice: trout is open; selective gear rules apply; hooks must measure 1/2 inch or less from point to shank.

(b) From Memorial Highway Bridge (Highway 536 at Mt. Vernon) to Gilligan Creek: June 1 through June 13 and June 30 until further notice: selective gear rules apply; hooks must measure 1/2 inch or less from point to shank. June 1 until further notice: Night closure. Salmon: Open June 14 through June 29: Daily limit 2 sockeye only; minimum length 12 inches.

(c) From Gilligan Creek to Dalles Bridge at Concrete: June 1 until further notice: selective gear rules apply; hooks must measure 1/2 inch or less from point to shank; night closure.

(d) From Dalles Bridge at Concrete to Highway 430 Bridge at Rockport: June 1 until further notice: selective gear rules apply; hooks must measure 1/2 inch or less form point to shank; night closure.

(e) From Highway 430 Bridge at Rockport to Cascade River Road: June 1 until further notice: Night closure. July 16 until further notice: selective gear rules apply; hooks must measure 1/2 inch or less from point to shank.

4. Skokomish River (Mason County):

(a) From mouth to Highway 101 Bridge: Open first Saturday in June through July 13 for gamefish: Catch and release rules only.

(b) From Highway 101 Bridge to forks: Open first Saturday in June until further notice for gamefish: Catch and release rules only; selective gear rules apply; fishing from a floating device equipped with an internal combustion motor is prohibited.

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 14-10-036

EMERGENCY RULES

HEALTH CARE AUTHORITY

(Washington Apple Health)

[Filed April 29, 2014, 3:22 p.m., effective April 30, 2014]

Effective Date of Rule: April 30, 2014.

Purpose: The health care authority (HCA) needs to amend rules, create new rules in order to implement new federal regulations under the federal Patient Protection and Affordable Care Act. This filing is to correctly reference rules that are final January 1, 2014, in the long-term care medical rules in addition to the elimination of the presumptive disability program as an eligibility group.

Citation of Existing Rules Affected by this Order: Amending WAC 182-513-1301, 182-513-1305, 182-513-1315, 182-513-1325, 182-513-1330, 182-513-1340, 182-513-1345, 182-513-1350, 182-513-1363, 182-513-1364, 182-513-1365, 182-513-1366, 182-513-1367, 182-513-1380, 182-513-1395, 182-513-1400, 182-513-1405, 182-513-1415, 182-513-1425, 182-513-1430, 182-513-1450, 182-513-1455, 182-515-1500, 182-515-1506, 182-515-1507, 182-515-1508, 182-515-1509, 182-515-1510, 182-515-1511, 182-515-1512, 182-515-1513, 182-515-1514, and 182-507-0125.

Statutory Authority for Adoption: RCW 41.05.021, chapter 74.39 RCW.

Other Authority: Patient Protection and Affordable Care Act established under Public Law 111-148; and Code of Federal Regulations at 42 C.F.R. § 431, 435, and 457, and at 45 C.F.R. § 155. Section 1917 of the Social Security Act.

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: Although the agency continues to work diligently with client advocates and other stakeholders in crafting the permanent rules to implement the provisions of the Affordable Care Act, the agency does not anticipate completing the permanent rule process before September 2014. In the interim, the agency must continue the emergency rules adopted under WSR 14-02-086 to avoid jeopardizing receipt of federal funding.

Number of Sections Adopted in Order to Comply with Federal Statute: New 4, Amended 33, 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 4, Amended 33, 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 4, Amended 33, Repealed 0.

Date Adopted: April 29, 2014.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-13-056, filed 6/15/12, effective 7/1/12)

WAC 182-507-0125 State-funded long-term care services program. (1) The state-funded long-term care services program is subject to caseload limits determined by legislative funding. Services cannot be authorized for eligible persons prior to a determination by the aging and ((~~disability services~~)) long-term supports administration ((~~(ADSA)~~)) (ALTSA) that caseload limits will not be exceeded as a result of the authorization.

(2) Long-term care services are defined in this section as services provided in one of the following settings:

(a) In a person's own home, as described in WAC 388-106-0010;

(b) Nursing facility, as defined in WAC 388-97-0001;

(c) Adult family home, as defined in RCW 70.128.010;

(d) Assisted living facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301;

(e) Enhanced adult residential care facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301;

(f) Adult residential care facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301.

(3) Long-term care services will be provided in one of the facilities listed in subsection (2)(b) through (f) of this section unless nursing facility care is required to sustain life.

(4) To be eligible for the state-funded long-term care services program described in this section, an adult nineteen years of age or older must meet all of the following conditions:

(a) Meet the general eligibility requirements for medical programs described in WAC ((~~388-503-0505~~)) 182-503-0505 (2) and (3)((~~(a), (b), (e), and (f)~~)) with the exception of subsection (3)(c) and (d) of this section;

(b) Reside in one of the settings described in subsection (2) of this section;

(c) Attain institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320;

(d) Meet the functional eligibility described in WAC 388-106-0355 for nursing facility level of care;

(e) Not have a penalty period due to a transfer of assets as described in WAC ((~~388-513-1363, 388-513-1364, 388-513-1365, and 388-513-1366~~)) 182-513-1363, 182-513-1364, or 182-513-1365;

(f) Not have equity interest in a primary residence more than the amount described in WAC ((~~388-513-1350 (7)(a)(ii)~~)) 182-513-1350; and

(g) Any annuities owned by the adult or spouse must meet the requirements described in chapter ((~~388-561~~)) 182-516 WAC.

(5) An adult who is related to the supplemental security income (SSI) program as described in WAC ((~~388-475-0050~~)) 182-512-0050 (1), (2), and (3) must meet the financial requirements described in WAC ((~~388-513-1325, 388-513-1330, and 388-513-1350~~)) 182-513-1315.

(6) An adult who does not meet the SSI-related criteria in subsection (2) of this section may be eligible under the family institutional medical program rules described in WAC ((~~388-505-0250 or 388-505-0255~~)) 182-514-0230.

(7) An adult who is not eligible for the state-funded long-term care services program under categorically needy (CN) rules may qualify under medically needy (MN) rules described in:

(a) WAC ((~~388-513-1395~~)) 182-513-1395 for adults related to SSI; or

(b) WAC ((~~388-505-0255~~)) 182-514-0255 for adults up to age twenty-one related to family institutional medical.

(8) All adults qualifying for the state-funded long-term care services program will receive CN scope of medical coverage described in WAC ((388-501-0060)) 182-500-0020.

(9) The department determines how much an individual is required to pay toward the cost of care using the following rules:

(a) For an SSI-related individual residing in a nursing home, see rules described in WAC ((388-513-1380)) 182-513-1380.

(b) For an SSI-related individual residing in one of the other settings described in subsection (2) of this section, see rules described in WAC ((388-515-1505)) 182-515-1505.

(c) For an individual eligible under the family institutional program, see WAC ((388-505-0265)) 182-514-0265.

(10) A person is not eligible for state-funded long-term care services if that person entered the state specifically to obtain medical care.

(11) A person eligible for the state-funded long-term care services program is certified for a twelve month period.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1301 Definitions related to long-term care (LTC) services. This section defines the meaning of certain terms used in chapters ((388-513)) 182-513 and ((388-515)) 182-515 WAC. Within these chapters, institutional, home and community based (HCB) waiver, and hospice services are referred to collectively as LTC services. Other terms related to LTC services that also apply to other programs are found in the sections in which they are used.

Additional medical definitions that are not specific to LTC services can be found in WAC 182-500-0005 through 182-500-0110 Medical definitions.

Definitions of terms used in certain rules that regulate LTC programs are as follows:

"Adequate consideration" means the reasonable value of the goods or services received in exchange for transferred property approximates the reasonable value of the property transferred.

"Aging and disability services (ADS)" means an umbrella agency for the behavioral health and service integration administration (BHSIA), aging and long-term support administration (ALTSA) and developmental disabilities administration (DDA) within the department of social and health services (DSHS).

"Aging and long-term supports administration (ALTSA)" means an administration within aging and disability services (ADS) of the department of social and health services (DSHS) and includes:

• Home and community services (HCS) that helps low income seniors and adults with disabilities and their families get information, support and services when long-term care is needed; and

• Residential care services (RCS) that regulates nursing facilities (NF), adult family homes (AFH), assisted living facilities (AL), intermediate care facilities for individuals with intellectual disabilities (ICF-ID), and certified community residential service providers and promotes and protects the health, safety, and well-being of individuals living in licensed or certified residential settings.

"Alternate living facility (ALF)" means one of the following community residential facilities that are contracted with the department to provide certain services:

(1) Adult family home (AFH), a licensed family home that provides its residents with personal care and board and room for two to six adults unrelated to the person(s) providing the care. Licensed as an adult family home under chapter 70.128 RCW.

(2) Adult residential care facility (ARC) (formerly known as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision. Licensed as an assisted living under chapter 18.20 RCW.

(3) Adult residential rehabilitation center (ARRC) described in WAC 388-865-0235 or adult residential treatment facility (ARTF) described in WAC 388-865-0465 are licensed facilities that provides their residents with twenty-four hour residential care for impairments related to mental illness.

(4) Assisted living facility (AL), a licensed facility for aged and disabled low-income persons with functional disabilities. COPES eligible clients are often placed in assisted living. Licensed as an assisted living facility under chapter 18.20 RCW.

(5) ((Division of)) Developmental disabilities (((DDD))) administration (DDA) group home (GH), a licensed facility that provides its residents with twenty-four hour supervision. Depending on the size, a ((DDD)) DDA group home may be licensed as an adult family home under chapter 70.128 RCW or an assisted living facility under chapter 18.20 RCW. Group homes provide community residential instruction, supports, and services to two or more clients who are unrelated to the provider.

(6) Enhanced adult residential care facility (EARC), a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs. Licensed as an assisted living facility under chapter 18.20 RCW.

"Authorization date" means the date payment begins for long-term care services described in WAC 388-106-0045.

"CARE assessment" means the evaluation process defined in chapter 388-106 WAC used by a department designated social services worker or a case manager to determine the client's need for long-term care services.

"Clothing and personal incidentals (CPI)" means the cash payment issued by the department for clothing and personal items for individuals living in an ALF described in WAC ((388-478-0045)) 182-515-1500 or medical institution described in WAC ((388-478-0040)) 182-513-1300.

"Community options program entry system (COPES)" means a medicaid home and community based (HCB) waiver program described in chapter 388-106 WAC that provides an aged or disabled person assessed as needing nursing facility care with the option to remain at home or in an alternate living facility (ALF).

"Community spouse (CS)" means a person who:

(1) Does not reside in a medical institution; and

(2) Is legally married to a client who resides in a medical institution or receives services from a home and community-based (HCB) waiver program. A person is considered married if not divorced, even when physically or legally separated from his or her spouse.

"Community spouse excess shelter" means the excess shelter standard is used to calculate whether a community spouse qualifies for the community spouse maintenance allowance because of high shelter costs. The federal maximum standard that is used to calculate the amount is found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Community spouse income and family allocation" means:

(1) The community spouse income standard is used when there is a community spouse. It is used when determining the total allocation for the community spouse from the institutional spouse's income.

(2) The family allocation income standard is used when a dependent resides with the community spouse. This amount is deducted from an institutional spouse's payment for their cost of care to help support the dependent. The federal maximum standard that is used to calculate the amount can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Community spouse maintenance allocation" means an amount deducted from an institutional spouse's payment toward their cost of care in order for the community spouse to have enough income to pay their shelter costs. This is a combination of the community spouse income allocation and the community spouse excess shelter calculation. The federal maximum standard that is used to calculate the amount can be found at: http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Community spouse resource allocation (CSRA)" means the resource amount the community spouse is allowed. A community spouse resource evaluation is completed to determine if the standard is more than the state standard up to the federal community spouse transfer maximum standard.

"Community spouse resource evaluation" means a review of the couple owned at the start of the current period of institutional status. This review may result in a resource standard for the community spouse that is higher than the state standard.

"Community spouse transfer maximum" means the federal maximum standard that is used to determine the community spouse resource allocation (CSRA). This standard is found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Developmental disabilities administration (DDA)" means an administration within aging and disability services (ADS) of department of social and health services (DSHS) supporting individuals with developmental disabilities.

"((~~DDD~~)) DDA waiver" means medicaid waiver programs described in chapter 388-845 WAC that provide home and community-based services as an alternative to an intermediate care facility for the intellectually disabled (ICF-ID) to persons determined eligible for services from ((~~DDD~~)) DDA.

"Dependent" means an individual who is financially dependent upon another for his well being as defined by financial responsibility regulations for the program. For the purposes of long-term care, rules allow allocation in post eligibility to a dependent. If the dependent is eighteen years or older and being claimed as a dependent for income tax purposes, a dependent allocation can be considered. This can include an adult child, a dependent parent or a dependent sibling.

"Equity" means the equity of real or personal property is the fair market value (see definition below) less any encumbrances (mortgages, liens, or judgments) on the property.

"Exception to rule (ETR)" means a waiver by the secretary's designee to a department policy for a specific client experiencing an undue hardship because of the policy. The waiver may not be contrary to law.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the open market at the time of transfer or assignment.

"Federal benefit rate (FBR)" means the basic benefit amount the Social Security administration (SSA) pays to clients who are eligible for the supplemental security income (SSI) program.

"Home and community based services" (HCBS) means services provided in the home or a residential setting to individuals assessed by the department.

"Home and community based (HCB) waiver programs" means section 1915(c) of the Social Security Act enables states to request a waiver of applicable federal medicaid requirements to provide enhanced community support services to those medicaid beneficiaries who would otherwise require the level of care provided in a hospital, nursing facility or intermediate care facility for the intellectually disabled (ICF-ID).

"Initial eligibility" means part one of institutional medical eligibility for long-term care services. Once resource and general eligibility is met, the gross nonexcluded income is compared to three hundred percent of the federal benefit rate (FBR) for a determination of CN or MN coverage.

"Institutional services" means services paid for by medicaid or state funds and provided in a medical institution, through a home and community based (HCB) waiver or program of all-inclusive care for the elderly (PACE).

"Institutional status" means what is described in WAC ((~~388-513-1320~~)) 182-513-1320.

"Institutionalized client" means a client who has attained institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320.

"Institutionalized spouse" means legally married person who has attained institutional status as described in chapter ((~~388-513~~)) 182-513 WAC, and receives services in a medical institution or from a home and community based waiver program described in chapters ((~~388-513~~)) 182-513 and ((~~388-515~~)) 182-515 WAC. A person is considered married if not divorced, even when physically or legally separated from his or her spouse.

"Legally married" means persons legally married to each other under provision of Washington state law. Washington recognizes other states' legal and common-law marriages. Persons are considered married if they are not divorced, even when they are physically or legally separated.

"Likely to reside" means a determination by the department that a client is reasonably expected to remain in a medical institution for thirty consecutive days. Once made, the determination stands, even if the client does not actually remain in the facility for that length of time.

"Look-back period" means the number of months prior to the month of application for LTC services that the department will consider for transfer of assets.

"Maintenance needs amount" means a monthly income amount a client keeps as a personal needs allowance or that is allocated to a spouse or dependent family member who lives in the client's home. (See community spouse maintenance allocation and community spouse income and family allocation.)

"Medicaid personal care (MPC)" means a medicaid state plan program authorized under RCW 74.09.520. Clients eligible for this program may receive personal care in their own home or in a residential facility. Financial eligibility is based on a client receiving a noninstitutional aged, blind, disabled (ABD) categorically needy (CN) medical program or receiving a modified adjusted gross income (MAGI) based medicaid program.

"Noninstitutional medical assistance" means any medical benefits or programs not authorized under chapter ((~~388-513~~)) 182-513 or ((~~388-515~~)) 182-515 WAC. The exception is WAC ((~~388-513-1305~~)) 182-513-1305 noninstitutional SSI-related clients living in an ALF.

"Participation" means the amount a client is responsible to pay each month toward the total cost of personal care they receive each month. It is the amount remaining after subtracting allowable deductions and allocations from available monthly income. Individuals receiving services in an ALF pay room and board in addition to calculated participation. Participation is the result of the post-eligibility process used in institutional and HCB waiver eligibility.

"Penalty period" means a period of time for which a client is not eligible to receive LTC services due to asset transfers.

"Personal needs allowance (PNA)" means a standard allowance for clothing and other personal needs for long-term care clients who live in a medical institution or alternate living facility, or at home.

"Short stay" means a person who has entered a medical institution but is not likely to remain institutionalized for thirty consecutive days.

"Special income level (SIL)" means the monthly income standard for the categorically needy (CN) program that is three hundred percent of the SSI federal benefit rate (FBR).

"Spousal impoverishment" means financial provisions to protect income and assets of the noninstitutional (community spouse) through income and resource allowances. The spousal allocation process is used to discourage the impoverishment of a spouse due to the need for LTC services by their husband or wife. That law and those that have extended and/or amended it are referred to as spousal impoverishment legislation. (Section 1924 of the Social Security Act.)

"State spousal resource standard" means minimum resource standard allowed for a community spouse. (See community spouse resource transfer maximum.)

"Swing bed" means a bed in a critical access hospital that is contracted to be used as either a hospital or a nursing facility bed based on the need of the individual.

"Third party resource (TPR)" means a resource where the purpose of the payment is for payment of assistance of daily living or medical services or personal care. Third party resources are described in WAC 182-501-0200. The department is considered the payer of last resort as described in WAC 182-502-0100.

"Transfer of a resource or asset" means changing ownership or title of an asset such as income, real property, or personal property by one of the following:

(1) An intentional act that changes ownership or title; or

(2) A failure to act that results in a change of ownership or title.

"Transfer date for real property or interest in real property" means:

(1) The date of transfer for real property is the day the deed is signed by the grantor if the deed is recorded; or

(2) The date of transfer for real property is the day the signed deed is delivered to the grantee.

"Transfer month" means the calendar month in which resources were legally transferred.

"Uncompensated value" means the fair market value (FMV) of an asset at the time of transfer minus the value of compensation the person receives in exchange for the asset.

"Undue hardship" means the person is not able to meet shelter, food, clothing, or health needs. Clients who are denied or terminated from LTC services due to a transfer of asset penalty or having excess home equity may apply for an undue hardship waiver based on criteria described in WAC ((~~388-513-1367~~)) 182-513-1367.

"Value of compensation received" means the consideration the purchaser pays or agrees to pay. Compensation includes:

(1) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable purchase agreement whereby the person transfers the asset; and

(2) The payment or assumption of a legal debt the seller owes in exchange for the asset.

"Veterans benefits" means different types of benefits paid by the federal Department of Veterans Affairs (VA). Some may include additional allowances for:

(1) Aid and attendance for an individual needing regular help from another person with activities of daily living;

(2) "Housebound" for an individual who, when without assistance from another person, is confined to the home;

(3) Improved pension, the newest type of VA disability pension, available to veterans and their survivors whose income from other sources (including service connected disability) is below the improved pension amount;

(4) Unusual medical expenses (UME), determined by the VA based on the amount of unreimbursed medical expenses reported by the person who receives a needs-based benefit. The VA can use UME to reduce countable income to allow

the person to receive a higher monthly VA payment, a one-time adjustment payment, or both;

(5) Dependent allowance veteran's payments made to, or on behalf of, spouses of veterans or children regardless of their ages or marital status. Any portion of a veteran's payment that is designated as the dependent's income is countable income to the dependent; or

(6) Special monthly compensation (SMC). Extra benefit paid to a veteran in addition to the regular disability compensation to a veteran who, as a result of military service, incurred the loss or loss of use of specific organs or extremities.

"Waiver programs/services" means programs for which the federal government authorizes exceptions to federal medicaid rules. Such programs provide to an eligible client a variety of services not normally covered under medicaid. In Washington state, home and community based (HCB) waiver programs are authorized by the ((~~division of~~)) developmental disabilities (((~~DDD~~))) administration (DDA), or home and community services (HCS).

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1305 Determining eligibility for SSI-related noninstitutional medical assistance in an alternate living facility (ALF). This section describes how the department defines the monthly income standard and uses it to determine eligibility for noninstitutional medical assistance for a client who lives in a department-contracted ALF. Refer to WAC ((~~388-478-0045~~)) 182-515-1500 for the personal needs allowance (PNA) amount that applies in this rule.

(1) The eligibility criteria for noninstitutional medical assistance in an ALF follows SSI-related medical rule described in chapter 182-512 WAC ((~~182-512-0050 through 182-512-0960~~)) with the exception of the higher medical standard based on the daily rate described in subsection (3) of this section.

(2) Alternate living facilities (((~~AFH) [(ALF)]~~)) (ALF) include the following:

(a) An adult family home (AFH), a licensed family home that provides its residents with personal care and board and room for two to six adults unrelated to the person(s) providing the care. Licensed as an adult family home under chapters 70.128 RCW and 388-76 WAC;

(b) An adult residential care facility (ARC) (formally known as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision. Licensed as an assisted living facility under chapters 18.20 RCW and 388-78A WAC;

(c) An adult residential rehabilitation center (ARRC) described in WAC 388-865-0235 or adult residential treatment facility (ARTF) described in WAC 388-865-0465. These are licensed facilities that provide its residents with twenty-four hour residential care for impairments related to mental illness;

(d) Assisted living facility (AL), a licensed facility for aged and disabled low-income persons with functional disabilities. COPES eligible clients are often placed in assisted living. Licensed as an assisted living facility under chapters 18.20 RCW and 388-78A WAC;

(e) ((~~Division of~~)) Developmental disabilities (((~~DDD~~))) administration (DDA) group home (GH), a licensed facility that provides its residents with twenty-four hour supervision. Depending on size of a ((~~DDD~~)) DDA group home may be licensed as an adult family home under chapter 70.128 RCW or a boarding home under chapter 18.20 RCW. Group home means a residence that is licensed as either an assisted living facility or an adult family home by the department under chapters 388-78A or 388-76 WAC. Group homes provide community residential instruction, supports, and services to two or more clients who are unrelated to the provider; and

(f) Enhanced adult residential care facility (EARC), a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs. Licensed as an assisted living facility under chapter 18.20 RCW.

(3) The monthly income standard for noninstitutional medical assistance under the categorically needy (CN) program has two steps:

(a) The gross nonexcluded monthly income cannot exceed the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); and

(b) The countable income cannot be greater than the department contracted daily rate times thirty-one days, plus the thirty-eight dollars and eighty-four cents PNA/CPI described in WAC ((~~388-478-0045~~)) 182-513-1300.

(4) The monthly income standard for noninstitutional medical assistance under the medically needy (MN) program equals the private facility daily rate times thirty one days, plus the thirty-eight dollars and eight-four cents PNA/CPI described in WAC ((~~388-478-0045~~)) 182-513-1300. Follow MN rules described in chapter 182-519 WAC.

(5) The department approves CN noninstitutional medical assistance for a period of up to twelve months for a client who is SSI-related as described in WAC 182-512-0050, if:

(a) The client's nonexcluded resources do not exceed the standard described in WAC ((~~388-513-1350~~)) 182-513-1350(1); and

(b) The client's nonexcluded income does not exceed the CN standard described in subsection (3) of this section. SSI-related program as described in chapter 182-512 WAC.

(6) The department approves MN noninstitutional medical assistance for a period of months described in chapter 182-504 WAC for an SSI-related client, if:

(a) The client's nonexcluded resources do not exceed the standard described in WAC ((~~388-513-1350~~)) 182-513-1350 (1); and

(b) The client satisfies any spenddown liability as described in chapter 182-519 WAC.

(7) ((~~The department determines eligibility for a cash grant for individuals residing in an alternate living facility using the following program rules:~~

~~(a) WAC 388-400-0005 temporary assistance for needy families (TANF);~~

~~(b) WAC 388-400-0060 aged, blind, disabled (ABD) cash benefit;~~

~~(c) WAC 388-400-0030 refugee assistance.~~

(8) The)) A client ((described in subsection (7))) residing in an adult family home (AFH) ((receives)) receiving a grant based on a payment standard described in WAC 388-478-0033 due to an obligation to pay shelter costs to the adult family home. The client keeps a CPI/PNA in the amount of thirty-eight dollars and eighty-four cents described in WAC ((388-478-0045)) 182-515-1500 and pays the remainder of the grant to the adult family home as room and board.

(((9) The client described in subsection (7) residing in an ALF described in subsections (2)(b), (c), (d), (e), (f) or (g) (all nonadult family home residential settings) keeps the thirty-eight dollars and eighty-four cents CPI amount based on WAC 388-478-0045.

(10))) (8) The client described in subsection (3) of this section and receiving medicaid personal care (MPC) from the department keeps sixty-two dollars and seventy-nine cents as a PNA and pays the remainder of their income to the ALF for room and board and personal care.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1315 Eligibility for long-term care (institutional, home and community based (HCB) waiver, and hospice) services. ((This section describes how the department determines a client's eligibility for medical for clients residing in a medical institution, on a waiver, or receiving hospice services under the categorically needy (CN) or medically needy (MN) programs. Also described are the eligibility requirements for these services under the aged, blind, or disabled (ABD) cash assistance, medical care services (MCS) and the state funded long-term care services program described in subsection (11).

(1) To be eligible for long-term care (LTC) services described in this section, a client must:

(a) Meet the general eligibility requirements for medical programs described in WAC 182-503-0505 (2) and (3)(a) through (g);

(b) Attain institutional status as described in WAC 388-513-1320;

(c) Meet functional eligibility described in chapter 388-106 WAC for home and community services (HCS) waiver and nursing facility coverage; or

(d) Meet criteria for division of developmental disabilities (DDD) assessment under chapter 388-828 WAC for DDD waiver or institutional services;

(e) Not have a penalty period of ineligibility as described in WAC 388-513-1363, 388-513-1364, or 388-513-1365;

(f) Not have equity interest in their primary residence greater than the home equity standard described in WAC 388-513-1350; and

(g) Must disclose to the state any interest the applicant or spouse has in an annuity and meet annuity requirements described in chapter 388-561 WAC:

(i) This is required for all institutional or waiver services and includes those individuals receiving supplemental security income (SSI).

(ii) A signed and completed eligibility review for long term care benefits or application for benefits form can be accepted for SSI individuals applying for long-term care services.

(2) To be eligible for institutional, waiver, or hospice services under the CN program, a client must either:

(a) Be related to the supplemental security income (SSI) program as described in WAC 182-512-0050 (1), (2) and (3) and meet the following financial requirements, by having:

(i) Gross nonexcluded income described in subsection (8)(a) that does not exceed the special income level (SIL) (three hundred percent of the federal benefit rate (FBR)); and

(ii) Countable resources described in subsection (7) that do not exceed the resource standard described in WAC 388-513-1350; or

(b) Be approved and receiving aged, blind, or disabled cash assistance described in WAC 388-400-0060 and meet citizenship requirements for federally funded medicaid described in WAC 388-424-0010; or

(c) Be eligible for CN apple health for kids described in WAC 182-505-0210; or CN family medical described in WAC 182-505-0240; or family and children's institutional medical described in WAC 182-514-0230 through 182-514-0260. Clients not meeting the citizenship requirements for federally funded medicaid described in WAC 388-424-0010 are not eligible to receive waiver services. Nursing facility services for noncitizen children require prior approval by aging and disability services administration (ADSA) under the state funded nursing facility program described in WAC 182-507-0125; or

(d) Be eligible for the temporary assistance for needy families (TANF) program as described in WAC 388-400-0005. Clients not meeting disability or blind criteria described in WAC 182-512-0050 are not eligible for waiver services.

(3) The department allows a client to reduce countable resources in excess of the standard. This is described in WAC 388-513-1350.

(4) To be eligible for waiver services, a client must meet the program requirements described in:

(a) WAC 388-515-1505 through 388-515-1509 for COPES, New Freedom, PACE, and WMIP services; or

(b) WAC 388-515-1510 through 388-515-1514 for DDD waivers.

(5) To be eligible for hospice services under the CN program, a client must:

(a) Meet the program requirements described in chapter 182-551 WAC; and

(b) Be eligible for a noninstitutional categorically needy program (CN) if not residing in a medical institution thirty days or more; or

(c) Reside at home and benefit by using home and community based waiver rules described in WAC 388-515-1505 through 388-515-1509 (SSI-related clients with income over the effective one-person MNIL and gross income at or below the 300 percent of the FBR or clients with a community spouse); or

(d) Receive home and community waiver (HCS) or DDD waiver services in addition to hospice services. The client's responsibility to pay toward the cost of care (participation) is applied to the waiver service provider first; or

~~(e) Be eligible for institutional CN if residing in a medical institution thirty days or more.~~

~~(6) To be eligible for institutional or hospice services under the MN program, a client must be:~~

~~(a) Eligible for MN children's medical program described in WAC 182-514-0230, 182-514-0255, or 182-514-0260; or~~

~~(b) Related to the SSI-program as described in WAC 182-512-0050 and meet all requirements described in WAC 388-513-1395; or~~

~~(c) Eligible for the MN SSI-related program described in WAC 182-512-0150 for hospice clients residing in a home setting; or~~

~~(d) Eligible for the MN SSI-related program described in WAC 388-513-1305 for hospice clients not on a medically needy waiver and residing in an alternate living facility.~~

~~(e) Be eligible for institutional MN if residing in a medical institution thirty days or more described in WAC 388-513-1395.~~

~~(7) To determine resource eligibility for an SSI-related client under the CN or MN program, the department:~~

~~(a) Considers resource eligibility and standards described in WAC 388-513-1350; and~~

~~(b) Evaluates the transfer of assets as described in WAC 388-513-1363, 388-513-1364, or 388-513-1365.~~

~~(8) To determine income eligibility for an SSI-related client under the CN or MN program, the department:~~

~~(a) Considers income available as described in WAC 388-513-1325 and 388-513-1330;~~

~~(b) Excludes income for CN and MN programs as described in WAC 388-513-1340;~~

~~(c) Disregards income for the MN program as described in WAC 388-513-1345; and~~

~~(d) Follows program rules for the MN program as described in WAC 388-513-1395.~~

~~(9) A client who meets the requirements of the CN program is approved for a period of up to twelve months.~~

~~(10) A client who meets the requirements of the MN program is approved for a period of months described in WAC 388-513-1395 for:~~

~~(a) Institutional services in a medical institution; or~~

~~(b) Hospice services in a medical institution.~~

~~(11) The department determines eligibility for state funded programs under the following rules:~~

~~(a) A client who is eligible for ABD cash assistance program described in WAC 388-400-0060 but is not eligible for federally funded medicaid due to citizenship requirements receives MCS medical described in WAC 182-508-0005. A client who is eligible for MCS may receive institutional services but is not eligible for hospice or HCB waiver services.~~

~~(b) A client who is not eligible for ABD cash assistance but is eligible for MCS coverage only described in WAC 182-508-0005 may receive institutional services but is not eligible for hospice or HCB waiver services.~~

~~(c) A noncitizen client who is not eligible under subsections (11)(a) or (b) and needs long-term care services may be eligible under WAC 182-507-0110 and 82-507-0125. This program must be pre-approved by aging and disability services administration (ADSA).~~

~~(12) A client is eligible for medicaid as a resident in a psychiatric facility, if the client:~~

~~(a) Has attained institutional status as described in WAC 388-513-1320; and~~

~~(b) Is under the age of twenty-one at the time of application; or~~

~~(c) Is receiving active psychiatric treatment just prior to their twenty-first birthday and the services extend beyond this date and the client has not yet reached age twenty-two; or~~

~~(d) Is at least sixty-five years old.~~

~~(13) The department determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.~~

~~(14) If an individual under age twenty one is not eligible for medicaid under SSI-related in WAC 182-512-0050 or ABD cash assistance described in WAC 388-400-0060 or MCS described in WAC 182-508-0005, consider eligibility under WAC 182-514-0255 or 182-514-0260.~~

~~(15) Noncitizen clients under age nineteen can be considered for the apple health for kids program described in WAC 182-505-0210 if they are admitted to a medical institution for less than thirty days. Once a client resides or is likely to reside in a medical institution for thirty days or more, the department determines eligibility under WAC 182-514-0260 and must be preapproved for coverage by ADSA as described in WAC 182-507-0125.~~

~~(16) Noncitizen clients not eligible under subsection (15) of this section can be considered for LTC services under WAC 182-507-0125. These clients must be preapproved by ADSA.~~

~~(17) The department determines a client's total responsibility to pay toward the cost of care for LTC services as follows:~~

~~(a) For SSI-related clients residing in a medical institution see WAC 388-513-1380;~~

~~(b) For clients receiving HCS CN waiver services see WAC 388-515-1509;~~

~~(c) For clients receiving DDD CN waiver services see WAC 388-515-1514; or~~

~~(d) For TANF related clients residing in a medical institution see WAC 182-514-0265.~~

~~(18) Clients not living in a medical institution who are considered to be receiving SSI-benefits for the purposes of medicaid do not pay service participation toward their cost of care. Clients living in a residential setting do pay room and board as described in WAC 388-515-1505 through 388-515-1509 or WAC 388-515-1514. Groups deemed to be receiving SSI and for medicaid purposes are eligible to receive CN medicaid. These groups are described in WAC 182-512-0880.~~)) This section describes how the medicaid agency or its designee determines a client's eligibility for Washington apple health (WAH) long-term care coverage for clients residing in a medical institution, receiving home and community based waiver services, or receiving hospice services under the categorically needy (CN) or medically needy (MN) programs. Also described are the eligibility requirements for these services under state-funded medical care services (MCS) program and the state funded long-term care services program.

This chapter includes the following sections;

(1) WAC 182-513-1316, General eligibility requirements for WAH long-term care programs.

(2) WAC 182-513-1317, Income and resource criteria for an institutionalized client.

(3) WAC 182-513-1318, Income and resource criteria for home and community based (HCB) waiver programs and hospice clients.

(4) WAC 182-513-1319, State-funded programs for noncitizen clients.

NEW SECTION

WAC 182-513-1316 General eligibility requirements for WAH long-term care programs. (1) To be eligible for long-term care (LTC) services, a client must:

(a) Meet the general eligibility requirements for medical programs described in WAC 182-503-0505;

(b) Attain institutional status as described in WAC 182-513-1320;

(c) Meet the functional eligibility described in:

(i) Chapter 388-106 WAC for a home and community services (HCS) waiver or nursing facility coverage; or

(ii) Chapter 388-828 WAC for DDA waiver or institutional services; and

(d) Meet either:

(i) SSI-related WAH criteria as described in WAC 182-512-0050; or

(ii) MAGI-based WAH criteria as described in WAC 182-503-0510(2). A client who is eligible for MAGI-based WAH is not subject to the provisions described in subsection (2) of this section.

(2) An SSI-related client, including supplemental security income (SSI) recipients, who needs LTC services must also:

(a) Not have a penalty period of ineligibility as described in WAC 182-513-1363, 182-513-1364, or 182-513-1365;

(b) Not have equity interest in their primary residence greater than the home equity standard described in WAC 182-513-1350;

(c) Disclose to the state any interest the applicant or spouse has in an annuity and meet annuity requirements described in chapter 182-516 WAC.

(3) An SSI recipient must submit a signed health care coverage application form attesting to the provisions described in subsection (2) of this section. A signed and completed eligibility review for long-term care benefits can be accepted for SSI clients applying for long-term care services.

(4) To be eligible for WAH LTC waiver services, a client must also meet the program requirements described in:

(a) WAC 182-515-1505 through 182-515-1509 for COPES, New Freedom PACE, and WMIP services; or

(b) WAC 182-515-1510 through 182-515-1514 for DDA waivers.

(5) A client who is eligible for categorically needy WAH coverage is certified for twelve months.

(6) A client who is eligible for medically needy WAH coverage is approved for a period of months described in WAC 182-513-1395(6) for:

(a) Institutional services in a medical institution; or

(b) Hospice services in a medical institution.

(7) The medicaid agency or its designee determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.

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

NEW SECTION

WAC 182-513-1317 Income and resource criteria for an institutionalized client. (1) This section provides an overview of the income and resource eligibility rules for a client who lives in an institutional setting. The term "institution" is defined in WAC 182-500-0050.

(2) To determine income eligibility for an SSI-related WAH long-term care (LTC) client under the categorically needy (CN) program, the medicaid agency or its designee:

(a) Considers income available as described in WAC 182-513-1325 and 182-513-1330;

(b) Excludes income as described in WAC 182-513-1340;

(c) Compares remaining gross nonexcluded income to the special income level (SIL) (three hundred percent of the federal benefit rate (FBR)). A client's gross income must be equal to or less than the SIL to be eligible for CN coverage.

(3) To determine income eligibility for an SSI-related WAH LTC client under the medically needy (MN) program, the agency or its designee:

(a) Considers income available as described in WAC 182-513-1325 and 182-513-1330;

(b) Excludes income as described in WAC 182-513-1340;

(c) Disregards income as described in WAC 182-513-1345; and

(d) Follows the income standards and eligibility rules described in WAC 182-513-1395.

(4) To be resource eligible under the SSI-related WAH LTC CN or MN program, the client must:

(a) Meet the resource eligibility requirements and standards described in WAC 182-513-1350;

(b) Not have a penalty period of ineligibility due to a transfer of asset as described in WAC 182-513-1363 or 182-513-1364;

(c) Disclose to the state any interest the client or the client's spouse has in an annuity and meet the annuity requirements described in chapter 182-516 WAC.

(5) The agency or its designee allows an institutionalized client to reduce countable resources in excess of the standard. This is described in WAC 182-513-1350.

(6) A client is eligible for medicaid as a resident in a psychiatric facility, if the client:

(a) Has attained institutional status as described in WAC 182-513-1320; and

(b) Is under the age of twenty-one at the time of application; or

(c) Is receiving active psychiatric treatment just prior to their twenty-first birthday and the services extend beyond this date and the client has not yet reached age twenty-two; or

(d) Is at least sixty-five years old.

(7) To determine CN or MN income eligibility for a MAGI-based WAH LTC client, the medicaid agency or its designee follows the rules described in WAC 182-514-0230 through 182-514-0265.

(8) There is no asset test for MAGI-based WAH LTC programs as described in WAC 182-514-0245.

(9) The agency or its designee determines a client's total responsibility to pay toward the cost of care for LTC services as follows:

(a) For SSI-related WAH clients residing in a medical institution see WAC 182-513-1380;

(b) For MAGI-based WAH clients residing in a medical institution see WAC 182-514-0265. Clients who are eligible for the MAGI-based WAH adult medical program described in WAC 182-505-0250 are not required to contribute toward the cost of care. Nursing home care is included in the alternative benefit plan scope of care for these clients.

NEW SECTION

WAC 182-513-1318 Income and resource criteria for home and community based (HCB) waiver programs and hospice clients. (1) This section provides an overview of the income and resource eligibility rules for a client to be eligible for a home and community based (HCB) waiver program or the Washington apple health (WAH) hospice program.

(2) To determine income eligibility for an SSI-related WAH long-term care (LTC) waiver client under the categorically needy (CN) program, the medicaid agency or its designee:

(a) Considers income available as described in WAC 182-513-1325 and 182-513-1330;

(b) Excludes income as described in WAC 182-513-1340;

(c) Compares remaining gross non excluded income to:

(i) The special income level (SIL) (three hundred percent of the federal benefit rate (FBR)); or

(ii) For home and community based (HCB) service programs authorized by aging and long-term supports administration (ALTSA), a higher standard is determined following the rules described in WAC 182-514-1508 if a client's income is above the SIL but net income is below the medically needy income level (MNIL).

(3) A client who receives MAGI-based WAH is not eligible for HCB waiver services unless found eligible based on program rules in chapter 182-515 WAC.

(4) There is no WAH HCB waiver medically needy program.

(5) To be resource eligible under the SSI-related WAH LTC CN waiver programs, the client must:

(a) Meet the resource eligibility requirements and standards described in WAC 182-513-1350;

(b) Not have a penalty period of ineligibility due to a transfer of asset as described in WAC 182-513-1363, 182-513-1364, or 182-513-1365;

(c) Disclose to the state any interest the client or the client's spouse has in an annuity and meet the annuity requirements described in chapter 182-516 WAC.

(6) The agency or its designee allows an HCB waiver client to use verified unpaid medical expenses to reduce countable resources in excess of the standard. This is described in WAC 182-513-1350.

(7) The agency or its designee determines a client's total responsibility to pay toward the cost of care for LTC services as follows:

(a) For clients receiving HCS CN waiver services see WAC 182-515-1509;

(b) For clients receiving DDA CN waiver services see WAC 182-515-1514.

(8) HCB waiver clients who are "deemed eligible" for SSI benefits as described in WAC 182-512-0880 do not pay service participation toward their cost of personal care. Clients living in a residential setting do pay room and board as described in WAC 182-515-1505 through 182-515-1509 or 182-515-1514.

(9) To be eligible for hospice services under the CN program, a client must:

(a) Meet the program requirements described in chapter 182-551 WAC governing client eligibility for hospice care; and

(b) Be eligible for a noninstitutional CN program if not residing in a medical institution thirty days or more.

(10) A client who is not eligible for a noninstitutional CN program who needs hospice care is eligible for the WAH hospice program if they meet the following criteria:

(a) Meet the hospice program requirements described in chapter 182-551 WAC; and

(b) Reside at home and would be eligible for coverage by using home and community services waiver rules described in WAC 182-515-1505 through 182-515-1509 (SSI-related clients with income over the effective one-person MNIL and gross income at or below the three hundred percent of the FBR or clients with a community spouse); or

(c) Receive WAH HCBS waiver services in addition to hospice services. The client's responsibility to pay toward the cost of care (participation) is applied to the waiver service provider first; or

(d) Be eligible for institutional CN if residing in a medical institution (including a hospice care center) for thirty days or more.

(11) To be eligible for hospice services under the MN program, a client must be:

(a) Eligible for the MN SSI-related program described in WAC 182-512-0150 for hospice clients residing in a home setting; or

(b) Eligible for the MN SSI-related program described in WAC 182-513-1305 for hospice clients not receiving HCBS waiver services who reside in an alternate living facility.

(c) Be eligible for institutional MN if residing in a medical institution thirty days or more described in WAC 182-513-1395.

NEW SECTION

WAC 182-513-1319 State-funded programs for noncitizen clients. (1) This section describes the programs that are available for noncitizen clients who do not meet the citizenship criteria described in WAC 182-503-0530 to be eligi-

ble for federally funded Washington apple health (WAH) coverage.

(2) Lawfully residing noncitizen clients who need nursing facility care or care in an alternate living facility may receive long-term care (LTC) coverage if the client meets the eligibility and incapacity criteria of the medical care services (MCS) program described in WAC 182-508-0005.

(3) Clients who receive MCS coverage are not eligible for home and community based (HCB) waiver programs or hospice care.

(4) Noncitizen clients under the age of nineteen who are eligible for the WAH for kids program described in WAC 182-505-0210 are eligible for LTC services if the client is admitted to a medical institution for less than thirty days. Once the client resides or is likely to reside in a medical institution for thirty days or more, the medicaid agency or its designee determines eligibility under WAC 182-514-0260, subject to being preapproved for coverage by aging and long-term supports administration (ALTSA) as described in WAC 182-507-0125.

(5) Noncitizen clients age nineteen or older may be eligible for the state-funded long-term care services WAH program described in WAC 182-507-0125. These clients must be preapproved by ALTSA as the program has enrollment limits. When the program is full, a client who needs LTC services is placed on a waiting list for services. Such an individual is not eligible for WAH waiver programs described in chapter 182-515 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1325 Determining available income for an SSI-related single client for long-term care (LTC) services (institutional, waiver or hospice). This section describes income the department considers available when determining an SSI-related single client's eligibility for LTC services (institutional, waiver or hospice).

(1) Refer to WAC ((~~388-513-1330~~)) 182-513-1330 for rules related to available income for legally married couples.

(2) The department must apply the following rules when determining income eligibility for SSI-related LTC services:

(a) WAC 182-512-0600 Definition of income;

(b) WAC 182-512-0650 Available income;

(c) WAC 182-512-0700 Income eligibility;

(d) WAC 182-512-0750 Countable unearned income;

(e) WAC 182-514-0840(3) Self-employment income-allowable expenses;

(f) WAC ((~~388-513-1315~~)) 182-513-1315(15), Eligibility for long-term care (institutional, waiver, and hospice) services; and

(g) WAC ((~~388-450-0155, 388-450-0156, 388-450-0160~~)) 182-512-0785, 182-512-0790, 182-512-0795, and 182-509-0155 for sponsored immigrants and how to determine if sponsors' income counts in determining benefits.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1330 Determining available income for legally married couples for long-term care (LTC) services. This section describes income the department considers available when determining a legally married client's eligibility for LTC services.

(1) The department must apply the following rules when determining income eligibility for LTC services:

(a) WAC 182-512-0600 Definition of income SSI-related medical;

(b) WAC 182-512-0650 Available income;

(c) WAC 182-512-0700 Income eligibility;

(d) WAC 182-512-0750 Countable unearned income;

(e) WAC 182-512-0840(3) Self-employment income-allowance expenses;

(f) WAC 182-512-0960, SSI-related medical clients; and

(g) WAC ((~~388-513-1315~~)) 182-513-1315, Eligibility for long-term care (institutional, waiver, and hospice) services.

(2) For an institutionalized client married to a community spouse who is not applying or approved for LTC services, the department considers the following income available, unless subsection (4) applies:

(a) Income received in the client's name;

(b) Income paid to a representative on the client's behalf;

(c) One-half of the income received in the names of both spouses; and

(d) Income from a trust as provided by the trust.

(3) The department considers the following income unavailable to an institutionalized client:

(a) Separate or community income received in the name of the community spouse; and

(b) Income established as unavailable through a court order.

(4) For the determination of eligibility only, if available income described in subsection((~~s~~)) (2)(a) through (d) of this section minus income exclusions described in WAC ((~~388-513-1340~~)) 182-513-1340 exceeds the special income level (SIL), then:

(a) The department follows community property law when determining ownership of income;

(b) Presumes all income received after marriage by either or both spouses to be community income; ((~~and~~))

(c) Considers one-half of all community income available to the institutionalized client((~~.~~)); and

(d) If the total of ((~~subsection (4)~~))(c) of this subsection plus the client's own income is over the SIL, follow subsection (2) of this section.

(5) The department considers income generated by a transferred resource to be the separate income of the person or entity to which it is transferred.

(6) The department considers income available to the client not generated by a transferred resource available to the client, even when the client transfers or assigns the rights to the stream of income to:

(a) The spouse; or

(b) A trust for the benefit of their spouse.

((~~(8)~~)) (7) The department evaluates the transfer of a resource described in subsection (5) of this section according to WAC ((~~388-513-1363, 388-513-1364, and 388-513-1365~~)) 182-513-1363, 182-513-1364, and 182-513-1365 to determine whether a penalty period of ineligibility is required.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1340 Determining excluded income for long-term care (LTC) services. This section describes income the department excludes when determining a client's eligibility and participation in the cost of care for LTC services with the exception described in subsection (31) of this section.

(1) Crime victim's compensation;

(2) Earned income tax credit (EITC) for twelve months after the month of receipt;

(3) Native American benefits excluded by federal statute (refer to WAC ((~~388-450-0040~~)) 182-512-0700);

(4) Tax rebates or special payments excluded by other statutes;

(5) Any public agency's refund of taxes paid on real property and/or on food;

(6) Supplemental security income (SSI) and certain state public assistance based on financial need;

(7) The amount a representative payee charges to provide services when the services are a requirement for the client to receive the income;

(8) The amount of expenses necessary for a client to receive compensation, e.g., legal fees necessary to obtain settlement funds;

(9) ((~~Any portion of a grant, scholarship, or fellowship used to pay tuition, fees, and/or other necessary educational expenses at any educational institution~~)) Education benefits described in WAC 182-509-0335;

(10) Child support payments received from an absent parent for a child living in the home are considered the income of the child;

(11) Self-employment income allowed as a deduction by the Internal Revenue Service (IRS);

(12) Payments to prevent fuel cut-offs and to promote energy efficiency that are excluded by federal statute;

(13) Assistance (other than wages or salary) received under the Older Americans Act;

(14) Assistance (other than wages or salary) received under the foster grandparent program;

(15) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(16) Interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become part of the separately identified burial funds set aside;

(17) Tax exempt payments received by Alaska natives under the Alaska Native Settlement Act established by P.L. 100-241;

(18) Compensation provided to volunteers in ACTION programs under the Domestic Volunteer Service Act of 1973 established by P.L. 93-113;

(19) Payments made from the Agent Orange Settlement Fund or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(20) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(21) Payments made under the Energy Employee Occupational Compensation Program Act of 2000, (EEOICPA) Pub. L. 106-398;

(22) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry established by P.L. 100-383;

(23) Payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

(24) Payments made from *Susan Walker v. Bayer Corporation, et, al*., 95-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds;

(25) Payments made from the Ricky Ray Hemophilia Relief Fund Act of 1998 established by P.L. 105-369;

(26) Payments made under the Disaster Relief and Emergency Assistance Act established by P.L. 100-387;

(27) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(28) Payments made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act;

(29) Interest or dividends received by the client is excluded as income. Interest or dividends received by the community spouse of an institutional individual is counted as income of the community spouse. Dividends and interest are returns on capital investments such as stocks, bond, or savings accounts. Institutional status is defined in WAC ((~~388-513-1320~~)) 182-513-1320;

(30) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible client, e.g., chore services;

(31) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent when determining LTC eligibility for the veteran. The VA dependent allowance is considered countable income to the dependent unless it is paid due to unusual medical expenses (UME);

(b) Unusual medical expenses, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance, with the exception described in subsection (32) of this section;

(32) Benefits described in subsection (31)(b) of this section for a client who receives long-term care services are excluded when determining eligibility, but are considered available as a third-party resource (TPR) when determining the amount the client contributes in the cost of care.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1345 Determining disregarded income for institutional or hospice services under the medically needy (MN) program. This section describes income the department disregards when determining a client's eligibility for institutional or hospice services under the MN program. The department considers disregarded income available when determining a client's participation in the cost of care.

(1) The department disregards the following income amounts in the following order:

(a) Income that is not reasonably anticipated, or is received infrequently or irregularly, when such income does not exceed:

(i) Twenty dollars per month if unearned; or

(ii) Ten dollars per month if earned.

(b) The first twenty dollars per month of earned or unearned income, unless the income paid to a client is:

(i) Based on need; and

(ii) Totally or partially funded by the federal government or a private agency.

(2) For a client who is related to the supplemental security income (SSI) program as described in WAC 182-512-0050(1), the first sixty-five dollars per month of earned income not excluded under WAC ((~~388-513-1340~~)) 182-513-1340, plus one-half of the remainder.

(3) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent when determining LTC eligibility for the veteran. The VA dependent allowance is considered countable income to the dependent unless it is paid due to unusual medical expenses (UME);

(b) Unusual medical expenses, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance, with the exception described in subsection (4) of this section.

(4) Benefits described in subsection (3)(b) of this section for a client who receives long-term care services are excluded when determining eligibility, but are considered available as a third-party resource (TPR) when determining the amount the client contributes in the cost of care.

(5) Income the Social Security Administration (SSA) withholds from SSA Title II benefits for the recovery of an SSI overpayment.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1350 Defining the resource standard and determining resource eligibility for long-term care (LTC) services. This section describes how the department defines the resource standard and countable or excluded resources when determining a client's eligibility for LTC services. The department uses the term "resource standard" to describe the maximum amount of resources a client can have and still be resource eligible for program benefits.

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

(a) Two thousand dollars for:

(i) A single client; or

(ii) A legally married client with a community spouse, subject to the provisions described in subsections (9) through (12) of this section; or

(b) Three thousand dollars for a legally married couple, unless subsection (4) of this section applies.

(2) Effective January 1, 2012, if an individual purchases a qualified long-term care partnership policy approved by the Washington insurance commissioner under the Washington long-term care partnership program, the department allows the individual with the long-term care partnership policy to retain a higher resource amount based on the dollar amount paid out by a partnership policy. This is described in WAC ((~~388-513-1400~~)) 182-513-1400.

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

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

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

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

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

(a) WAC 182-512-0300, Resource eligibility;

(b) WAC 182-512-0250, How to determine who owns a resource; and

(c) WAC ((~~388-470-0060~~)) 182-512-0260, Resources of an alien's sponsor.

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

(a) The department determines countable resources for SSI-related clients as described in chapter 182-512 WAC ((~~182-512-0350 through 182-512-0550~~)) and resources excluded by federal law with the exception of:

(i) WAC 182-512-0550 pension funds owned by an:

((~~(I)~~)) (A) Ineligible spouse. Pension funds are defined as funds held in an individual retirement account (IRA) as described by the IRS code; or

((~~(II)~~)) (B) Work-related pension plan (including plans for self-employed individuals, known as Keogh plans).

(ii) WAC 182-512-0350 (1)(b) clients who have submitted an application for LTC services on or after May 1, 2006, and have an equity interest greater than five hundred thousand dollars in their primary residence are ineligible for LTC services. This exception does not apply if a spouse or blind, disabled or dependent child under age twenty-one is lawfully residing in the primary residence. Clients denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver described in WAC ((~~388-513-1367~~)) 182-513-1367. Effective January 1, 2011, the excess home equity limits increase to five hundred six thousand dollars. On January 1, 2012, and on January 1st of each year thereafter, this standard may be increased or decreased by the percentage increased or decreased in the consumer price index-urban (CPIU). For current excess home equity standard starting January 1, 2011, and each year thereafter, see ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

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

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

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

(c) For an SSI-related client, the department adds together the countable resources of both spouses if subsections (3), (6), and (9)(a) or (b) of this section apply, but not if subsection (4) or (5) of this section apply.

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

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

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

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

(C) Medically necessary ((~~medical~~)) care covered under the state's medicaid plan incurred prior to medicaid eligibility. Expenses for nursing facility care are reduced at the state rate for the facility that the client owes the expense to.

(ii) As long as the incurred medical expenses:

(A) Were not incurred more than three months before the month of the medicaid application;

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

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

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

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

(F) Were not incurred during a transfer of asset penalty described in WAC ((~~388-513-1363, 388-513-1364, and 388-513-1365~~)) 182-513-1363, 182-513-1364, and 182-513-1365; and

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

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

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

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

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

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

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

(B) In a medical institution, excess resources and income must be under the state medicaid rate based on the number of days in the medical institution in the month.

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

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

(A) State medical institution rate based on the number of days in the medical institution in the month, plus the amount of recurring medical expenses; or

(B) State hospice rate based on the number of days in the medical institution in the month plus the amount of recurring medical expenses, in a medical institution.

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

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

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

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

(i) The institutionalized spouse; or

(ii) Both spouses.

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

(i) Either spouse; or

(ii) Both spouses.

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

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

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

(i) A spousal share equal to one-half of the couple's combined countable resources as of the first day of the month of the current period of institutional status, up to the amount described in subsection (10)(a) of this section; or

(ii) The state spousal resource standard of forty-eight thousand six hundred thirty-nine dollars (this standard may change every odd year on July 1st). This standard is based on

the consumer price index published by the federal bureau of labor statistics. For the current standard starting July 2009 and each year thereafter, see long-term care standards at ((~~http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(c) Resources are verified on the first moment of the first day of the month institutionalization began as described in WAC 182-512-0300(1).

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

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

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

(12) The amount of allocated resources described in subsection (10) of this section can be increased, only if:

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

(b) An administrative law judge establishes in ((~~a fair~~)) an administrative hearing described in chapter ((~~388-02~~)) 182-526 WAC, that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.

(13) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsection (6) or (14)(a), (b), or (c) of this section applies.

(14) A redetermination of the couple's resources as described in subsection (8) of this section is required, if:

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

(b) The institutionalized spouse's countable resources exceed the standard described in subsection (1)(a) of this section, if subsection (9)(b) of this section applies; or

(c) The institutionalized spouse does not transfer the amount described in subsection((~~s~~)) (10) or (12) of this section to the community spouse by either:

(i) The end of the month of the first regularly scheduled eligibility review; or

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

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1363 Evaluating the transfer of assets on or after May 1, 2006 for persons applying for or receiving long-term care (LTC) services. This section describes how the department evaluates asset transfers made on or after May 1, 2006, and their ((~~affect~~)) effect on LTC services. This applies to transfers by the client, spouse, a guardian or through an attorney in fact. Clients subject to asset transfer penalty periods are not eligible for LTC services. LTC services for the purpose of this rule include nursing facility services, services offered in any medical institution equivalent to nursing facility services, and home and community-based services furnished under a waiver program. Program of all-inclusive care of the elderly (PACE) and hospice services are not subject to transfer of asset rules. The department must consider whether a transfer made within a specified time before the month of application, or while the client is receiving LTC services, requires a penalty period.

- Refer to WAC ((~~388-513-1364~~)) 182-513-1364 for rules used to evaluate asset transfers made on or after April 1, 2003, and before May 1, 2006.
- Refer to WAC ((~~388-513-1365~~)) 182-513-1365 for rules used to evaluate asset transfer made prior to April 1, 2003.

(1) When evaluating the effect of the transfer of asset made on or after May 1, 2006, on the client's eligibility for LTC services the department counts sixty months before the month of application to establish what is referred to as the "look-back" period.

(2) The department does not apply a penalty period to transfers meeting the following conditions:

(a) The total of all gifts or donations transferred do not exceed the average daily private nursing facility rate in any month;

(b) The transfer is an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 with the exception of the client's home, unless the transfer of the home meets the conditions described in ((~~subsection (2)~~))(d) of this subsection;

(c) The asset is transferred for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation. To establish such an intent, the department must be provided with written evidence of attempts to dispose of the asset for fair market value as well as evidence to support the value (if any) of the disposed asset.

(ii) The transfer is not made to qualify for LTC services, continue to qualify, or avoid Estate Recovery. Convincing evidence must be presented regarding the specific purpose of the transfer.

(iii) All assets transferred for less than fair market value have been returned to the client.

(iv) The denial of eligibility would result in an undue hardship as described in WAC ((~~388-513-1367~~)) 182-513-1367.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided verifiable care that enabled the individual to remain in the home. A physician's statement of needed care is required; or

(iii) Brother or sister, who has:

(A) Equity in the home((~~,~~)); and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);

(f) The transfer meets the conditions described in subsection (3), and the asset is transferred:

(i) To another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To trust established for the sole benefit of the individual's child who meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(3) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (2)(f) of this section, if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable;

(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term of the trust, whichever is less; and

(d) The requirements in subsection (2)(c) of this section do not apply to trusts described in WAC 388-561-0100 (6)(a) and (b) and (7)(a) and (b).

(4) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of long-term care service if:

(a) The transfer is in exchange for care services the family member provided the client;

(b) The client has a documented need for the care services provided by the family member;

(c) The care services provided by the family member are allowed under the medicaid state plan or the department's HCB waiver services;

(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(f) The time for which care services are claimed is reasonable based on the kind of services provided; and

(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

(5) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (4) of this section as the transfer of an asset without adequate consideration.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the individual is not eligible for LTC services.

(7) If a client or the client's spouse transfers an asset on or after May 1, 2006, the department must establish a penalty period by adding together the total uncompensated value of all transfers made on or after May 1, 2006. The penalty period:

(a) For a LTC services applicant, begins on the date the client would be otherwise eligible for LTC services based on an approved application for LTC services or the first day after any previous penalty period has ended; or

(b) For a LTC services recipient, begins the first of the month following ten-day advance notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous penalty period has ended; and

(c) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later.

(8) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 does not affect the client's eligibility;

(b) That remain after an acquisition described in ((~~subsection (8)~~))(a) of this subsection becomes an available resource as of the first day of the following month.

(9) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC ((~~388-513-1330~~)) 182-513-1330 (5) through (7).

(10) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in ((~~subsection (10)~~))(a) of this subsection is divided by the statewide average daily private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole days found by following subsection((~~s~~)) (7)(a), (b), and (c) of this section.

(11) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses are receiving LTC services. When both spouses are receiving LTC services;

(a) We divide the penalty between the two spouses.

(b) If one spouse is no longer subject to a penalty (e.g., the spouse is no longer receiving institutional services or is deceased) any remaining penalty that applies to both spouses must be served by the remaining spouse.

(12) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter ((~~388-02~~)) 182-526 WAC.

(13) Additional statutes which apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:

(a) RCW 74.08.331 Unlawful practices—Obtaining assistance—Disposal of realty;

(b) RCW 74.08.338 Real property transfers for inadequate consideration;

(c) RCW 74.08.335 Transfers of property to qualify for assistance; and

(d) RCW 74.39A.160 Transfer of assets—Penalties.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1364 Evaluating the transfer of an asset made on or after April 1, 2003 for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC ((~~388-513-1365~~)) 182-513-1365 for rules used to evaluate the transfer of an asset made before April 1, 2003. Refer to WAC ((~~388-513-1363~~)) 182-513-1363 for rules used to evaluate the transfer of an asset made on or after May 1, 2006.

(1) The department does not apply a penalty period to the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 with the exception of the client's home, unless the transfer of the client's home meets the conditions described in ((~~subsection (1)~~))(d) of this subsection;

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided care that enabled the client to remain in the home; or

(iii) Brother or sister, who has:

(A) Equity in the home; and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset, if the transfer meets the conditions described in subsection (4) of this section, and the asset is transferred:

(i) To another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To trust established for the sole benefit of the client's child who meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(f) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c).

(2) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of institutional status, if:

(a) The transfer is in exchange for care services the family member provided the client;

(b) The client has a documented need for the care services provided by the family member;

(c) The care services provided by the family member are allowed under the medicaid state plan or the department's ((~~waivered~~)) HCB waiver services;

(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(f) The time for which care services are claimed is reasonable based on the kind of services provided; and

(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

(3) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (2) of this section as the transfer of an asset without adequate consideration.

(4) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a per-

son described in subsection (1)(e) of this section, if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable;

(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term or the trust, whichever is less; and

(d) The requirements in ((~~subsection (4)~~))(c) of this ((~~section~~)) subsection do not apply to trusts described in WAC ((~~388-561-0100~~)) 182-516-0100 (6)(a) and (b).

(5) If a client or the client's spouse transfers an asset within the look-back period described in WAC ((~~388-513-1365~~)) 182-513-1365 without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that begin on the latter of:

(i) The first day of the month in which the transfer is made; or

(ii) The first day after any previous penalty period has ended and end on the last day of the whole number of days as described in ((~~subsection (5)~~))(a)(ii) of this subsection.

(6) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 does not affect the client's eligibility;

(b) That remain after an acquisition described in subsection (6)(a) becomes an available resource as of the first day of the following month.

(7) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC ((~~388-513-1330~~)) 182-513-1330 (5) through (7).

(8) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in ((~~subsection (8)~~))(a) of this subsection is divided by the statewide average daily private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole days found by following subsection((~~s~~)) (5)(a) and (b) and ((~~(8)~~))(a) and (b) of this subsection is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(9) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(10) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter ((~~388-02~~)) 182-526 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997, and before April 1, 2003, for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after March 1, 1997, and before April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC ((~~388-513-1364~~)) 182-513-1364 for rules used to evaluate the transfer of an asset made on or after March 31, 2003. Refer to WAC ((~~388-513-1363~~)) 182-513-1363 for rules used to evaluate the transfer of an asset made on or after May 1, 2006.

(1) The department disregards the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 with the exception of the client's home, unless the transfer meets the conditions described in ((~~subsection (1)~~))(d) of this subsection;

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department that satisfies one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(iii) A son or daughter, who:

(A) Lived in the home for at least two years immediately before the client's current period of institutional status; and

(B) Provided care that enabled the client to remain in the home; or

(iv) A brother or sister, who has:

(A) Equity in the home, and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset other than the home, if the transfer meets the conditions described in subsection (4) of this section, and the asset is transferred:

(i) To the client's spouse or to another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To the client's child who meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c) or to a trust established for the sole benefit of this child; or

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c).

(f) The transfer of an asset to a member of the client's family in exchange for care the family member provided the client before the current period of institutional status, if a written agreement that describes the terms of the exchange:

(i) Was established at the time the care began;

(ii) Defines a reasonable FMV for the care provided that reflects a time frame based on the actuarial life expectancy of the client who transfers the asset; and

(iii) States that the transferred asset is considered payment for the care provided.

(2) When the fair market value of the care described in subsection (1)(f) of this section is less than the value of the transferred asset, the department considers the difference the transfer of an asset without adequate consideration.

(3) The department considers the transfer of an asset in exchange for care given by a family member without a written agreement as described under subsection (1)(f) of this section as the transfer of an asset without adequate consideration.

(4) The transfer of an asset or the establishment of a trust is considered to be for the sole benefit of a person described in subsection (1)(e) of this section, if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable; and

(b) Provides for spending all funds involved for the benefit of the person for whom the transfer is made within a time frame based on the actuarial life expectancy of that person.

(5) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received on or after October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty-six months, if all or part of the assets were transferred on or after August 11, 1993; and

(b) Sixty months, if all or part of the assets were transferred into a trust as described in WAC ((~~388-561-0100~~)) 182-516-0100.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after March 1, 1997, and before April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that:

(i) Begin on the latter of:

(A) The first day of the month in which the transfer is made; or

(B) The first day after any previous penalty period has ended; and

(ii) End on the last day of the whole number of months as described in ((~~subsection (6)~~))(a)(ii) of this subsection.

(7) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 does not affect the client's eligibility;

(b) That remains after an acquisition described in ((~~subsection (7)~~)) (a) of this subsection becomes an available resource as of the first day of the following month.

(8) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC ((~~388-513-1330~~)) 182-513-1330 (5) through (7).

(9) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in ((~~(9)~~))(a) of this subsection is divided by the statewide average monthly private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole months found by following ((~~subsections (9)~~))(a) and (b) of this subsection is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(10) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(11) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter ((~~388-02~~)) 182-526 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1366 Evaluating the transfer of an asset made before March 1, 1997, for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made before March 1, 1997, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC ((~~388-513-1365~~)) 182-513-1365 for rules used to evaluate the transfer of an asset on or after March 1, 1997.

(1) When evaluating the transfer of an asset made before March 1, 1997, the department must apply rules described in WAC ((~~388-513-1365~~)) 182-513-1365 (1) through (4) and (7) through (11) in addition to the rules described in this section.

(2) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received before October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty months, if the asset was transferred before August 11, 1993; or

(b) Thirty-six months, if the asset was transferred on or after August 11, 1993.

(3) If a client or the client's spouse transferred an asset without receiving adequate compensation before August 11, 1993, the department must establish a penalty period that:

(a) Runs concurrently for transfers made in more than one month in the look-back period; and

(b) Begins on the first day of the month in which the asset is transferred and ends on the last day of the month which is the lesser of:

(i) Thirty months after the month of transfer; or

(ii) The number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(4) If a client or the client's spouse transferred an asset without receiving adequate compensation on or after August 11, 1993, and before March 1, 1997, the department must establish a penalty period as follows:

(a) If the transfer is made during the look-back period, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months described in ((~~subsection (3)~~))(b)(ii) of this subsection.

(b) If the transfer is made while the client is receiving LTC services or during a period of ineligibility, then the penalty period:

(i) Begins on the latter of the first day of the month:

(A) In which the transfer is made; or

(B) After a previous penalty period has ended; and

(ii) Ends on the last day of the number of whole months described in ((~~subsection (3)~~))(b)(ii) of this subsection.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1367 Hardship waivers for long-term care (LTC) services. Clients who are denied or terminated from LTC services due to a transfer of asset penalty (described in WAC ((~~388-513-1363, 388-513-1364 and 388-513-1365~~)) 182-513-1363, 182-513-1364, and 182-513-1365), or having excess home equity (described in WAC ((~~388-513-1350~~)) 182-513-1350) may apply for an undue hardship waiver. Notice of the right to apply for an undue hardship waiver will be given whenever there is a denial or termination based on an asset transfer or excess home equity. This section:

- Defines undue hardship;
- Specifies the approval criteria for an undue hardship request;
- Establishes the process the department follows for determining undue hardship; and
- Establishes the appeal process for a client whose request for an undue hardship is denied.

(1) When does undue hardship exist?

(a) Undue hardship may exist:

(i) When a transfer of an asset occurs between:

(A) Registered domestic partners as described in chapter 26.60 RCW; or

(B) Same-sex couples who were married in states and the District of Columbia where same-sex marriages are legal; and

(C) The transfer would not have caused a period of ineligibility if made between an opposite sex married couple under WAC ((~~388-513-1363~~)) 182-513-1363.

(ii) When a client who transferred the assets or income, or on whose behalf the assets or income were transferred, either personally or through a spouse, guardian or attorney-in-fact, has exhausted all reasonable means including legal remedies to recover the assets or income or the value of the transferred assets or income that have caused a penalty period; and

(iii) The client provides sufficient documentation to support their efforts to recover the assets or income; or

(iv) The client is unable to access home equity in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350; and

(v) When, without LTC benefits, the client is unable to obtain:

(A) Medical care to the extent that his or her health or life is endangered; or

(B) Food, clothing, shelter or other basic necessities of life.

(b) Undue hardship can be approved for an interim period while the client is pursuing recovery of the assets or income.

(2) Undue hardship does not exist:

(a) When the transfer of asset penalty period or excess home equity provision inconveniences a client or restricts their lifestyle but does not seriously deprive him or her as defined in subsection (1)(a)(iii) of this section;

(b) When the resource is transferred to a person who is handling the financial affairs of the client; or

(c) When the resource is transferred to another person by the individual that handles the financial affairs of the client.

((~~(d)~~)) (3) Undue hardship may exist under subsection (2)(b) and (c) of this section if DSHS has found evidence of financial exploitation.

((~~(3)~~)) (4) How is an undue hardship waiver requested?

(a) An undue hardship waiver may be requested by:

(i) The client;

(ii) The client's spouse;

(iii) The client's authorized representative;

(iv) The client's power of attorney; or

(v) With the consent of the client or their guardian, a medical institution, as defined in WAC ((~~182-500-0005~~)) 182-500-0050, in which an institutionalized client resides.

(b) Request must:

(i) Be in writing;

(ii) State the reason for requesting the hardship waiver;

(iii) Be signed by the requestor and include the requestor's name, address and telephone number. If the request is being made on behalf of a client, then the client's name, address and telephone number must be included;

(iv) Be made within thirty days of the date of denial or termination of LTC services; and

(v) Returned to the originating address on the denial/termination letter.

((~~(4)~~)) (5) What if additional information is needed to determine a hardship waiver? ((~~(a)~~)) A written notice to the client is sent requesting additional information within fifteen days of the request for an undue hardship waiver. Additional time to provide the information can be requested by the client.

((~~(5)~~)) (6) What happens if my hardship waiver is approved?

(a) The department sends a notice within fifteen days of receiving all information needed to determine a hardship waiver. The approval notice specifies a time period the undue hardship waiver is approved.

(b) Any changes in a client's situation that led to the approval of a hardship must be reported to the department ((~~by the tenth of the month following~~)) within thirty days of the change per WAC ((~~388-418-0007~~)) 182-504-0110.

((~~(6)~~)) (7) What happens if my hardship waiver is denied?

(a) The department sends a denial notice within fifteen days of receiving the requested information. The letter will state the reason it was not approved.

(b) The denial notice will have instructions on how to request an administrative hearing. The department must receive an administrative hearing request within ninety days of the date of the adverse action or denial.

((~~(7)~~)) (8) What statute or rules govern administrative hearings? ((~~(a)~~)) An administrative hearing held under this section is governed by chapters 34.05 RCW and ((~~chapter 388-02~~)) 182-526 WAC and this section. If a provision in this section conflicts with a provision in chapter ((~~388-02~~)) 182-526 WAC, the provision in this section governs.

((~~(8)~~)) (9) Can the department revoke an approved undue hardship waiver? ((~~(a)~~)) The department may revoke approval of an undue hardship waiver if any of the following occur:

((~~(i)~~)) (a) A client, or his or her authorized representative, fails to provide timely information and/or resource verifications as it applies to the hardship waiver when requested by the department per WAC ((~~388-490-0005 and 388-418-0007~~)) 182-503-0050 and 182-504-0120 or 182-504-0125;

((~~(ii)~~)) (b) The lien or legal impediment that restricted access to home equity in excess of five hundred thousand dollars is removed; or

((~~(iii)~~)) (c) Circumstances for which the undue hardship was approved have changed.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1380 Determining a client's financial participation in the cost of care for long-term care (LTC) services. This rule describes how the department allocates income and excess resources when determining participation in the cost of care (the post-eligibility process). The department applies rules described in WAC ((~~388-513-1315~~)) 182-513-1315 to define which income and resources must be used in this process.

(1) For a client receiving institutional or hospice services in a medical institution, the department applies all subsections of this rule.

(2) For a client receiving waiver services at home or in an alternate living facility, the department applies only those subsections of this rule that are cited in the rules for those programs.

(3) For a client receiving hospice services at home, or in an alternate living facility, the department applies rules used for the community options program entry system (COPES) for hospice applicants with gross income under the medicaid special income level (SIL) (300% of the federal benefit rate (FBR)), if the client is not otherwise eligible for another non-institutional categorically needy medicaid program. (Note: For hospice applicants with income over the medicaid SIL, medically needy medicaid rules apply.)

(4) The department allocates nonexcluded income in the following order and the combined total of ((~~(4)~~))(a), (b), (c),

and (d) of this subsection cannot exceed the effective one-person medically needy income level (MNIL):

(a) A personal needs allowance (PNA) of:

(i) Seventy dollars for the following clients who live in a state veteran's home and receive a needs based veteran's pension in excess of ninety dollars:

(A) A veteran without a spouse or dependent child.

(B) A veteran's surviving spouse with no dependent children.

(ii) The difference between one hundred sixty dollars and the needs based veteran's pension amount for persons specified in ((~~subsection (4)~~))(a)(i) of this ((~~section~~)) subsection who receive a veteran's pension less than ninety dollars.

(iii) One hundred sixty dollars for a client living in a state veterans' home who does not receive a needs based veteran's pension;

(iv) Forty-one dollars and sixty-two cents for all clients in a medical institution receiving ABD cash assistance.

(v) For all other clients in a medical institution the PNA is fifty-seven dollars and twenty-eight cents.

(vi) Current PNA and long-term care standards can be found at ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(b) Mandatory federal, state, or local income taxes owed by the client.

(c) Wages for a client who:

(i) Is related to the supplemental security income (SSI) program as described in WAC 182-512-0050(1); and

(ii) Receives the wages as part of a department-approved training or rehabilitative program designed to prepare the client for a less restrictive placement. When determining this deduction employment expenses are not deducted.

(d) Guardianship fees and administrative costs including any attorney fees paid by the guardian, after June 15, 1998, only as allowed by chapter 388-79 WAC.

(5) The department allocates nonexcluded income after deducting amounts described in subsection (4) of this section in the following order:

(a) Current or back child support garnished or withheld from income according to a child support order in the month of the garnishment if it is for the current month:

(i) For the time period covered by the PNA; and

(ii) Is not counted as the dependent member's income when determining the family allocation amount.

(b) A monthly maintenance needs allowance for the community spouse not to exceed, effective January 1, 2008, two thousand six hundred ten dollars, unless a greater amount is allocated as described in subsection (7) of this section. The community spouse maintenance allowance may change each January based on the consumer price index. Starting January 1, 2008, and each year thereafter the community spouse maintenance allocation can be found in the long-term care standards chart at ((~~http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx. The monthly maintenance needs allowance:

(i) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st; and

(B) Excess shelter expenses as described under subsection (6) of this section.

(ii) Is reduced by the community spouse's gross countable income; and

(iii) Is allowed only to the extent the client's income is made available to the community spouse.

(c) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of the community spouse or institutionalized person who:

(i) Resides with the community spouse: ((~~(A)~~)) For each child, one hundred and fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income). This standard is called the community spouse (CS) and family maintenance standard and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(ii) Does not reside with the community spouse or institutionalized person, in an amount equal to the effective one-person MNIL for the number of dependent family members in the home less the dependent family member's income.

(iii) Child support received from a noncustodial parent is the child's income.

(d) Medical expenses incurred by the institutional client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(e) Maintenance of the home of a single institutionalized client or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the client is likely to return to the home within the six-month period; and

(iv) When social services staff documents the need for the income exemption.

(6) For the purposes of this section, "excess shelter expenses" means the actual expenses under ((~~subsection (6)~~))(b) of this subsection less the standard shelter allocation under ((~~subsection (6)~~))(a) of this subsection. For the purposes of this rule:

(a) The standard shelter allocation is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and is found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(b) Shelter expenses are the actual required maintenance expenses for the community spouse's principal residence for:

(i) Rent;

(ii) Mortgage;

(iii) Taxes and insurance;

(iv) Any maintenance care for a condominium or cooperative; and

(v) The food stamp standard utility allowance described in WAC 388-450-0195, provided the utilities are not included in the maintenance charges for a condominium or cooperative.

(7) The amount allocated to the community spouse may be greater than the amount in subsection (6)(b) of this section only when:

(a) A court enters an order against the client for the support of the community spouse; or

(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(8) A client who is admitted to a medical facility for ninety days or less and continues to receive full SSI benefits is not required to use the SSI income in the cost of care for medical services. Income allocations are allowed as described in this section from non-SSI income.

(9) Standards described in this section for long-term care can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1395 Determining eligibility for institutional or hospice services for individuals living in a medical institution under the medically needy (MN) program. This section describes how the department determines a client's eligibility for institutional or hospice services in a medical institution and for facility care only under the MN program. In addition, this section describes rules used by the department to determine whether a client approved for these benefits is also eligible for noninstitutional medical assistance in a medical institution under the MN program.

(1) To be eligible for institutional or hospice services under the MN program for individuals living in a medical institution, a client must meet the financial requirements described in subsection (5) of this section. In addition, a client must meet program requirements described in WAC ((~~388-513-1315~~)) 182-513-1315; and

(a) Be an SSI-related client with countable income as described in subsection (4)(a) of this section that is more than the special income level (SIL); or

(b) Be a child not described in ((~~subsection (1)~~))(a) of this subsection with countable income as described in subsection (4)(b) of this section that exceeds the categorically needy (CN) standard for the ((~~children's medical~~)) Washington apple health (WAH) for kids program.

(2) For an SSI-related client, excess resources are reduced by medical expenses as described in WAC ((~~388-513-1350~~)) 182-513-1350 to the resource standard for a single or married individual.

(3) The department determines a client's countable resources for institutional and hospice services under the MN programs as follows:

(a) For an SSI-related client, the department determines countable resources per WAC ((~~388-513-1350~~)) 182-513-1350.

(b) For a child not described in ((~~subsection (3)~~))(a) of this subsection, no determination of resource eligibility is required.

(4) The department determines a client's countable income for institutional and hospice services under the MN program as follows:

(a) For an SSI-related client, the department reduces available income as described in WAC ((~~388-513-1325 and 388-513-1330~~)) 182-513-1325 and 182-513-1330 by:

(i) Excluding income described in WAC ((~~388-513-1340~~)) 182-513-1340;

(ii) Disregarding income described in WAC ((~~388-513-1345~~)) 182-513-1345; and

(iii) Subtracting previously incurred medical expenses incurred by the client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(b) For a child not described in ((~~subsection (4)~~))(a) of this subsection, the department:

(i) Follows the income rules described in WAC 182-505-0210 for the ((~~children's medical~~)) WAH for kids program; and

(ii) Subtracts the medical expenses described in this subsection (((~~4~~))).

(5) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380, plus countable resources in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350(1), is less than the department-contracted rate times the number of days residing in the facility the client:

(a) Is eligible for institutional or hospice services in a medical institution, and medical assistance;

(b) Is approved for twelve months; and

(c) Participates income and excess resources toward the cost of care as described in WAC ((~~388-513-1380~~)) 182-513-1380.

(6) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380 plus countable resources in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350(1) is more than the department-contracted rate times the number of days residing in the facility the client:

(a) Is not eligible for payment of institutional services; and

(b) Eligibility is determined for medical assistance only as described in chapter 182-519 WAC.

(7) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380 is more than the department contracted nursing facility rate based on the number of days the client is in the facility, but less than the private nursing rate plus the amount of medical expenses not used to reduce excess resources the client:

(a) Is eligible for nursing facility care only and is approved for a three or six month based period as described in chapter 182-519 WAC. This does not include hospice in a nursing facility; and

(i) Pays the nursing home at the current state rate;

(ii) Participates in the cost of care as described in WAC ((~~388-513-1380~~)) 182-513-1380; and

(iii) Is not eligible for medical assistance or hospice services unless the requirements in subsection (6)(b) of this section is met.

(b) Is approved for medical assistance for a three or six month base period as described in chapter 182-519 WAC, if:

(i) No income and resources remain after the post eligibility treatment of income process described in WAC ((~~388-513-1380~~)) 182-513-1380.

(ii) Medicaid certification is approved beginning with the first day of the base period.

(c) Is approved for medical assistance for up to three or six months when they incur additional medical expenses that are equal to or more than excess income remaining after the post eligibility treatment of income process described in WAC ((~~388-513-1380~~)) 182-513-1380.

(i) This process is known as spenddown and is described in WAC 182-519-0100.

(ii) Medicaid certification is approved on the day the spenddown is met.

(8) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380, plus countable resources in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350 is more than the private nursing facility rate times the number of days in a month residing in the facility, the client:

(a) Is not eligible for payment of institutional services.

(b) Eligibility is determined for medical assistance only as described in chapter 182-519 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1400 Long-term care (LTC) partnership program (index). Under the long term care (LTC) partnership program, individuals who purchase qualified long-term care partnership insurance policies can apply for long-term care medicaid under special rules for determining financial eligibility. These special rules generally allow the individual to protect assets up to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for long-term care medicaid and will not subsequently be subject to estate recovery for medicaid and long-term care services paid. The Washington long term care partnership program is effective on December 1, 2011.

The following rules govern long-term care eligibility under the long-term care partnership program:

(1) WAC ((~~388-513-1405~~)) 182-513-1405 Definitions.

(2) WAC ((~~388-513-1410~~)) 182-513-1410 What qualifies as a LTC partnership policy?

(3) WAC ((~~388-513-1415~~)) 182-513-1415 What assets can't be protected under the LTC partnership provisions?

(4) WAC ((~~388-513-1420~~)) 182-513-1420 Who is eligible for asset protection under a LTC partnership policy?

(5) WAC ((~~388-513-1425~~)) 182-513-1425 When would I not qualify for LTC medicaid if I have a LTC partnership policy that does not have exhausted benefits?

(6) WAC ((~~388-513-1430~~)) 182-513-1430 What change of circumstances must I report when I have a LTC partnership policy paying a portion of my care?

(7) WAC ((~~388-513-1435~~)) 182-513-1435 Will Washington recognize a LTC partnership policy purchased in another state?

(8) WAC ((~~388-513-1440~~)) 182-513-1440 How many of my assets can be protected?

(9) WAC ((~~388-513-1445~~)) 182-513-1445 How do I designate a protected asset and what proof is required?

(10) WAC ((~~388-513-1450~~)) 182-513-1450 How does transfer of assets affect LTC partnership and medicaid eligibility?

(11) WAC ((~~388-513-1455~~)) 182-513-1455 If I have protected assets under a LTC partnership policy, what happens after my death?

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1405 Definitions. For purposes of this section, the following terms have the meanings given them. Additional definitions can be found at chapter ((~~388-500~~)) 182-500 WAC and WAC ((~~388-513-1301~~)) 182-513-1301.

"Issuer" means any entity that delivers, issues for delivery, or provides coverage to, a resident of Washington, any policy that claims to provide asset protection under the Washington long-term care partnership act, chapter 48.85 RCW. Issuer as used in this chapter specifically includes insurance companies, fraternal benefit societies, health care service contractors, and health maintenance organizations.

"Long-term care (LTC) insurance" means a policy described in Chapter 284-83 WAC.

"Long-term care services" means services received in a medical institution, or under a home and community based waiver authorized by home and community services (HCS) or ((~~division of~~)) developmental disabilities administration (DDA). Hospice services are considered long-term care services for the purposes of the long-term care partnership when medicaid eligibility is determined under chapter ((~~388-513 or 388-515~~)) 182-513 or 182-515 WAC.

"Protected assets" means assets that are designated as excluded or not taken into account upon determination of long-term care medicaid eligibility described in WAC ((~~388-513-1315~~)) 182-513-1315. The protected or excluded amount is up to the dollar amount of benefits that have been paid for long-term care services by the qualifying long-term care partnership policy on the medicaid applicant's or client's behalf. The assets are also protected or excluded for the purposes of estate recovery described in chapter ((~~388-527~~)) 182-527 WAC, in up to the amount of benefits paid by the qualifying policy for medical and long-term care services.

"Qualified long-term care insurance partnership" means an agreement between the Centers for Medicare and Medicaid Services (CMS), and the health care authority (HCA) which allows for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy that has been determined by the Washington state insurance commission to meet the requirements of section 1917 (b)(1)(c)(iii) of the act. These policies are described in chapter 284-83 WAC.

"Reciprocity Agreement" means an agreement between states approved under section 6021(b) of the Deficit Reduction Act of 2005, Public Law 109-171 (DRA) under which the states agree to provide the same asset protections for qualified partnership policies purchased by an individual while residing in another state and that state has a reciprocity agreement with the state of Washington.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1415 What assets can't be protected under the LTC partnership provisions? The following assets cannot be protected under a LTC partnership policy.

(1) Resources in a trust described in WAC ((~~388-561-0100~~)) 182-516-0100 (6) and (7).

(2) Annuity interests in which Washington must be named as a preferred remainder beneficiary as described in WAC ((~~388-561-0201~~)) 182-516-0201.

(3) Home equity in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350. Individuals who have excess home equity interest are not eligible for long-term care medicaid services.

(4) Any portion of the value of an asset that exceeds the dollar amount paid out by the LTC partnership policy.

(5) The unprotected value of any partially protected asset (an example would be the home) is subject to estate recovery described in chapter ((~~388-527~~)) 182-527 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1425 When would I not qualify for LTC medicaid if I have a LTC partnership policy in pay status? You are not eligible for LTC medicaid when the following applies:

(1) The income you have available to pay toward your cost of care described in WAC ((~~388-513-1380~~)) 182-513-1380, combined with the amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate at the institution.

(2) The income you have available to pay toward your cost of care on a home and community based (HCB) waiver described in chapter ((~~388-515~~)) 182-515 WAC, combined with the amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate in a home or residential setting.

(3) You fail to meet another applicable eligibility requirement for LTC medicaid.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1430 What change of circumstances must I report when I have a LTC partnership policy paying a portion of my care? You must report changes described in WAC ((~~388-418-0005~~)) 182-418-0005 plus the following:

(1) You must report and verify the value of the benefits that your issuer has paid on your behalf under the LTC partnership policy upon request by the department, and at each annual eligibility review.

(2) You must provide proof when you have exhausted the benefits under your LTC partnership policy.

(3) You must provide proof if you have given away or transferred assets that you have previously designated as protected. Although, there is no penalty for the transfer of protected assets once you have been approved for LTC medicaid, the value of transferred assets reduces the total dollar amount that is designated as protected and must be verified.

(4) You must provide proof if you have sold an asset or converted a protected asset into cash or another type of asset. You will need to make changes in the asset designation and verify the type of transaction and new value of the asset.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1450 How does transfer of assets affect LTC partnership and medicaid eligibility? (1) If you transfer an asset within the sixty months prior to the medicaid application or after medicaid eligibility has been established, we will evaluate the transfer based on WAC ((~~388-513-1363~~)) 182-513-1363 and determine if a penalty period applies unless:

(a) You have already been receiving institutional services;

(b) Your LTC partnership policy has paid toward institutional services for you; and

(c) The value of the transferred assets has been protected under the LTC partnership policy.

(2) The value of the transferred assets that exceed your LTC partnership protection will be evaluated for a transfer penalty.

(3) If you transfer assets whose values are protected, you lose that value as future protection unless all the transferred assets are returned.

(4) The value of your protected assets less the value of transferred assets equals the adjusted value of the assets you are able to protect.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1455 If I have protected assets under a LTC partnership policy, what happens after my death? Assets designated as protected prior to death are not subject to estate recovery for medical or LTC services paid on your behalf as described in chapter ((~~388-527~~)) 182-527 WAC as long as the following requirements are met:

(1) A personal representative who asserts an asset is protected under this section has the initial burden of providing proof as described in chapter ((~~388-527~~)) 182-527 WAC.

(2) A personal representative must provide verification from the LTC insurance company of the dollar amount paid out by the LTC partnership policy.

(3) If the LTC partnership policy paid out more than was previously designated, the personal representative has the right to assert that additional assets should be protected based on the increased protection. The personal representative must

use the DSHS LTCP asset designation form and send it to the office of financial recovery.

(4) The amount of protection available to you at death through the estate recovery process is decreased by the FMV of any protected assets that were transferred prior to death.

AMENDATORY SECTION (Amending WSR 13-03-096, filed 1/15/13, effective 1/15/13)

WAC 182-515-1500 Payment standard for persons in certain group living facilities. (1) A monthly grant payment of thirty-eight dollars and eighty-four cents will be made to eligible persons in ((~~the following facilities:~~

~~(a) Congregate care facilities (CCF);~~

~~(b) Adult residential rehabilitation centers/adult residential treatment facilities (AARC/ARTF); and~~

~~(c) Division of developmental disabilities (DDD) group home facilities~~)) alternative living facilities (ALF) described in WAC 182-513-1301.

(2) The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1506 What are the general eligibility requirements for home and community based (HCB) services authorized by home and community services (HCS) and hospice? (1) To be eligible for home and community based (HCB) services and hospice you must:

(a) Meet the program and age requirements for the specific program:

(i) COPES, per WAC 388-106-0310;

(ii) PACE, per WAC 388-106-0705;

(iii) WMIP waiver services, per WAC 388-106-0750;

(iv) New Freedom, per WAC 388-106-1410;

(v) Hospice, per chapter 182-551 WAC; or

(vi) Roads to community living (RCL), per WAC 388-106-0250, 388-106-0255 and 388-106-0260.

(b) Meet the disability criteria for the supplemental security income (SSI) program as described in WAC 182-512-0050;

(c) Require the level of care provided in a nursing facility described in WAC 388-106-0355;

(d) Be residing in a medical institution as defined in WAC 182-500-0050, or likely to be placed in one within the next thirty days without HCB services provided under one of the programs listed in ((~~subsection (1)~~))(a) of this subsection;

(e) Have attained institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320;

(f) Be determined in need of services and be approved for a plan of care as described in ((~~subsection (1)~~))(a) of this subsection;

(g) Be able to live at home with community support services and choose to remain at home, or live in a department-contracted:

(i) Enhanced adult residential care (EARC) facility;

(ii) Licensed adult family home (AFH); or

(iii) Assisted living (AL) facility.

(h) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC ((~~388-513-1363 through 388-513-1365~~)) 182-513-1363 through 182-513-1365;

(i) Not have a home with equity in excess of the requirements described in WAC ((~~388-513-1350~~)) 182-513-1350.

(2) Refer to WAC ((~~388-513-1315~~)) 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care services.

(3) Current income and resource standard charts are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.html~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1507 What are the financial requirements for home and community based (HCB) services authorized by home and community services (HCS) when you are eligible for a noninstitutional SSI-related categorically needy (CN) medicaid program? (1) You are eligible for medicaid under one of the following programs:

(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001 and chapter 182-510 WAC. This includes SSI clients under 1619B status;

(b) SSI-related CN medicaid described in WAC 182-512-0100 (2)(a) and (b);

(c) SSI-related health care for workers with disabilities program (HWD) described in WAC 182-511-1000. If you are receiving HWD, you are responsible to pay your HWD premium as described in WAC 182-511-1250((~~;~~

~~(d) Aged, blind, or disabled (ABD) cash assistance described in WAC 388-400-0060 and are receiving CN medicaid~~)).

(2) You do not have a penalty period of ineligibility for the transfer of an asset as described in WAC ((~~388-513-1363 through 388-513-1365~~)) 182-513-1363 through 182-513-1365. This does not apply to PACE or hospice services.

(3) You do not have a home with equity in excess of the requirements described in WAC ((~~388-513-1350~~)) 182-513-1350.

(4) You do not have to meet the initial eligibility income test of having gross income at or below the special income level (SIL).

(5) You do not pay (participate) toward the cost of your personal care services.

(6) If you live in a department contracted facility listed in WAC ((~~388-515-1506~~)) 182-515-1506 (1)(g), you pay room and board up to the ((~~ADSA~~)) aging and disability services (ADS) room and board standard. The ((~~ADSA~~)) ADS room and board standard is based on the federal benefit rate (FBR) minus the current personal needs allowance (PNA) for HCS CN waivers in an alternate living facility.

(a) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH) you keep a PNA of sixty-two dollars and seventy-nine cents and use your income to pay up to the room and board standard.

(b) If ((~~subsection (6)~~))(a) of this subsection applies and you are receiving HWD described in WAC 182-511-1000, you are responsible to pay your HWD premium as described

in WAC 182-511-1250, in addition to the ((~~ADSA~~)) ADS room and board standard.

(7) If you are eligible for aged, blind or disabled (ABD) cash assistance program described in WAC 388-400-0060 and receiving SSI-related CN medicaid, you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under WAC 388-478-0033;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ((~~ADSA~~)) ADS room and board standard; or

(c) When you live in an assisted living facility or enhanced adult residential center, you are only eligible to receive an ABD cash grant of thirty-eight dollars and eighty-four cents as described in WAC ((~~388-478-0045~~)) 182-515-1500, which you keep for your PNA.

(8) Current resource and income standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(9) Current PNA and ((~~ADSA~~)) ADS room and board standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1508 How does the department determine if you are financially eligible for home and community based (HCB) services authorized by home and community services (HCS) and hospice if you are not eligible for medicaid under a categorically needy (CN) program listed in WAC ((~~388-515-1507~~)) 182-515-1507(1)? (1) If you are not eligible for medicaid under a categorically needy (CN) program listed in WAC ((~~388-515-1507~~)) 182-515-1507(1), the department must determine your eligibility using institutional medicaid rules. This section explains how you may qualify using institutional medicaid rules.

(2) You must meet the general eligibility requirements described in WAC ((~~388-513-1315 and 388-515-1506~~)) 182-513-1315 and 182-515-1506.

(3) You must meet the following resource requirements:

(a) Resource limits described in WAC ((~~388-513-1350~~)) 182-513-1350.

(b) If you have resources over the standard allowed in WAC ((~~388-513-1350~~)) 182-513-1350, the department reduces resources over the standard by your unpaid medical expenses described in WAC ((~~388-513-1350~~)) 182-513-1350 if you verify these expenses.

(4) You must meet the following income requirements:

(a) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); or

(b) For home and community based (HCB) service programs authorized by HCS your gross nonexcluded income is:

(i) Above the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); and

(ii) Net income is no greater than the effective one-person medically needy income level (MNIL). Net income is calculated by reducing gross nonexcluded income by:

(A) Medically needy (MN) disregards found in WAC ((~~388-513-1345~~)) 182-513-1345; and

(B) The average monthly nursing facility state rate is five thousand six hundred and twenty six dollars. This rate will be updated annually starting October 1, 2012, and each year thereafter on October 1st. This standard will be updated annually in the long-term care standard section of the EAZ manual described at ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(5) The department follows the rules in WAC ((~~388-515-1325, 388-513-1330, and 388-513-1340~~)) 182-513-1325, 182-513-1330, and 182-513-1340 to determine available income and income exclusions.

(6) Current resource and income standards (including the SIL, MNIL and FBR) for long-term care are found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1509 How does the department determine how much of my income I must pay towards the cost of my care if I am only eligible for home and community based (HCB) services under WAC ((~~388-515-1508~~)) 182-515-1508? If you are only eligible for medicaid under WAC ((~~388-515-1508~~)) 182-515-1508, the department determines how much you must pay based upon the following:

(1) If you are single and living at home as defined in WAC 388-106-0010, you keep all your income up to the federal poverty level (FPL) for your personal needs allowance (PNA).

(2) If you are married living at home as defined in WAC 388-106-0010, you keep all your income up to the effective one-person medically needy income level (MNIL) for your PNA if your spouse lives at home with you. If you are married and living apart from your spouse, you're allowed to keep your income up to the FPL for your PNA.

(3) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH), you:

(a) Keep a PNA from your gross nonexcluded income. The PNA is sixty-two dollars and seventy-nine cents effective July 1, 2008; and

(b) Pay for your room and board up to the ((~~ADSA~~)) ADS room and board standard.

(4) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and ((~~any~~)) room and board ((~~deduction~~)) liability if residing in an alternate living facility is reduced by allowable deductions in the following order:

(a) If you are working, the department allows an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income((~~.~~));

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If the department allows this as deduction from your income, the department will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC ((~~388-513-1380~~)) 182-513-1380 (5)(b) unless a greater amount is allocated as described in ((~~subsection~~)) (e) of this ((~~section~~)) subsection. This amount:

(i) Is allowed only to the extent that your income is made available to your community spouse; and

(ii) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative, plus;

(V) The food assistance standard utility allowance (SUA) described in WAC 388-450-0195 provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;

(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(VII) Is reduced by your community spouse's gross countable income.

(iii) The amount allocated to the community spouse may be greater than the amount in ((~~subsection~~)) (d)(ii) of this subsection only when:

(A) There is a court order approving a higher amount for the support of your community spouse; or

(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent, or dependent sibling of your community or institutionalized spouse. The amount the department allows is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the effective one-person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowance in subsections (1), (2), and (3)(a) and (b) of this section; and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in ((~~subsection (4)~~))(a) of this subsection; and

(iii) Guardianship fees and administrative costs in ((~~subsection (4)~~))(b) of this subsection.

(5) You must pay your provider the combination of the room and board amount and the cost of personal care services after all allowable deductions.

(6) You may have to pay third party resources described in WAC 182-501-0200 in addition to the room and board and participation. The combination of room and board, participation, and third party resources is the total amount you must pay.

(7) Current income and resource standards for long-term care (including SIL, MNIL, FPL, FBR) are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(8) If you are in multiple living arrangements in a month (an example is a move from an adult family home to a home setting on HCB services), the department allows you the highest PNA available based on all the living arrangements and services you have in a month.

(9) Current PNA and ((~~ADSA~~)) ADS room and board standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1510 Division of developmental disabilities ((~~(DDD)~~)) administration (DDA) home and community based ((~~services~~)) (HCB) waivers. The four sections that follow describe the general and financial eligibility requirements for home and community based (HCB) waivers authorized by the ((~~division of~~)) developmental disabilities ((~~(DDD) home and community based services (HCBS) waivers~~)) administration (DDA).

(1) WAC ((388-515-1511)) 182-515-1511 describes the general eligibility requirements under the ((DDD HCBS)) DDA HCB waivers.

(2) WAC ((388-515-1512)) 182-515-1512 describes the financial requirements for the ((DDD)) DDA waivers if you are eligible for medicaid under the noninstitutional categorically needy program (CN).

(3) WAC ((388-515-1513)) 182-515-1513 describes the initial financial requirements for the ((DDD)) DDA HCB waivers if you are not eligible for medicaid under a categorically needy program (CN) listed in WAC ((388-515-1512)) 182-515-1512(1).

(4) WAC ((388-515-1514)) 182-515-1514 describes the post eligibility financial requirements for the ((DDD)) DDA waivers if you are not eligible for medicaid under a categorically needy program CN listed in WAC ((388-515-1512)) 182-515-1512(1).

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1511 What are the general eligibility requirements for waiver services under the ((division of)) developmental disabilities (((DDD))) administration (DDA) home and community based ((services (HCBS))) (HCB) waivers? (1) This section describes the general eligibility requirements for waiver services under the ((DDD)) DDA home and community based ((services (HCBS))) (HCB) waivers.

(2) The requirements for services for ((DDD HCBS)) DDA HCB waivers are described in chapter 388-845 WAC. The department establishes eligibility for ((DDD HCBS)) DDA HCB waivers. To be eligible, you must:

(a) Be an eligible client of the ((division of)) developmental disabilities (((DDD))) administration (DDA);

(b) Meet the disability criteria for the supplemental security income (SSI) program as described in WAC 182-512-0050;

(c) Require the level of care provided in an intermediate care facility for the intellectually disabled (ICF/ID);

(d) Have attained institutional status as described in WAC ((388-513-1320)) 182-513-1320;

(e) Be able to reside in the community and choose to do so as an alternative to living in an ICF/ID;

(f) Need waiver services as determined by your plan of care or individual support plan, and:

(i) Be able to live at home with waiver services; or

(ii) Live in a department contracted facility, which includes:

(A) A group home;

(B) Group training home;

(C) Child foster home, group home or staffed residential facility;

(D) Adult family home (AFH); or

(E) Adult residential care (ARC) facility.

(iii) Live in your own home with supported living services from a certified residential provider; or

(iv) Live in the home of a contracted companion home provider; and

(g) Be both medicaid eligible under the ((categorically needy program (CN))) HCB waiver eligibility described in WAC 182-515-1510 and be approved for services by ((the division of developmental disabilities)) DDA.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1512 What are the financial requirements for the ((DDD)) DDA waiver services if I am eligible for medicaid under the noninstitutional categorically needy program (CN)? (1) You ((automatically)) meet income and resource eligibility for ((DDD)) DDA waiver services if you are eligible for medicaid under a categorically needy program (CN) under one of the following programs:

(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001 and chapter 182-510 WAC. This includes SSI clients under 1619B status((. These clients have medicaid eligibility determined and maintained by the Social Security Administration));

(b) Health care for workers with disabilities (HWD) described in WAC 182-511-1000 through 182-511-1250;

(c) SSI-related (CN) medicaid described in WAC 182-512-0100 (2)(a) and (b) or meets the requirements in WAC 182-512-0880 and is (CN) eligible after the income disregards have been applied((;

(d) CN medicaid for a child as described in WAC 182-505-0210 (1), (2), (7) or (8); or

(e) Aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060)).

(2) If you are eligible for a CN medicaid program listed in subsection (1) ((above)) of this section, you do not have to pay (participate) toward the cost of your personal care and/or habilitation services. You are responsible to pay room and board if residing in a residential setting.

(3) If you are eligible for a CN medicaid program listed in subsection (1) ((above)) of this section, you do not need to meet the initial eligibility income test of gross income at or below the special income level (SIL), which is three hundred percent of the federal benefit rate (FBR).

(4) If you are eligible for a CN medicaid program listed in subsection (1) of this section, you pay up to the ((ADSA)) aging and disability services (ADS) room and board standard ((described in WAC 388-515-1507)) based on the medically needy income level (MNIL) minus the sixty-two dollars and seventy-nine cents personal needs allowance (PNA). Room and board and long-term care standards are located at ((http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml)): http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(((a))) If you live in an ARC, AFH or ((DDD)) DDA group home, you keep a personal needs allowance (PNA) and use your income to pay up to the ((ADSA)) ADS room and board standard. Effective January 1, 2009, the PNA is sixty-two dollars and seventy-nine cents.

(5) If you are eligible for ((a)) the premium based medicaid program ((such as)), health care for workers with disabilities (HWD), you must continue to pay the medicaid premium to remain eligible for that ((CN-P)) CN program and

pay the ADS room and board rate if residing in a residential ALF setting.

(6) If you are eligible for a CN medicaid program listed in subsection (1) of this section you are subject to equity interest in primary residence, annuity disclosure requirements and are not subject to a penalty period of ineligibility described in WAC 182-513-1315.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1513 How does the department determine if I am financially eligible for ((~~DDD~~)) DDA waiver service medical coverage if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1)? If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1), we must determine your eligibility using institutional medicaid rules. This section explains how you may qualify under this program. You may be required to pay towards the cost of your care if you are eligible under this program. The rules explaining how much you have to pay are listed in WAC ((~~388-515-1514~~)) 182-515-1514. To qualify, you must meet both the resource and income requirements.

(1) Resource limits are described in WAC ((~~388-513-1350~~)) 182-513-1350. If you have resources which are higher than the standard allowed, we may be able to reduce resources by your unpaid medical expenses described in WAC ((~~388-513-1350~~)) 182-513-1350.

(2) You are not subject to a transfer of asset penalty described in WAC ((~~388-513-1363 through 388-513-1365~~)) 182-513-1363 through 182-513-1365.

((~~(d)~~)) (3)Not have a home with equity in excess of the requirements described in WAC ((~~388-513-1350~~)) 182-513-1350.

((~~(3)~~)) (4) Must disclose to the state any interest the applicant or spouse has in an annuity and meeting annuity requirements described in chapter 182-516 WAC.

(5) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit level. The department follows the rules in WAC ((~~388-515-1325, 388-513-1330 and 388-513-1340~~)) 182-513-1325, 182-513-1330, and 182-513-1340 to determine available income and income exclusions.

((~~(4)~~)) (6) Refer to WAC ((~~388-513-1315~~)) 182-513-1315 for rules used to determine countable resources, income and eligibility standards for long-term care services.

((~~(5)~~)) (7) Current income and resources standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1514 How does the department determine how much of my income I must pay towards the cost of my ((~~DDD~~)) DDA waiver services if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1)? If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512 (1), the department determines how much you must pay based upon the following:

(1) If you are an SSI-related client living at home as defined in WAC 388-106-0010, you keep all your income up to the SIL (three hundred percent of the FBR) for your personal needs allowance (PNA).

(2) If you are an SSI-related client and you live in an ARC, AFH or ((~~DDD~~)) DDA group home, you:

(a) Keep a personal needs allowance (PNA) from your gross nonexcluded income. Effective January 1, 2009, the PNA is sixty-two dollars and seventy-nine cents; and

(b) Pay for your room and board up to the ((~~ADSA~~)) ADS room and board rate described in ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)): http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(3) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and any room and board deduction described in subsection (2) ((~~above~~)) of this section, is reduced by allowable deductions in the following order:

(a) If you are working, we allow an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;

(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If we allow this as deduction from your income, we will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC ((~~388-513-1380~~)) 182-513-1380 (5)(b) unless a greater amount is allocated as described in ((~~subsection~~)) (e) of this ((~~section~~)) subsection. This amount:

(i) Is allowed only to the extent that your income is made available to your community spouse; and

(ii) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative plus;

(V) The food assistance standard utility allowance (SUA) provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;

(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(VII) Is reduced by your community spouse's gross countable income.

(iii) May be greater than the amount in ((~~subsection~~)) (d)(ii) of this subsection only when:

(A) There is a court order approving a higher amount for the support of your community spouse; or

(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of your community or institutionalized spouse. The amount we allow is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the effective one-person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowances in subsection (1) of this section for in home or subsection (2)(a) of this section in a residential setting; and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in ((~~subsection (3)~~))(a) of this subsection; and

(iii) Guardianship fees and administrative costs in ((~~subsection (3)~~))(b) of this subsection.

(4) If you are eligible for aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060 and CN medicaid based on ABD criteria, you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under the ABD cash program;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ((~~ADSA~~)) ADS room and board standard described in ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)): http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; or

(c) When you live in an ARC or ((~~DDD~~)) DDA group home, you are only eligible to receive a cash grant of thirty-eight dollars and eighty-four cents which you keep for your PNA.

(5) You may have to pay third party resources (TPR) described in WAC 182-501-0200 in addition to room and board and the cost of personal care and/or habilitation services (participation) after all allowable deductions have been considered is called your total responsibility. You pay this amount to the ARC, AFH or ((~~DDD~~)) DDA group home provider.

WSR 14-10-037
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed April 29, 2014, 3:26 p.m., effective April 29, 2014, 3:26 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: This rule creates a habilitative services section (WAC 182-545-400) as required under the Patient Protection and Affordable Care Act. WAC 182-545-900 and 182-551-2110 must be updated to reflect the creation of habilitative services.

Citation of Existing Rules Affected by this Order: Amending WAC 182-545-900 and 182-551-2110.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: Patient Protection and Affordable Care Act (Public Law 111-148).

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

Reasons for this Finding: This rule is necessary to create a habilitative services section by January 1, 2014, to timely comply with service requirements in the Patient Protection and Affordable Care Act, and to update related sections to reflect the creation of habilitative services.

Following the adoption of the first emergency filing (WSR 14-02-082), the agency filed CR-101 (WSR 14-02-089) to begin the permanent rule-making process. The agency is currently working with stakeholders to develop the permanent rule and expects to complete the permanent rule-making process in mid-2014.

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

Date Adopted: April 29, 2014.

Kevin M. Sullivan
Rules Coordinator

NEW SECTION

WAC 182-545-400 Habilitative services. (1) Habilitative services are medically necessary services to assist the client in partially or fully attaining, learning, maintaining, or improving developmental-age appropriate skills that were not fully acquired as a result of a congenital, genetic, or early acquired health condition, and are required to maximize, to the extent practical, the client's ability to function in his or her environment.

(2) Eligibility is limited to clients who are enrolled in the alternative benefits plan defined in WAC 182-501-0060 and who have a diagnosis which is one of the qualifying conditions listed in the medicaid provider guide for habilitative services. Clients enrolled in an agency-contracted managed care organization (MCO) must arrange for habilitative services through their MCO.

(3) The following licensed health professionals may enroll with the agency to provide habilitative services within their scope of practice to eligible clients:

(a) Physiatrists;

(b) Occupational therapists;

(c) Occupational therapy assistants supervised by a licensed occupational therapist;

(d) Physical therapists;

(e) Physical therapist assistants supervised by a licensed physical therapist;

(f) Speech-language pathologists who have been granted a certificate of clinical competence by the American Speech, Hearing and Language Association; and

(g) Speech-language pathologists who have completed the equivalent educational and work experience necessary for such a certificate.

(4) The agency pays for habilitative services that are:

(a) Covered within the scope of the client's alternative benefit plan under WAC 182-501-0060;

(b) Medically necessary;

(c) Within currently accepted standards of evidence-based medical practice;

(d) Ordered by a physician, physician assistant, or an advanced registered nurse practitioner;

(e) Begun within thirty calendar days of the date ordered;

(f) Provided by one of the health professionals listed in subsection (3) of this section;

(g) Authorized under this chapter, chapters 182-501 and 182-502 WAC, and the agency's published medicaid provider guides and published provider notices;

(h) Billed under this chapter, chapters 182-501 and 182-502 WAC, and the agency's published medicaid provider guides and published provider notices; and

(i) Provided as part of a habilitative treatment program:

(i) In an office or outpatient hospital setting;

(ii) In the home, by a home health agency as described in chapter 182-551 WAC; or

(iii) In a neurodevelopmental center, as described in WAC 182-545-900.

(5) For billing purposes under this section:

(a) Each fifteen minutes of timed procedure code equals one unit.

(b) Each nontimed procedure code equals one unit, regardless of how long the procedure takes.

(c) Duplicate services for habilitative services are not allowed for the same client when both providers are performing the same or similar procedure on the same day.

(d) The agency does not reimburse a health care professional for habilitative services performed in an outpatient hospital setting when the health care professional is not employed by the hospital. The hospital must bill the agency for the services.

(6) For eligible clients twenty years of age and younger, the agency covers unlimited outpatient habilitative services.

(7) For eligible clients twenty-one years of age and older, the agency covers limited outpatient habilitative services that include an ongoing management plan for the client or the client's caregiver to support continued client progress. The agency limits outpatient habilitative services as follows:

(a) Occupational therapy, per client, per year:

(i) Without authorization:

(A) One occupational therapy evaluation;

(B) One occupational therapy reevaluation at time of discharge; and

(C) Twenty-four units of occupational therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to twenty-four additional units of occupational therapy may be available to continue treatment when the client's diagnosis is cerebral palsy and the therapy is required as part of a botulinum toxin injection protocol when botulinum toxin has been authorized by the agency.

(b) Physical therapy, per client, per year:

(i) Without authorization:

(A) One physical therapy evaluation;

(B) One physical therapy reevaluation at time of discharge; and

(C) Twenty-four units of physical therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to twenty-four additional units of occupational therapy may be available to continue treatment when the client's diagnosis is cerebral palsy and the therapy is required as part of a botulinum toxin injection protocol when botulinum toxin has been authorized by the agency.

(c) Speech therapy, per client, per year:

(i) Without authorization:

(A) One speech language pathology evaluation;

(B) One speech language pathology reevaluation at the time of discharge; and

(C) Six units of speech therapy (which equals approximately six hours).

(ii) With expedited prior authorization, up to twenty-four additional units of occupational therapy may be available to continue treatment when:

(A) The client's diagnosis is cerebral palsy and the therapy is required as part of a botulinum toxin injection protocol when botulinum toxin has been authorized by the agency; or

(B) The client has a speech deficit caused by the qualifying condition which requires a speech generating device.

(d) Two durable medical equipment needs assessments, per client, per year. The agency covers devices and other durable medical equipment for habilitative purposes to treat qualified conditions under chapter 182-543 WAC.

(e) Two program units of orthotics management and training of upper and lower extremities, per client, per day.

(f) Two program units for checkout for prosthetic or orthotic use, per established client, per year.

(g) One muscle testing procedure, per client, per day.

(h) One wheelchair-needs assessment, per client, per year.

(8) The agency evaluates requests for outpatient habilitative services that exceed the limitations in this section under WAC 182-501-0169. Prior authorization is required for additional units when:

(a) The criteria for expedited prior authorization do not apply;

(b) The number of available units under the EPA have been used and services are requested beyond the limits; or

(c) The provider requests it as a medically necessary service.

(9) The following services are not covered:

(a) Day habilitation services designed to provide training, structured activities, and specialized services to adults;

(b) Chore services to assist basic needs;

(c) Vocational services;

(d) Custodial services;

(e) Respite;

(f) Recreational care;

(g) Residential treatment;

(h) Social services; and

(i) Educational services of any kind.

AMENDATORY SECTION (Amending WSR 11-21-066, filed 10/17/11, effective 11/17/11)

WAC 182-545-900 Neurodevelopmental centers. (1) This section describes:

(a) Neurodevelopmental centers that may be reimbursed by the agency;

(b) Clients who may receive covered services at a neurodevelopmental center; and

(c) Covered services that may be provided at and reimbursed to a neurodevelopmental center.

(2) In order to provide and be reimbursed for the services listed in subsection (4) of this section, the agency requires a neurodevelopmental center provider to do all of the following:

(a) Be contracted with the department of health (DOH) as a neurodevelopmental center;

(b) Provide documentation of the DOH contract to the agency; and

(c) Have an approved core provider agreement with the agency.

(3) Clients, twenty years of age or younger, may receive outpatient rehabilitation and habilitative services (occupational therapy, physical therapy, and speech therapy) in agency-approved neurodevelopmental centers.

(4) The agency reimburses neurodevelopmental centers for providing the following services to clients:

(a) Outpatient rehabilitation and habilitative services as described in chapter 182-545 WAC ((~~182-545-200~~)); and

(b) Specific pediatric evaluations and team conferences that are:

(i) Attended by the center's medical director; and

(ii) Identified as payable in the agency's billing instructions.

(5) In order to be reimbursed, neurodevelopmental centers must meet the agency's billing requirements in WAC 182-502-0020, 182-502-0100 and 182-502-0150.

AMENDATORY SECTION (Amending WSR 11-21-066, filed 10/17/11, effective 11/17/11)

WAC 182-551-2110 Home health services—Covered specialized therapy. The agency covers specialized therapy (((~~also known as outpatient rehabilitation~~))), including outpatient rehabilitation and habilitative services, in an in-home setting by a home health agency. ((~~See chapter 182-545 WAC outpatient rehabilitation for coverage and limitations.~~)) Outpatient rehabilitation and habilitative services are described in chapter 182-545 WAC. Specialized therapy is defined in WAC 182-551-2010.

WSR 14-10-038
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed April 29, 2014, 3:28 p.m., effective April 30, 2014]

Effective Date of Rule: April 30, 2014.

Purpose: The health care authority must implement federal requirements under the Affordable Care Act and changes under the legislative session of 2013 concerning eligibility for TAKE CHARGE in accordance with the federal waiver amendments.

Citation of Existing Rules Affected by this Order: Amending WAC 182-532-720.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: Patient Protection and Affordable Care Act (Public Law 111-148), RCW 41.05.021, and 3ESSB 5034, section 213(29), chapter 4, Laws of 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.

Reasons for this Finding: This rule is necessary to update eligibility criteria for TAKE CHARGE to comply with changes under the legislative session of 2013 and in federal law that take effect January 1, 2014.

Following the adoption of the first emergency filing (WSR 14-02-079), the agency filed CR-101 (WSR 14-02-088) to begin the permanent rule-making process. The

agency is currently working with stakeholders to develop the permanent rule and expects to complete the permanent rule-making process in 2014.

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

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

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

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

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

Date Adopted: April 29, 2014.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-16-008, filed 7/25/13, effective 9/1/13)

WAC 182-532-720 TAKE CHARGE program—Eligibility. (1) The TAKE CHARGE program is for men and women. To be eligible for the TAKE CHARGE program, an applicant must:

(a) Be a United States citizen, U.S. National, or "qualified alien" as described in WAC 182-503-0530, and give proof of citizenship or qualified alien status and identity upon request from the medicaid agency;

(b) Provide a valid Social Security number (SSN);

(c) Be a resident of the state of Washington as described in WAC 388-468-0005;

(d) Have an income at or below two hundred ((~~fifty~~)) sixty percent of the federal poverty level as described in WAC 182-505-0100;

(e) Need family planning services;

(f) Have applied for and been denied full-scope medicaid coverage by the agency;

(g) Apply voluntarily for family planning services with a TAKE CHARGE provider; and

((~~(g)~~)) (h) Not be covered currently through another medical assistance program for family planning.

(2) ((~~A client~~)) An applicant who is pregnant or sterilized is not eligible for TAKE CHARGE.

(3) An applicant who has concurrent coverage under a creditable health insurance policy is not eligible for TAKE CHARGE unless the applicant is a minor seeking confidential services.

(4) A client is authorized for TAKE CHARGE coverage for one year from the date the medicaid agency determines eligibility. Upon reapplication for TAKE CHARGE by the client, the medicaid agency may renew the coverage for an additional period of up to one year, or for the duration of the waiver, whichever is shorter.

WSR 14-10-039
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed April 29, 2014, 3:30 p.m., effective April 29, 2014, 3:30 p.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The health care authority (HCA) is amending the estate recovery policy for medicaid in order to eliminate a barrier to applying for health care coverage under the Affordable Care Act. Currently, state regulation mandates the cost of all medicaid services be subject to state recovery. A client's estate will no longer be liable for the cost of medicaid services received by the client, other than long-term care services.

Citation of Existing Rules Affected by this Order: Amending WAC 182-527-2742.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: Patient Protection and Affordable Care Act (Public Law 111-148).

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

Reasons for this Finding: This rule is necessary to remove a financial barrier to applying for health care coverage under the Affordable Care Act. For the Affordable Care Act to be implemented successfully, it is important to get as many people as possible to apply for health care coverage through the health benefit exchange.

Following the adoption of the first emergency filing (WSR 14-02-076), the agency filed CR-101 (WSR 14-02-065) to begin the permanent rule-making process. The agency is currently working with external stakeholders to develop the permanent rule and expects to complete the permanent rule-making process in mid-2014.

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

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

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

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

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

Date Adopted: April 29, 2014.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-19-038, filed 9/11/13, effective 10/12/13)

WAC 182-527-2742 Services subject to recovery. The medicaid agency or its designee considers the medical services the client received and the dates when the services were provided to the client, in order to determine whether the client's estate is liable for the cost of medical services provided. Subsection (1) of this section covers liability for medicaid services, subsection (2) of this section covers liability for state-only funded long-term care services, and subsection (3) of this section covers liability for all other state-funded services. An estate can be liable under any of these subsections.

(1) The client's estate is liable for:

(a) All medicaid services provided from July 26, 1987, through June 30, 1994;

(b) The following medicaid services provided after June 30, 1994 and before July 1, 1995:

(i) Nursing facility services;

(ii) Home and community-based services; and

(iii) Hospital and prescription drug services provided to a client while receiving nursing facility services or home and community-based services.

(c) The following medicaid services provided after June 30, 1995, and before June 1, 2004:

(i) Nursing facility services;

(ii) Home and community-based services;

(iii) Adult day health;

(iv) Medicaid personal care;

(v) Private duty nursing administered by the aging and long-term support administration of the department of social and health services (DSHS); and

(vi) Hospital and prescription drug services provided to a client while receiving services described under (c)(i), (ii), (iii), (iv), or (v) of this subsection.

(d) The following services provided on and after June 1, 2004, through December 31, 2009:

(i) All medicaid services, including those services described in subsection (c) of this section;

(ii) Medicare savings programs services for individuals also receiving medicaid;

(iii) Medicare premiums only for individuals also receiving medicaid; and

(iv) Premium payments to managed care organizations.

(e) The following services provided on or after January 1, 2010, through December 31, 2013:

(i) All medicaid services except those ((~~defined under~~)) described in (d)(ii) and (iii) of this subsection;

(ii) All institutional medicaid services described in (c) of this subsection ((~~(c) of this section~~));

(iii) Premium payments to managed care organizations; and

(iv) The client's proportional share of the state's monthly contribution to the centers for medicare and medicaid services (CMS) to defray the costs for outpatient prescription drug coverage provided to a person who is eligible for medicare Part D and medicaid.

(f) The following services provided after December 31, 2013:

(i) Nursing facility services, including those provided in a developmental disabilities administration (DDA) residential habilitation center (RHC);

(ii) Home and community-based services authorized by the aging and long-term supports administration (ALTSA) or DDA, as follows:

(A) Community options program entry system (COPES);

(B) New Freedom consumer directed services (NFCDS);

(C) Basic Plus waiver;

(D) CORE waiver;

(E) Community protection waiver;

(F) Children's intensive in-home behavioral support (CIIBS) waiver;

(iii) The portion of the Washington apple health (WAH) managed care premium used to pay for long-term care services under the program of all-inclusive care for the elderly (PACE) authorized by ALTSA;

(iv) The portion of the WAH managed care premium used to pay for long-term care services under the Washington medicaid integration partnership (WMIP) authorized by ALTSA or DDA;

(v) Roads to community living (RCL) demonstration project;

(vi) Personal care services funded under Title 19 or 21;

(vii) Private duty nursing administered by ALTSA or DDA;

(viii) Intermediate care facility for individuals with intellectual disabilities (ICF/ID) services provided in either a private community setting or in an RHC;

(ix) Hospital and prescription drug services provided to a client while receiving services under subsection (1)(f)(i) through (viii) of this section;

(x) Client's proportional share of the state's monthly contribution to the Centers for Medicare and Medicaid Services (CMS) to defray the costs for outpatient prescription drug coverage provided to a person who is eligible for medicare Part D and medicaid.

(2) The client's estate is liable for all state-only funded long-term care services (excluding the services listed in subsection (3)(a) through (d) of this section) and related hospital and prescription drug services provided to:

(a) Clients of the home and community services division of DSHS on and after July 1, 1995; and

(b) Clients of the developmental disabilities administration of DSHS on and after June 1, 2004.

(3) The client's estate is liable for all state-funded services provided regardless of the age of the client at the time the services were provided, with the following exceptions:

(a) State-only funded adult protective services (APS);

(b) Supplemental security payment (SSP) authorized by DDA;

(c) Offender reentry community safety program (ORCSP); and

(d) Volunteer chore services.

WSR 14-10-041
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 14-97—Filed April 29, 2014, 4:28 p.m., effective May 1, 2014]

Effective Date of Rule: May 1, 2014.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-07100E.

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

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

Reasons for this Finding: Sea cucumber harvest quota shares have been taken in all areas. 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 0, 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: April 29, 2014.

Joe Stohr
for Philip Anderson
Director

REPEALER

The following section of the Washington Administrative Code is repealed effective May 1, 2014:

WAC 220-52-07100E Sea cucumbers. (14-94)

WSR 14-10-042
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed April 30, 2014, 7:14 a.m., effective April 30, 2014, 7:14 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: These amendments are already in effect via emergency rule making filed on December 31, 2013, as WSR 14-02-096. Amendments in Title 388 WAC remove medical references, support the creation of the housing and essential needs (HEN) referral program and remove references to the Alcohol and Drug Addiction Treatment and Support Act (ADATSA). 2E2SHB 1738, Laws of 2011, designated the health care authority (HCA) as the single state agency responsible for the administration and supervision of Washington's medical assistance programs. HCA recodified medical assistance program rules to Title 182 WAC. Accordingly, the department must eliminate corresponding rules and medical references under Title 388 WAC. Amendments support the creation of the new HEN referral program created under SHB 2069 (2013 legislative session). Amendments also remove references related to ADATSA. The legislature did not appropriate any funds for ADATSA in the new biennium budget. ADATSA related medical care services recipients are medicaid eligible under the Affordable Care Act (ACA) starting January 1, 2014. Additional amendments spell out the acronym, ABD, identifying it as the aged, blind or disabled program.

Citation of Existing Rules Affected by this Order: Amending WAC 388-406-0005, 388-406-0035, 388-406-0045, 388-406-0055, 388-418-0005, 388-424-0010, 388-424-0015, 388-436-0030, 388-450-0015, 388-450-0025, 388-450-0040, 388-450-0156, 388-450-0162, 388-450-0170, 388-472-0005, and 388-473-0010.

Statutory Authority for Adoption: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.100, 74.04.770, 74.62.030.

Other Authority: 2E2SHB 1738, chapter 15, Laws of 2011; SHB 2069; and RCW 41.05.021, 74.04.050, 74.08.-090, 74.09.035, 74.09.530, and the 2013 biennial budget.

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: Amendments remove medical references. More specifically, 2E2SHB 1738, Laws of 2011, designated HCA as the single state agency responsible for the administration and supervision of Washington's medical assistance programs. DSHS worked with HCA to repeal medical assistance program rules under Title 388 WAC in support of HCA's efforts to recodify medical assistance program rules under Title 182 WAC. HCA recodified medical assistance program rules at Title 182 WAC, effective October 1, 2013. Accordingly, the department must eliminate corresponding rules under Title 388 WAC. Amendments remove references to the ADATSA program. The legislature did not appropriate any funds for ADATSA in the new biennium budget. ADATSA-related medical care services recipient[s] will be medicaid eligible under the ACA starting January 1, 2014. Amendments support the creation of the new HEN referral program created under SHB 2069, which was signed by the governor on June 30, 2013.

The department is in the process of proposing amendments to these rules permanently via the regular rule-making process. Amendments to WAC 388-406-0055 were proposed in WSR 14-07-101 and are scheduled for a public hearing on April 22, 2014. The department is currently working on proposing amendments to the other WACs.

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 16, 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 16, Repealed 0.

Date Adopted: April 21, 2014.

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 14-11 issue of the Register.

WSR 14-10-043
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)
[Filed April 30, 2014, 7:20 a.m., effective May 1, 2014]

Effective Date of Rule: May 1, 2014.

Purpose: The department is amending WAC 388-436-0002 If my family has an emergency, can I get help from DSHS to get or keep our housing utilities?, to change the maximum allowable additional requirements for emergent needs (AREN) payment from $750.00 in a lifetime to $750.00 in a twelve month period.

Citation of Existing Rules Affected by this Order: Amending WAC 388-436-0002.

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

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

Reasons for this Finding: This amendment updates WAC 388-436-0002 to increase the amount of AREN payments that can be issued from a $750.00 maximum lifetime limit to a $750.00 maximum in a twelve month period. This population is, by definition, in need of funds to preserve their health, safety, or general welfare. This rule change is also supported by the 2014 supplemental budget that passed the 63rd legislature on March 13, 2014.

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: April 21, 2014.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-02-047, filed 12/30/11, effective 2/1/12)

WAC 388-436-0002 If my family has an emergency, can I get help from DSHS to get or keep our housing or utilities? DSHS has a program called additional requirements for emergent needs (AREN). If your family has an emergency and you need assistance to get or keep safe housing or utilities, you may be eligible. The special AREN payment is in addition to the regular monthly cash grant your family may already get.

(1) To get AREN, you must:

(a) Be eligible for temporary assistance for needy families (TANF), state family assistance (SFA), or refugee cash assistance (RCA);

(b) Have an emergency housing or utility need;

(c) Have a good reason that you do not have enough money to pay your housing or utility costs; and

(d) Have not previously received the AREN maximum ((~~lifetime~~)) limit of seven hundred fifty dollars in a 12-month period. We will count all AREN payments received ((~~since April 2001~~)) in a 12-month period by any adult in your TANF assistance unit, for any assistance unit, when we calculate your ((~~lifetime~~)) AREN limit.

(2) To get AREN, you must be eligible for TANF, SFA, or RCA. This means you must:

(a) Get benefits through TANF, SFA, or RCA. For RCA you must also be pregnant or have an eligible child; or

(b) Apply for TANF, SFA, and RCA, and meet all eligibility criteria including:

(i) The maximum earned income limit under WAC 388-478-0035;

(ii) The requirement that your unearned income not exceed the grant payment standard;

(iii) The requirement that your countable income as defined under WAC 388-450-0162 must be below the payment standard in WAC 388-478-0020 when you have both earned income and unearned income;

(iv) The resource limits under chapter 388-470 WAC;

(v) The program summary rules for either TANF (WAC 388-400-0005); SFA (WAC 388-400-0010); or RCA (WAC 388-400-0030); and

(vi) The requirement that you must be pregnant or have an eligible child.

(3) If you do not get or do not want to get TANF, SFA or RCA, you cannot get AREN to help with housing or utility costs. We will look to see if you are eligible for diversion cash assistance (DCA) under WAC 388-432-0005.

(4) To get AREN, you must have an emergency housing or utility need. You may get AREN to help pay to:

(a) Prevent eviction or foreclosure;

(b) Get housing if you are homeless or need to leave your home because of domestic violence;

(c) Hook up or prevent a shut off of utilities related to your health and safety. We consider the following utilities to be needed for health and safety:

(i) Electricity or fuel for heating, lighting, or cooking;

(ii) Water;

(iii) Sewer; and

(iv) Basic local telephone service if it is necessary for your basic health and safety. If you receive TANF or SFA, the Washington telephone assistance program (WTAP) may be used to help you pay for basic local telephone service.

(d) Repair damage or defect to your home when it causes a risk to your health or safety:

(i) If you own the home, we may approve AREN for the least expensive method of ending the risk to your health or safety;

(ii) If you do not own the home, you must ask the landlord in writing to fix the damage according to the Residential Landlord-Tenant Act at chapter 59.18 RCW. If the landlord refuses to fix the damage or defect, we may pay for the repair or pay to move you to a different place whichever cost is lower.

(e) If you receive TANF or SFA, WorkFirst support services under WAC 388-310-0800 may be used to help you relocate to new housing to get a job, keep a job, or participate in WorkFirst activities. Nonhousing expenses that are not covered under AREN may be paid under WorkFirst support services. This includes expenses such as car repair, diapers, or clothing.

(5) To get AREN, you must have a good reason for not having enough money to pay for your housing or utility costs. You must prove that you:

(a) Did not have money available that you normally use to pay your rent and utilities due to an emergency situation that reduced your income (such as a long-term illness or injury);

(b) Had to use your money to pay for necessary or emergency expenses. Examples of necessary or emergency expenses include:

(i) Basic health and safety needs for shelter, food and clothing;

(ii) Medical care;

(iii) Dental care needed to get a job or because of pain;

(iv) Emergency child care;

(v) Emergency expenses due to a natural disaster, accident, or injury; and

(vi) Other reasonable and necessary expenses.

(c) Are currently homeless; or

(d) Had your family's cash grant reduced or suspended when we budgeted your expected income for the month, but the income will not be available to pay for the need when the payment is due. You must make attempts to negotiate later payments with your landlord or utility company before you can get AREN.

(6) In addition to having a good reason for not having enough money to pay for your costs, you must also explain how you will afford to pay for the on-going need in the future. We may deny AREN if your expenses exceed your income (if you are living beyond your means). We may approve AREN to help you get into housing you can afford.

(7) If you meet the above requirements, we decide the amount we will pay based on the following criteria.

(a) AREN payments may be made up to a maximum of seven hundred fifty dollars in a ((~~lifetime~~)) in a 12-month period.

(b) The number of AREN payments you can receive is not limited, as long as the total amount received by all adults in the assistance unit for any assistance unit, does not exceed the seven hundred fifty dollar ((~~lifetime~~)) limit in a 12-month period. If you or another adult in your assistance unit have already received the ((~~lifetime~~)) limit, you may not be eligible to receive additional payments.

(c) We will determine if any adult TANF/SFA recipient living in your household has already received the AREN ((~~lifetime~~)) limit.

(d) We have the discretion to approve an AREN payment above the seven hundred fifty dollar ((~~lifetime~~)) limit when your health and safety are in imminent danger.

(e) The amount of AREN is in addition to the amount of your monthly TANF, SFA, or RCA cash grant.

(f) We will decide the lowest amount we must pay to end your housing or utility emergency. We will contact your landlord, utility company, or other vendor for information to make this decision. We may take any of the following steps when deciding the lowest amount to pay:

(i) We may ask you to arrange a payment plan with your landlord or utility company. This could include us making a partial payment, and you setting up a plan for you to repay the remaining amount you owe over a period of time.

(ii) We may have you use some of the money you have available in cash, checking, or savings to help pay for the expense. We will look at the money you have available as well as your bills when we decide how much we will pay.

(iii) We may consider income that is excluded or disregarded for cash assistance benefit calculations, such as SSI, as available to meet your emergency housing need.

(iv) We may consider money other individuals such as family or friends voluntarily give you. We will not count loans of money that you must repay to friends or family members.

(v) We may consider money from a nonneedy caretaker relative that lives in the home.

(vi) We may look at what other community resources you currently have to help you with your need.

(g) The seven hundred fifty dollar ((~~lifetime~~)) limit applies to the following people even if they leave the assistance unit:

(i) Adults; and

(ii) Minor parents that get AREN when no adults are in the assistance unit.

(8) We pay AREN directly to the landlord, mortgage company, utility, or other vendor.

(9) We may assign you a protective payee for your monthly grant under WAC 388-460-0020.

WSR 14-10-048
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed May 1, 2014, 8:45 a.m., effective May 1, 2014, 8:45 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: **Medicaid expansion rules - Phase 5**, repealing WAC sections related to the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) and psychiatric indigent inpatient (PII) programs which are ending December 31, 2013; also striking references to ADATSA and PII in WAC sections that are being retained; correcting an income threshold percentage; and other miscellaneous changes related to implementation of the Affordable Care Act.

Citation of Existing Rules Affected by this Order: Repealing WAC 182-503-532, 182-503-555, 182-503-560, 182-504-0030, 182-504-0040, 182-504-0100, 182-506-0020, 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, 182-508-0300, 182-508-0305, 182-508-0310, 182-508-0315, 182-508-0320, 182-508-0325, 182-508-0330, 182-508-0335, 182-508-0340, 182-508-0345, 182-508-0350, 182-508-0355, 182-508-0360, 182-508-0365, 182-508-0370, 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, 182-509-0210, 182-509-0225, 182-523-0110, 182-523-0120 and 182-550-5125; and amending WAC 182-505-0120, 182-508-0005, 182-508-0150, 182-523-0100, 182-523-0130, 182-534-0100, 182-546-5550, 182-550-1200, 182-550-1700, 182-550-2521, 182-550-2650, and 182-550-6700.

Statutory Authority for Adoption: RCW 41.05.021; 3ESSB 5034 (sections 201, 204, 208, and 213, chapter 4, Laws of 2013); Patient Protection and Affordable Care Act (Public Law 111-148); 42 C.F.R. § 431, 435, and 457; and 45 C.F.R. § 155.

Under RCW 34.05.350 the agency for good cause finds that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal years 2009, 2010, 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: This rule-making action continues the emergency rules that have been in place since January 1, 2014, under WSR 14-02-090. These rules are necessary to meet the requirements in 3ESSB 5034, chapter 4, Laws of 2013, 63rd legislature.

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 12, Repealed 66.

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 12, Repealed 66.

Date Adopted: May 1, 2014.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-19-051, filed 9/13/12, effective 10/14/12)

WAC 182-508-0005 Eligibility for Washington apple health medical care services. (1) ((~~An individual~~)) A person is eligible for state-funded Washington apple health (WAH) medical care services (MCS) ((~~benefits~~)) coverage to the extent of available funds if the ((~~individual~~)) person is:

(a) ((~~Completes an interview with the agency or its designee;~~

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

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

~~(d) 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;~~

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

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

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

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

~~(i) 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 rule without good cause.~~

~~(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) Refuses or fails to follow a Social Security Administration (SSA) program rule or application requirement without good cause 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.~~

~~(i) Is eligible for a categorically needy (CN) medicaid program.~~

~~(j) Refuses or fails to cooperate with CN medicaid program rules or requirements.~~

~~(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)~~)) Determined by the department of social and health services to be eligible for benefits under either the aged, blind, or disabled program as described in WAC 388-400-0060 or the housing and essential needs referral program as described in WAC 388-400-0070; and

(b) Not eligible for another WAH program.

(2) A person is not eligible for WAH-MCS if he or she is eligible for federally funded or federally matched programs (see WAC 182-503-0505(2)).

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

AMENDATORY SECTION (Amending WSR 12-19-051, filed 9/13/12, effective 10/14/12)

WAC 182-508-0150 Enrollment cap for medical care services (MCS). (1) Enrollment in medical care services (MCS) coverage is subject to available funds.

(2) The agency may limit enrollment into MCS coverage by implementing an enrollment cap and ((~~waiting~~)) wait list.

(3) If ((~~an individual~~)) a person is denied MCS coverage due to an enrollment cap:

(a) The ((~~individual~~)) person is added to the MCS ((~~waiting~~)) wait list based on the date the ((~~individual~~)) person applied.

(b) Applicants with the oldest application date will be the first to receive an opportunity for enrollment when MCS coverage is available as long as the person remains on the MCS wait list.

(4) ((~~An individual~~)) A person is exempted from the enrollment cap and wait list rules when:

(a) MCS was terminated due to agency error;

(b) The ((~~individual~~)) person is in the thirty-day reconsideration period for incapacity reviews under WAC ((~~182-508-0160(4)~~)) 388-447-0110(4); ((~~or~~))

(c) The ((~~individual~~)) person is being terminated from a CN medical program and was receiving and eligible for CN coverage prior to the date a wait list was implemented and ((~~the following conditions are met:~~

~~(i) The individual met financial and program eligibility criteria for MCS at the time their CN coverage ended; and~~

~~(ii) The individual met the incapacity criteria for MCS at the time their CN coverage ended.~~

~~(d) The individual applied for medical coverage and an eligibility decision was not completed prior to the enrollment cap effective date.~~

~~(5) If the individual is sent an offer for MCS enrollment, the individual must submit a completed application no later than the last day of the month following the month of enrollment offer. The individual must reapply within this time period and subsequently be determined eligible before MCS coverage can begin. The individual must reapply and requalify even if the individual was previously determined eligible for MCS.~~

~~(6)~~)) at the time their CN coverage ended, the person met eligibility criteria to receive benefits under either the aged, blind, or disabled program as described in WAC 388-400-0060 or the housing and essential needs referral program as described in WAC 388-400-0070; or

(d) The person applied for a determination by the department of social and health services (DSHS) to be eligible for benefits under either the aged, blind, or disabled program as described in WAC 388-400-0060 or the housing and essential needs referral program as described in WAC 388-400-0070, but the determination was not completed prior to the enrollment cap effective date.

(5) The ((~~individual~~)) person is removed from the MCS wait list if the ((~~individual~~)) person:

(a) Is not a Washington resident;

(b) Is deceased;

(c) Requests removal from the wait list;

(d) ((~~Fails to submit an application after an enrollment offer is sent as described in subsection (5) of this section;~~

~~(e) Reapplies as described in subsection (5) of this section, but does not qualify for MCS; or~~

~~(f)~~)) Is found eligible for categorically or medically needy coverage; or

(e) Is no longer determined by DSHS to be eligible for benefits under either the aged, blind, or disabled program as described in WAC 388-400-0060 or the housing and essential needs referral program as described in WAC 388-400-0070.

AMENDATORY SECTION (Amending WSR 12-13-056, filed 6/15/12, effective 7/1/12)

WAC 182-523-0100 ((Medical extensions—Eligibility.)) Washington apple health—Medical extension. (((1) A family who received temporary assistance for needy families (TANF), or family medical program in any three of the last six months in the state of Washington is eligible for extended medical benefits when they become ineligible for their current medical program because the family receives:

(a) Child or spousal support, which exceeds the payment standard described in WAC 388-478-0065, and they are not eligible for any other categorically needy (CN) medical program; or

(b) Increased earned income, resulting in income exceeding the CN income standard described in WAC 388-478-0065.

(2) A family is eligible to receive extended medical benefits beginning the month after termination from TANF cash or family medical program for:

(a) Four months for a family described in subsection (1)(a) of this section; or

(b) Up to twelve months, in two six-month segments, for a family described in subsection (1)(b) of this section. For the purposes of this chapter, months one through six are the initial six-month extension period. Months seven through twelve are the second six-month extension period.

(3) A family member is eligible to receive six months of medical extension benefits as described in subsection (2)(b) of this section unless:

(a) The individual family member:

(i) Moves out of state;

(ii) Dies;

(iii) Becomes an inmate of a public institution;

(iv) Leaves the household; or

(v) Does not cooperate, without good cause, with the division of child support or with third-party liability requirements.

(b) The family:

(i) Moves out of state;

(ii) Loses contact with the department or the department does not know the whereabouts of the family; or

(iii) No longer includes a child as defined in WAC 388-404-0005(1).

(4) A family member is eligible to receive the second six months of medical extension benefits as described in subsection (2)(b) of this section unless:

(a) The family is no longer eligible for the reasons described in subsection (3)(a) or (b); or

(b) The individual family member is the caretaker adult who:

(i) Stops working or whose earned income stops;

(ii) Does not, without good cause, complete and return the completed medical extension report or otherwise provide the required income and child care information; or

(iii) Does not, without good cause, pay the billed premium amount for one month.

(5) A family described in subsection (3) will not receive medical extension benefits for any family member who has been found ineligible for TANF/SFA cash because of fraud in any of the six months prior to the medical extension period.

(6) For the purposes of this chapter, only individual family members that are eligible for medicaid are certified to receive medical benefits under this program.)) (1) A parent or caretaker relative who received coverage under Washington apple health (WAH) for parents and caretaker relatives, (described in WAC 182-505-0240), in any three of the last six months is eligible, along with all dependent children living in the household, for twelve months' extended health care coverage if the person becomes ineligible for his or her current coverage due to increased earnings or hours of employment.

(2) A person remains eligible for WAH medical extension unless:

(a) The person:

(i) Moves out of state;

(ii) Dies;

(iii) Becomes an inmate of a public institution; or

(iv) Leaves the household.

(b) The family:

(i) Moves out of state;

(ii) Loses contact with the agency or its designee or the whereabouts of the family are unknown; or

(iii) No longer includes an eligible dependent child as defined in WAC 182-503-0565(2).

(3) When a person or family is determined ineligible for WAH coverage under subsection (2)(a)(i) through (iii) or (b)(i) or (ii) of this section during the medical extension period, the agency or its designee redetermines eligibility for the remaining household members as described in WAC 182-504-0125 and sends written notice as described in chapter 182-518 WAC before WAH medical extension is terminated.

AMENDATORY SECTION (Amending WSR 12-13-056, filed 6/15/12, effective 7/1/12)

WAC 182-523-0130 Medical extension—Redetermination. (1) When the ((department)) agency or its designee determines the family or an individual family member is ineligible during the medical extension period, the ((department)) agency or its designee must determine if they are eligible for another medical program.

(2) Children are eligible for twelve month continuous eligibility beginning with the first month of the medical extension period.

(3) When a family reports a reduction of income, the family may be eligible for ((a family medical program)) the Washington apple health for parents and caretaker relatives program (described in WAC 182-505-0240) instead of medical extension benefits.

(4) When a medical extension period is ending, the family is required to complete a renewal of eligibility as described in WAC 182-504-0035.

(5) Postpartum and family planning extensions are described in WAC ((388-462-0015)) 182-505-0115.

AMENDATORY SECTION (Amending WSR 12-22-046, filed 11/2/12, effective 12/3/12)

WAC 182-534-0100 EPSDT. (1) Persons who are eligible for medicaid((, except those identified in subsection (4) of this section,)) are eligible for coverage through the early and

periodic screening, diagnosis, and treatment (EPSDT) program up through the day before their twenty-first birthday.

(2) Access and services for EPSDT are governed by federal rules at 42 C.F.R., Part 441, Subpart B which were in effect as of January 1, 1998.

(a) The standard for coverage for EPSDT is that the services, treatment or other measures are:

(i) Medically necessary;

(ii) Safe and effective; and

(iii) Not experimental.

(b) EPSDT services are exempt from specific coverage or service limitations which are imposed on the rest of the CN and MN program. Examples of service limits which do not apply to the EPSDT program are the specific numerical limits in WAC 182-545-200.

(c) Services not otherwise covered under the medicaid program are available to children under EPSDT. The services, treatments and other measures which are available include but are not limited to:

(i) Nutritional counseling;

(ii) Chiropractic care;

(iii) Orthodontics; and

(iv) Occupational therapy (not otherwise covered under the MN program).

(d) Prior authorization and referral requirements are imposed on medical service providers under EPSDT. Such requirements are designed as tools for determining that a service, treatment or other measure meets the standards in subsection (2)(a) of this section.

(3) Transportation requirements of 42 C.F.R. 441, Subpart B are met through a contract with transportation brokers throughout the state.

((~~(4) Persons who are nineteen through twenty years of age who are eligible for any of the following programs that receive medicaid funding under the transitional bridge demonstration waiver allowed under section 1115 (a)(2) of the Social Security Act are not eligible for EPSDT services:~~

~~(a) Basic health;~~

~~(b) Medical care services; or~~

~~(c) Alcohol and Drug Addiction Treatment and Support Act (ADATSA).~~))

AMENDATORY SECTION (Amending WSR 11-17-059, filed 8/15/11, effective 8/15/11)

WAC 182-546-5550 Nonemergency transportation—Exclusions and limitations. (1) The following service categories cited in WAC ((~~388-501-0060~~)) 182-501-0060 are subject to the following exclusions and limitations:

(a) Adult day health (ADH) - Nonemergency transportation for ADH services is not provided through the brokers. ADH providers are responsible for arranging or providing transportation to ADH services.

(b) Ambulance - Nonemergency ambulance transportation is not provided through the brokers except as specified in WAC ((~~388-546-5200~~)) 182-546-5200 (1)(d).

(c) Family planning services - Nonemergency transportation is not provided through the brokers for clients that are enrolled only in TAKE CHARGE or family planning only services.

(d) Hospice services - Nonemergency transportation is not provided through the brokers when the health care service is related to a client's hospice diagnosis. See WAC ((~~388-551-1210~~)) 182-551-1210.

(e) Medical equipment, durable (DME) - Nonemergency transportation is not provided through the brokers for DME services, with the exception of DME equipment that needs to be fitted to the client.

(f) Medical nutrition services - Nonemergency transportation is not provided through the brokers to pick up medical nutrition products.

(g) Medical supplies/equipment, nondurable (MSE) - Nonemergency transportation is not provided through the brokers for MSE services.

(h) Mental health services:

(i) Nonemergency transportation brokers generally provide one round trip per day to or from a mental health service. Additional trips for off-site activities, such as a visit to a recreational park, are the responsibility of the provider/facility.

(ii) Nonemergency transportation of involuntarily detained persons under the Involuntary Treatment Act (ITA) is not a service provided or authorized by transportation brokers. Involuntary transportation is a service provided by an ambulance or a designated ITA transportation provider. See WAC ((~~388-546-4000~~)) 182-546-4000.

(i) Substance abuse services - Nonemergency transportation is not provided through the brokers for substance abuse services for clients under the state-funded medical programs (medical care services program (MCS)). See WAC ((~~388-546-5200~~)) 182-546-5200(2).

(j) Chemical dependency services - Nonemergency transportation is not provided through the brokers to or from the following:

(i) Residential treatment;

(ii) Intensive inpatient;

(iii) Recovery house;

(iv) Long-term treatment;

(v) Information and assistance services, which include:

(A) Alcohol and drug information school;

(B) Information and crisis services; and

(C) Emergency service patrol.

(2) The ((~~following medical assistance programs have limitations on trips:~~

~~(a)~~)) state-funded medical care services (MCS) program ((~~for clients covered by the disability lifeline program and the Alcohol and Drug Addiction Treatment and Support Act (ADATSA)~~)) - Nonemergency transportation for mental health services and substance abuse services is not provided through the brokers. The ((~~department~~)) agency does pay for nonemergency transportation to and from medical services as specified in WAC ((~~388-501-0060~~)) 182-501-0060, excluding mental health services and substance abuse services, and subject to any other limitations in this chapter or other program rules.

((~~(b) Transitional bridge waiver for clients covered by the disability lifeline program and the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) - Nonemergency transportation for mental health services and substance abuse services is not provided through the brokers. The department does pay for nonemergency transportation to~~

and from medical services as covered in the transitional bridge waiver approved by the Centers for Medicare and Medicaid Services, excluding mental health services and substance abuse services, and subject to any other limitations in this chapter or other program rules.))

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

WAC 182-550-1200 Restrictions on hospital coverage. A hospital covered service provided to a ((client)) person eligible under a ((medical assistance)) Washington apple health (WAH) program that is paid by the ((department's)) agency's fee-for-services payment system must be within the scope of the ((client's medical assistance)) person's WAH program. Coverage restriction includes, but is not limited to the following:

(1) ((Clients)) Persons enrolled with the ((department's)) agency's managed care organization (MCO) plans are subject to the respective plan's policies and procedures for coverage of hospital services;

(2) ((Clients)) Persons covered by primary care case management are subject to the ((clients')) persons' primary care physicians' approval for hospital services;

(3) For emergency care exemptions for ((clients)) persons described in subsections (1) and (2) of this section, see WAC ((388-538-100.)) 182-538-100;

(4) ((Coverage for psychiatric indigent inpatient (PII) clients is limited to voluntary inpatient psychiatric hospital services, subject to the conditions and limitations of WAC 388-865-0217 and this chapter:

(a) Out-of-state health care is not covered for clients under the PII program; and

(b) Bordering city hospitals and critical border hospitals are not considered instate hospitals for PII program claims.

(5))) Health care services provided by a hospital located out-of-state are:

(a) Not covered for ((clients)) persons eligible under the medical care services (MCS) program. However, ((clients)) persons eligible for MCS are covered for that program's scope of care in bordering city and critical border hospitals.

(b) Covered for:

(i) Emergency care for eligible medicaid and ((SCHIP clients)) CHIP persons without prior authorization, based on the medical necessity and utilization review standards and limits established by the ((department)) agency.

(ii) Nonemergency out-of-state care for medicaid and ((SCHIP clients)) CHIP persons when prior authorized by the ((department)) agency based on the medical necessity and utilization review standards and limits.

(iii) Hospitals in bordering cities and critical border hospitals, based on the same client eligibility criteria and authorization policies as for instate hospitals. See WAC ((388-501-0175)) 182-501-0175 for a list of bordering cities.

(c) Covered for out-of-state voluntary inpatient psychiatric hospital services for eligible medicaid and ((SCHIP)) CHIP clients based on authorization by a ((mental health division (MHD))) division of behavioral health and recovery (DBHR) designee.

(((6))) (5) See WAC ((388-550-1100)) 182-550-1100 for hospital services for chemical-using pregnant (CUP) women((.));

(((7))) (6) All psychiatric inpatient hospital admissions, length of stay extensions, and transfers must be prior authorized by a ((MHD)) DBHR designee. See WAC ((388-550-2600.)) 182-550-2600;

(((8))) (7) For ((clients)) persons eligible for both medicare and medicaid (dual eligibles), the ((department)) agency pays deductibles and coinsurance, unless the ((client)) person has exhausted his or her medicare Part A benefits. If medicare benefits are exhausted, the ((department)) agency pays for hospitalization for such ((clients)) persons subject to ((department)) agency rules. See also chapter ((388-502)) 182-502 WAC((.));

(((9))) (8) The ((department)) agency does not pay for covered inpatient hospital services for a ((medical assistance)) WAH client:

(a) Who is discharged from a hospital by a physician because the ((client)) person no longer meets medical necessity for acute inpatient level of care; and

(b) Who chooses to stay in the hospital beyond the period of medical necessity.

(((10))) (9) If the hospital's utilization review committee determines the ((client's)) person's stay is beyond the period of medical necessity, as described in subsection (((9))) (8) of this section, the hospital must:

(a) Inform the ((client)) person in a written notice that the ((department)) agency is not responsible for payment (42 C.F.R. 456);

(b) Comply with the requirements in WAC ((388-502-0160)) 182-502-0160 in order to bill the ((client)) person for the service(s); and

(c) Send a copy of the written notice in (a) of this subsection to the ((department)) agency.

(((11))) (10) Other coverage restrictions, as determined by the ((department)) agency.

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

WAC 182-550-1700 Authorization and utilization review (UR) of inpatient and outpatient hospital services. (1) This section applies to the ((department's)) agency's authorization and utilization review (UR) of inpatient and outpatient hospital services provided to ((medical assistance)) Washington apple health (WAH) clients receiving services through the fee-for-service program. For clients eligible under other ((medical assistance)) WAH programs, see chapter ((388-538)) 182-538 WAC for managed care organizations, ((chapters 388-800 and 388-810 WAC for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA),)) and chapter 388-865 WAC for mental health treatment programs coordinated through the ((mental health division)) department of social and health services' division of behavioral health and recovery or its designee((,)). See chapter ((388-546)) 182-546 WAC for transportation services.

(2) All hospital services paid for by the ((~~department~~)) agency are subject to UR for medical necessity, appropriate level of care, and program compliance.

(3) Authorization for inpatient and outpatient hospital services is valid only if a client is eligible for covered services on the date of service. Authorization does not guarantee payment.

(4) The ((~~department~~)) agency will deny, recover, or adjust hospital payments if the ((~~department~~)) agency or its designee determines, as a result of UR, that a hospital service does not meet the requirements in federal regulations and WAC.

(5) The ((~~department~~)) agency may perform one or more types of UR described in subsection (6) of this section.

(6) The ((~~department's~~)) agency's UR:

(a) Is a concurrent, prospective, and/or retrospective (including postpay and prepay) formal evaluation of a client's documented medical care to assure that the services provided are proper and necessary and of good quality. The review considers the appropriateness of the place of care, level of care, and the duration, frequency or quantity of services provided in relation to the conditions(s) being treated; and

(b) Includes one or more of the following:

(i) "Concurrent utilization review"—An evaluation performed by the ((~~department~~)) agency or its designee during a client's course of care. A continued stay review performed during the client's hospitalization is a form of concurrent UR;

(ii) "Prospective utilization review"—An evaluation performed by the ((~~department~~)) agency or its designee prior to the provision of health care services. Preadmission authorization is a form of prospective UR; and

(iii) "Retrospective utilization review"—An evaluation performed by the ((~~department~~)) agency or its designee following the provision of health care services that includes both a post-payment retrospective UR (performed after health care services are provided and paid), and a prepayment retrospective UR (performed after health care services are provided but prior to payment). Retrospective UR is routinely performed as an audit function.

(7) During the UR process, the ((~~department~~)) agency or its designee notifies the appropriate oversight entity if either of the following is identified:

(a) A quality of care concern; or

(b) Fraudulent conduct.

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

WAC 182-550-2521 Client eligibility requirements for acute PM&R services. (1) Only a client who is eligible for one of the ((~~following~~)) Washington apple health programs may receive acute PM&R services, subject to the restrictions and limitations in this section and WAC ((~~388-550-2501, 388-550-2511, 388-550-2531, 388-550-2541, 388-550-2551, 388-550-2561, 388-550-3381~~)) 182-550-2501, 182-550-2511, 182-550-2531, 182-550-2541, 182-550-2551, 182-550-2561, 182-550-3381, and other rules:

(a) Categorically needy program (CNP);

(b) ((~~State~~)) Children's health insurance program (((~~SCHIP~~))) (CHIP);

(c) ((~~Limited casualty program -~~)) Medically needy program (LCP-MNP);

(d) Alien emergency medical (AEM)(CNP);

(e) Alien emergency medical (AEM)(LCP-MNP);

(f) ((~~General assistance unemployable (GA-U - No out-of-state care); or~~

~~(g) Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)~~)) Medical care services.

(2) If a client is enrolled in ((~~a department~~)) an agency managed care organization (MCO) plan at the time of acute care admission, that plan pays for and coordinates acute PM&R services as appropriate.

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

WAC 182-550-2650 Base community psychiatric hospitalization payment method for medicaid and ((~~SCHIP~~)) CHIP clients and nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients. (1) Effective for dates of admission from July 1, 2005 through June 30, 2007, and in accordance with legislative directive, the ((~~department~~)) agency implemented two separate base community psychiatric hospitalization payment rates, one for medicaid and ((~~SCHIP~~)) children's health insurance program (CHIP) clients and one for nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients. Effective for dates of admission on and after July 1, 2007, the base community psychiatric hospitalization payment method for medicaid and ((~~SCHIP~~)) CHIP clients and nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients is no longer used. (For the purpose of this section, a "nonmedicaid or ((~~non-SCHIP~~)) non-CHIP client" is defined as a client eligible under the ((~~general assistance-unemployable (GA-U) program, the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA), the psychiatric indigent inpatient (PII) program, or other state-administered~~)) medical care services (MCS) program, as determined by the ((~~department~~)) agency.)

(a) The medicaid base community psychiatric hospital payment rate is a minimum per diem for claims for psychiatric services provided to medicaid and ((~~SCHIP~~)) CHIP covered patients, paid to hospitals that accept commitments under the Involuntary Treatment Act (ITA).

(b) The nonmedicaid base community psychiatric hospital payment rate is a minimum allowable per diem for claims for psychiatric services provided to indigent patients paid to hospitals that accept commitments under the ITA.

(2) For the purposes of this section, "allowable" means the calculated allowed amount for payment based on the payment method before adjustments, deductions, or add-ons.

(3) To be eligible for payment under the base community psychiatric hospitalization payment method:

(a) A client's inpatient psychiatric voluntary hospitalization must:

(i) Be medically necessary as defined in WAC ((~~388-500-0005~~)) 182-500-0070. In addition, the ((~~department~~)) agency considers medical necessity to be met when:

(A) Ambulatory care resources available in the community do not meet the treatment needs of the client;

(B) Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician;

(C) The inpatient services can be reasonably expected to improve the client's condition or prevent further regression so that the services will no longer be needed; and

(D) The client, at the time of admission, is diagnosed as having an emotional/behavioral disturbance as a result of a mental disorder as defined in the current published Diagnostic and Statistical Manual of the American Psychiatric Association. The ((~~department~~)) agency does not consider detoxification to be psychiatric in nature.

(ii) Be approved by the professional in charge of the hospital or hospital unit.

(iii) Be authorized by the appropriate ((~~mental health division (MHD)~~)) division of behavioral health and recovery (DBHR) designee prior to admission for covered diagnoses.

(iv) Meet the criteria in WAC ((~~388-550-2600~~)) 182-550-2600.

(b) A client's inpatient psychiatric involuntary hospitalization must:

(i) Be in accordance with the admission criteria in chapters 71.05 and 71.34 RCW.

(ii) Be certified by a ((~~MHD~~)) DBHR designee.

(iii) Be approved by the professional in charge of the hospital or hospital unit.

(iv) Be prior authorized by the regional support network (RSN) or its designee.

(v) Meet the criteria in WAC ((~~388-550-2600~~)) 182-550-2600.

(4) The provider requesting payment must complete the appropriate sections of the Involuntary Treatment Act patient claim information (form DSHS 13-628) in triplicate and route both the form and each claim form submitted for payment, to the county involuntary treatment office.

(5) Payment for all claims is based on covered days within a client's approved length of stay (LOS), subject to client eligibility and ((~~department-covered~~)) agency-covered services.

(6) The medicaid base community psychiatric hospitalization payment rate applies only to a medicaid or ((~~SCHIP~~)) CHIP client admitted to a nonstate-owned free-standing psychiatric hospital located in Washington state.

(7) The nonmedicaid base community psychiatric hospitalization payment rate applies only to a nonmedicaid or ((~~SCHIP~~)) CHIP client admitted to a hospital:

(a) Designated by the ((~~department~~)) agency as an ITA-certified hospital; or

(b) That has ((~~a department-certified~~)) an agency-certified ITA bed that was used to provide ITA services at the time of the nonmedicaid or ((~~non-SCHIP~~)) non-CHIP admission.

(8) For inpatient hospital psychiatric services provided to eligible clients for dates of admission on and after July 1, 2005, through June 30, 2007, the ((~~department~~)) agency pays:

(a) A hospital's department of health (DOH)-certified distinct psychiatric unit as follows:

(i) For medicaid and ((~~SCHIP~~)) CHIP clients, inpatient hospital psychiatric services are paid using the ((~~department-specific~~)) agency-specific nondiagnosis related group (DRG) payment method.

(ii) For nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-administered program DRG allowable (including the high cost outlier allowable, if applicable), or the ((~~department-specified~~)) agency-specified non-DRG payment method if no relative weight exists for the DRG in the ((~~department's~~)) agency's payment system; or

(B) The nonmedicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(b) A hospital without a DOH-certified distinct psychiatric unit as follows:

(i) For medicaid and ((~~SCHIP~~)) CHIP clients, inpatient hospital psychiatric services are paid using:

(A) The DRG payment method; or

(B) The ((~~department-specified~~)) agency-specified non-DRG payment method if no relative weight exists for the DRG in the ((~~department's~~)) agency's payment system.

(ii) For nonmedicaid and ((~~SCHIP~~)) CHIP clients, the allowable for inpatient hospital psychiatric services is the greater of:

(A) The state-administered program DRG allowable (including the high cost outlier allowable, if applicable), or the ((~~department-specified~~)) agency-specified non-DRG payment method if no relative weight exists for the DRG in the ((~~department's~~)) agency's payment system; or

(B) The nonmedicaid base community psychiatric hospitalization payment rate multiplied by the covered days.

(c) A nonstate-owned free-standing psychiatric hospital as follows:

(i) For medicaid and ((~~SCHIP~~)) CHIP clients, inpatient hospital psychiatric services are paid using as the allowable, the greater of:

(A) The ratio of costs-to-charges (RCC) allowable; or

(B) The medicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(ii) For nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients, inpatient hospital psychiatric services are paid the same as for medicaid and ((~~SCHIP~~)) CHIP clients, except the base community inpatient psychiatric hospital payment rate is the nonmedicaid rate, and the RCC allowable is the state-administered program RCC allowable.

(d) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the certified public expenditure (CPE) payment program, as follows:

(i) For medicaid and ((~~SCHIP~~)) CHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC ((~~388-550-4650~~)) 182-550-4650.

(ii) For nonmedicaid and ((~~non-SCHIP~~)) non-CHIP clients, inpatient hospital psychiatric services are paid using the methods identified in WAC ((~~388-550-4650~~)) 182-550-4650 in conjunction with the nonmedicaid base community psychiatric hospitalization payment rate multiplied by covered days.

(e) A hospital, or a distinct psychiatric unit of a hospital, that is participating in the critical access hospital (CAH) program, as follows:

(i) For medicaid and ((~~SCHIP~~)) CHIP clients, inpatient hospital psychiatric services are paid using the ((~~department-specified~~)) agency-specified non-DRG payment method.

(ii) For nonmedicaid ((~~[and] non-SCHIP~~)) and non-CHIP clients, inpatient hospital psychiatric services are paid using the ((~~department-specified~~)) agency-specified non-DRG payment method.

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

WAC 182-550-6700 Hospital services provided out-of-state. (1) The ((~~department~~)) agency pays:

(a) For dates of admission before August 1, 2007, for only emergency care for an eligible medicaid and ((~~SCHIP~~)) CHIP client who goes to another state, except specified border cities, specifically for the purpose of obtaining medical care that is available in the state of Washington. See WAC ((~~388-501-0175~~)) 182-501-0175 for a list of border cities.

(b) For dates of admission on and after August 1, 2007, for both emergency and nonemergency out-of-state hospital services, including those provided in bordering city hospitals and critical border hospitals, for eligible medicaid and ((~~SCHIP~~)) CHIP clients based on the medical necessity and utilization review standards and limits established by the ((~~department~~)) agency.

(i) Prior authorization by the ((~~department~~)) agency is required for the nonemergency out-of-state hospital medical care provided to medicaid and ((~~SCHIP~~)) CHIP clients.

(ii) Bordering city hospitals are considered the same:

(A) As instate hospitals for coverage of hospital services; and

(B) As out-of-state hospitals for payment methodology. ((~~Department~~)) Agency designated critical border hospitals are paid as instate hospitals. See WAC ((~~388-550-3900 and 388-550-4000~~)) 182-550-3900 and 182-550-4000.

(c) For out-of-state voluntary psychiatric inpatient hospital services for eligible medicaid and ((~~SCHIP~~)) CHIP clients based on authorization by a ((~~mental health~~)) division of behavioral health designee.

(d) Based on the ((~~department's~~)) agency's limitations on hospital coverage under WAC ((~~388-550-1100 and 388-550-1200~~)) 182-550-1100 and 182-550-1200 and other applicable rules.

(2) The ((~~department~~)) agency authorizes and pays for comparable hospital services for a medicaid and ((~~SCHIP~~)) CHIP client who is temporarily outside the state to the same extent that such services are furnished to an eligible medicaid client in the state, subject to the exceptions and limitations in this section. See WAC ((~~388-550-3900 and 388-550-4000~~)) 182-550-3900 and 182-550-4000.

(3) The ((~~department~~)) agency limits out-of-state hospital coverage for ((~~clients~~)) persons eligible under state-administered programs as follows:

(a) For a ((~~client eligible under the psychiatric indigent inpatient (PII) program or~~)) person who receives services under the Involuntary Treatment Act (ITA), the ((~~department~~)) agency does not pay for hospital services provided in any hospital outside the state of Washington (including bordering city and critical border hospitals).

(b) For a ((~~client~~)) person eligible under ((~~a department's~~)) an agency's general assistance program, the ((~~department~~)) agency pays only for hospital services covered under the ((~~client's~~)) person's medical care services' program scope of care that are provided in a bordering city hospital or a critical border hospital. The ((~~department~~)) agency does not pay for hospital services provided to ((~~clients~~)) persons eligible under a general assistance program in other hospitals located outside the state of Washington. The ((~~department~~)) agency or its designee may require prior authorization for hospital services provided in a bordering city hospital or a critical border hospital. See WAC ((~~388-550-1200~~)) 182-550-1200.

(4) The ((~~department~~)) agency covers hospital care provided to medicaid or ((~~SCHIP~~)) CHIP clients in areas of Canada as described in WAC ((~~388-501-0180~~)) 182-501-0180, and based on the limitations described in the state plan.

(5) The ((~~department~~)) agency may review all cases involving out-of-state hospital services, including those provided in bordering city hospitals and critical border hospitals, to determine whether the services are within the scope of the ((~~client's medical assistance~~)) person's WAH program.

(6) If the ((~~client~~)) person can claim deductible or coinsurance portions of medicare, the provider must submit the claim to the intermediary or carrier in the provider's own state on the appropriate medicare billing form. If the state of Washington is checked on the form as the party responsible for medical bills, the intermediary or carrier may bill on behalf of the provider or may return the claim to the provider for submission to the state of Washington.

(7) For payment for out-of-state inpatient hospital services, see WAC ((~~388-550-3900 and 388-550-4000~~)) 182-550-3900 and 182-550-4000.

(8) Out-of-state providers, including bordering city hospitals and critical border hospitals, must present final charges to the ((~~department~~)) agency within three hundred sixty-five days of the "statement covers period from date" shown on the claim. The state of Washington is not liable for payment of charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-550-5125 Payment method—Psychiatric indigent inpatient disproportionate share hospital (PIIDSH).

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-503-0532 Citizenship requirements for the medical care services (MCS) and ADATSA programs.

WAC 182-503-0555 Age requirement for MCS and ADATSA.

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

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-504-0030 Medical certification periods for recipients of medical care services (MCS).

WAC 182-504-0040 Requirements for a midcertification review for medical care services (MCS).

WAC 182-504-0100 Changes of circumstances—Changes that must be reported by a recipient of medical care services (MCS).

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-506-0020 Assistance units for medical care services (MCS).

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-508-0010 Incapacity requirements for medical care services (MCS).

WAC 182-508-0015 Determining if an individual is incapacitated.

WAC 182-508-0020 Acceptable medical evidence.

WAC 182-508-0030 Required medical evidence.

WAC 182-508-0035 How severity ratings of impairment are assigned.

WAC 182-508-0040 PEP Step I—Review of medical evidence required for eligibility determination.

WAC 182-508-0050 PEP Step II—Determining the severity of mental impairments.

WAC 182-508-0060 PEP Step III—Determining the severity of physical impairments.

WAC 182-508-0070 PEP Step IV—Determining the severity of multiple impairments.

WAC 182-508-0080 PEP Step V—Determining level of function of mentally impaired individuals in a work environment.

WAC 182-508-0090 PEP Step VI—Determining level of function of physically impaired individuals in a work environment.

WAC 182-508-0100 PEP Step VII—Evaluating a client's capacity to perform relevant past work.

WAC 182-508-0110 PEP Step VIII—Evaluating a client's capacity to perform other work.

WAC 182-508-0120 Deciding how long a client is incapacitated.

WAC 182-508-0130 Medical care services—Limited coverage.

WAC 182-508-0160 When medical care services benefits end.

WAC 182-508-0220 How alcohol or drug dependence affects an individual's eligibility for medical care services (MCS).

WAC 182-508-0230 Eligibility standards for medical care services (MCS); aged, blind, or disabled (ABD); and Alcohol and Drug Addiction Treatment and Support Act (ADATSA).

WAC 182-508-0300 What is the purpose of this chapter?

WAC 182-508-0305 Detoxification—Covered services.

WAC 182-508-0310 ADATSA—Purpose.

WAC 182-508-0315 ADATSA—Covered services.

WAC 182-508-0320 ADATSA—Eligible individuals.

WAC 182-508-0325 When am I eligible for ADATSA treatment services?

WAC 182-508-0330 What clinical incapacity must I meet to be eligible for ADATSA treatment services?

WAC 182-508-0335 Will I still be eligible for ADATSA outpatient services if I abstain from using alcohol or drugs, become employed, or have a relapse?

WAC 182-508-0340 What is the role of the certified chemical dependency service provider in determining ADATSA eligibility?

WAC 182-508-0345 What are the responsibilities of the certified chemical dependency service provider in determining eligibility?

WAC 182-508-0350 What happens after I am found eligible for ADATSA services?

WAC 182-508-0355 What criteria does the certified chemical dependency service provider use to plan my treatment?

WAC 182-508-0360 Do I have to contribute to the cost of residential treatment?

WAC 182-508-0365 What happens when I withdraw or am discharged from treatment?

WAC 182-508-0370 What are the groups that receive priority for ADATSA services?

WAC 182-508-0375 ADATSA—Eligibility for state-funded medical care services (MCS).

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-509-0005 MCS income—Ownership and availability.
WAC 182-509-0015 MCS income—Excluded income types.
WAC 182-509-0025 MCS income—Unearned income.
WAC 182-509-0030 MCS income—Earned income.
WAC 182-509-0035 MCS income—Educational benefits.
WAC 182-509-0045 MCS income—Employment and training programs.
WAC 182-509-0055 MCS income—Needs-based assistance from other agencies or organizations.
WAC 182-509-0065 MCS income—Gifts—Cash and non-cash.
WAC 182-509-0080 MCS income—Self-employment income.
WAC 182-509-0085 MCS income—Self-employment income—Calculation of countable income.
WAC 182-509-0095 MCS income—Allocating income—General.
WAC 182-509-0100 MCS income—Allocating income—Definitions.
WAC 182-509-0110 MCS income—Allocating income to legal dependents.
WAC 182-509-0135 MCS income—Allocating income of an ineligible spouse to a medical care services (MCS) client.
WAC 182-509-0155 MCS income—Exemption from sponsor deeming for medical care services (MCS).
WAC 182-509-0165 MCS income—Income calculation.
WAC 182-509-0175 MCS income—Earned income work incentive deduction.
WAC 182-509-0200 MCS resources—How resources affect eligibility for medical care services (MCS).
WAC 182-509-0205 MCS resources—How resources count toward the resource limits for medical care services (MCS).
WAC 182-509-0210 MCS resources—How vehicles count toward the resource limit for medical care services (MCS).

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-509-0225 Excluded resources for family medical programs.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-523-0110 Medical extensions—Reporting requirements.
WAC 182-523-0120 Medical extensions—Premiums.

WSR 14-10-076
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 14-98—Filed May 6, 2014, 2:49 p.m., effective May 6, 2014, 6:00 p.m.]

Effective Date of Rule: May 6, 2014, 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: Amending WAC 220-32-051.

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

Other Authority: *United States v. Oregon,* Civil No. 68-513-KI (D. Or.), Order Adopting 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: Allows the sale of platform and hook and line caught fish from mainstem tribal fisheries in Zone 6. Sales of fish landed in the area downstream of Bonneville Dam (consistent with tribal MOU/MOAs) may occur if the area is lawfully open for sales under tribal regulations. Similarly, the sale of fish caught in Yakama Nation tributary fisheries are allowed when open under Yakama Nation regulations. The upriver spring chinook return is expected to be a minimum of 185,000 fish, and harvestable fish are available to the treaty tribes. Fisheries are consistent with the 2008-

2017 management agreement and the associated biological opinion. Rule is consistent with action of the Columbia River compact on May 5, 2014. Conforms state rules with tribal rules. There is insufficient time to promulgate permanent regulations.

The Yakama, Warm Springs, Umatilla, and Nez Perce Indian tribes have treaty fishing rights in the Columbia River and inherent sovereign authority to regulate their fisheries. Washington and Oregon also have some authority to regulate fishing by treaty Indians in the Columbia River, authority that the states exercise jointly under the congressionally ratified Columbia River compact. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969). The tribes and the states adopt parallel regulations for treaty Indian fisheries under the supervision of the federal courts. A court order sets the current parameters. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 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 0; Federal Rules or Standards: New 1, 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: May 6, 2014.

Philip Anderson
Director

NEW SECTION

WAC 220-32-05100Z Columbia River salmon seasons above Bonneville Dam. Notwithstanding the provisions of WAC 220-32-050, WAC 220-32-051, WAC 220-32-052 and WAC 220-32-058, effective immediately until further notice, it is unlawful for a person to take or possess salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch taken for commercial purposes in Columbia River Salmon Management and Catch Reporting Areas 1F, 1G, and 1H, and in the Wind River, Klickitat River, and Drano Lake and specific areas of SMCRA 1E. However, those individuals possessing treaty fishing rights under the Yakama, Warm Springs, Umatilla, and Nez Perce treaties may fish for salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch under the following provisions.

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

(a) Season: 6:00 p.m. May 6, 2014, until further notice.

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

(c) Allowable sale: salmon, steelhead, shad, carp, catfish, walleye, bass, or yellow perch. Sturgeon between 38-54 inches in fork length in the Bonneville Pool and sturgeon between 43-54 inches in fork length in The Dalles and John Day pools may be retained for subsistence purposes only. Live release of all oversize and under-size sturgeon is required.

(d) All Dam sanctuaries for these gear types are in effect.

(2) Open Area: SMCRA 1E. Each of the four Columbia River treaty tribes has an MOA or MOU with the Washington Department of Fish and Wildlife regarding tribal fisheries in the area just downstream of Bonneville Dam. Tribal fisheries in this area may only occur in accordance with the appropriate MOA or MOU specific to each tribe, and only within any specific regulations set by each tribe.

(a) Participants: Tribal members may participate under the conditions described in the 2007 Memorandum of Agreement (MOA) with the Yakama Nation (YN), in the 2010 Memorandum of Understanding (MOU) with the Confederated Tribes of the Umatilla Indian Reservation (CTUIR), in the 2010 MOU with the Confederated Tribes of the Warm Spring Reservation (CTWS), and in the 2011 MOU with the Nez Perce Tribe. Tribal members fishing below Bonneville Dam must carry an official tribal enrollment card.

(b) Season: 6:00 p.m. May 6, 2014, until further notice. Open only during those days and hours when open under lawfully enacted tribal subsistence fishery regulations for enrolled tribal members.

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

(d) Allowable Sales: salmon, steelhead, shad, carp, catfish, walleye, bass, or yellow perch. Sturgeon retention is prohibited, and sturgeon may not be sold or retained for ceremonial or subsistence purposes. Sale of platform or hook-and-line-caught fish is allowed. Sales may not occur on USACE property.

(3) Columbia River Tributaries upstream of Bonneville Dam

(a) Season: 6:00 p.m. May 6, 2014, until further notice, and only during those days and hours when the tributaries listed below are open under lawfully enacted Yakama Nation tribal subsistence fishery regulations for enrolled Yakama Nation members.

(b) Area: Drano Lake, Wind River and Klickitat River.

(c) Gear: Hoop nets, dip bag nets, and rod and reel with hook-and-line. Gill nets may only be used in Drano Lake.

(d) Allowable Sales: salmon, steelhead, shad, carp, catfish, walleye, bass, or yellow perch. Sturgeon between 43-54 inches fork length harvested in tributaries within The Dalles or John Day Pools and sturgeon between 38-54 inches fork length harvested in tributaries within Bonneville pool may not be sold but may be kept for subsistence

(4) 24-hour quick reporting is required for Washington wholesale dealers for all areas, as provided in WAC 220-69-240.

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

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.

WSR 14-10-078
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 14-99—Filed May 6, 2014, 3:23 p.m., effective May 7, 2014, 1:00 p.m.]

Effective Date of Rule: May 7, 2014, 1:00 p.m.

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

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

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

Other Authority: *United States v. Oregon,* Civil No. 68-513-KI (D. Or.), Order Adopting 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: Opens a mainstem commercial fishery in Zones 1-5. Modifies the reduced hour restriction in the Tongue Point/South Channel select area sites for one evening. Opens Knappa Slough to include the lower "fall boundary" effective May 8. The upriver spring chinook run-size has been updated to a minimum of one hundred eighty-five thousand fish, which increases the number of fish available for harvest. Upriver spring chinook mortalities are expected to remain within the ESA and catch balance limits allowed. The fishery is consistent with the *U.S. v. Oregon* Management Agreement and the associated biological opinion. Conforms Washington state rules with Oregon state rules. Regulation is consistent with compact action of January 29 and May 6, 2014. There is insufficient time to adopt permanent rules.

Washington and Oregon jointly regulate Columbia River fisheries under the congressionally ratified Columbia River compact. Four Indian tribes have treaty fishing rights in the Columbia River. The treaties preempt state regulations that fail to allow the tribes an opportunity to take a fair share of the available fish, and the states must manage other fisheries accordingly. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969). A federal court order sets the current parameters for sharing between treaty Indians and others. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546).

Some Columbia River Basin salmon and steelhead stocks are listed as threatened or endangered under the federal ESA. On May 5, 2008, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allows for some incidental take of these species in treaty and nontreaty Columbia River fisheries governed by the 2008-2017 *U.S. v. Oregon* Management Agreement. The Washington and Oregon fish and wildlife commissions have developed policies to guide the implementation of such biological opinions in the states' regulation of nontreaty fisheries.

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

Number of Sections Adopted in Order to Comply with Federal Statute: New 1, Amended 0, Repealed 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: May 6, 2014.

Philip Anderson
Director

NEW SECTION

WAC 220-33-01000R Columbia River seasons below Bonneville. Notwithstanding the provisions of WAC 220-33-010, WAC 220-33-020, and WAC 220-33-030, it is unlawful for a person to take or possess salmon, sturgeon, and shad for commercial purposes from Columbia River Salmon Management and Catch Reporting Areas 1A, 1B, 1C, 1D, 1E and Select Areas, except during the times and conditions listed below:

(1) Mainstem Columbia River

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

(b) **Dates:** 1:00 – 10:00 PM Wednesday May 7, 2014.

(c) **Allowable Possession:** Adipose fin-clipped Chinook salmon and shad

(d) **Sanctuaries:** Grays River, Elochoman-B, Cowlitz River, Kalama-B, Lewis-B, Sandy, and Washougal rivers, as applicable.

(e) **Gear:** Drift nets only. 4 1/4" maximum mesh size (tangle net). Single-wall multi-filament net only. Monofilament tangle nets are not allowed. Mesh size is determined by placing three consecutive meshes under hand tension, and the measurement is taken from the inside of one knot to the inside of the opposite knot of the center mesh. Hand tension means sufficient linear tension to draw opposing knots of meshes into contact. Net length not to exceed 150 fathoms. There are no restrictions on the use of slackers or stringers to slacken the net vertically. There are no restrictions on the hang ratio. The hang ratio is used to horizontally add slack to the net and is determined by the length of the web per length of the corkline.

Net length may be increased from 150 to 175 fathoms for nets constructed with a steelhead excluder panel, weedlines, or droppers. An optional use of a steelhead excluder panel of mesh may be hung between the corkline and the 4 1/4" maximum mesh size tangle net. The excluder panel web must be a minimum mesh size of 12" stretched measure when taut under hand tension. Monofilament mesh is allowed for the excluder panel only. The excluder panel must be a minimum of five feet in depth and must not exceed ten feet in depth as measured from the corkline to the upper margin of the tangle net mesh as the net hangs naturally from a taut corkline. Weedlines or droppers (bobber type) may be used in place of the steelhead excluder panel. A weedline-type excluder means the net is suspended below the corkline by lines of no less than five feet in length between the corkline and the upper margin of the tangle net. A dropper-type excluder means the entire net is suspended below the surface of the water by lines of no less than five feet in length extending from individual surface floats to a submersed corkline. The corkline cannot be capable of floating the net in its entirety (including the leadline) independent of the attached floats. Weedlines or droppers must extend a minimum of five feet above the 4 1/4" maximum mesh size tangle net. Tangle nets constructed with a steelhead excluder panel, weedlines, or droppers must have two red corks at each end of the net, as well as the red corks as required under subsection (1)(f)(ii) of this section.

(f) **Miscellaneous Regulations:**

(i) **Soak times** are defined as the time elapsed from when the first of the gillnet web is deployed into the water until the gillnet web is fully retrieved from the water, must not exceed 45 minutes.

(ii) **Red corks** are required at 25-fathom intervals, and red corks must be in contrast to the corks used in the remainder of the net.

(iii) **Recovery Box:** Each boat will be required to have two operable recovery boxes or one box with two chambers, on board. Each chamber of the recovery box(es) must include an operating water pumping system capable of delivering a minimum flow of 16 gallons per minute, not to exceed 20 gallons per minute of freshwater per chamber. Each box and chamber and associated pump shall be operating during any time that the net is being retrieved or picked. Each chamber of the recovery box must meet the following dimensions as measured from within the box: the inside length measurement must be at or within 39 1/2 inches to 48 inches; the inside width measurements must be at or within 8 to 10 inches; and the inside height measurement must be at or within 14 to 16 inches.

Each chamber of the recovery box must include a water inlet hole between 3/4 inch and 1 inch in diameter, centered horizontally across the door or end wall of the chamber and 1 3/4 inches from the floor of the chamber. Each chamber of the recovery box must include a water outlet hole that is a least 1 1/2 inches in diameter located on either the same or opposite end as the inlet. The center of the outlet hole must be located a minimum of 12 inches above the floor of the box or chamber.

The fisher must demonstrate to WDFW and ODFW employees, fish and wildlife enforcement officers, or other peace officers, upon request, that the pumping system is delivering the proper volume of fresh river water into each chamber.

All sturgeon, non-adipose fin-clipped salmon, and steelhead must be released immediately to the river with care and with the least possible injury to the fish, or placed into an operating recovery box.

Any salmonid that is bleeding or lethargic must be placed in the recovery box prior to being released. All fish placed in recovery boxes must be released to the river prior to landing or docking.

(iv) **Observer program**: As a condition of fishing, owners or operators of commercial fishing vessels must cooperate with department observers or observers collecting data for the department, when notified by the observer of his or her intent to board the commercial vessel for observation and sampling during the fishery. In addition, cooperation with department personal prior to a fishing period is expected.

(v) **Live Capture workshop**: Only licensed Columbia River commercial fishers that have completed the required state-sponsored workshop concerning live-capture commercial fishing techniques may participate in this fishery. At least one fisher on each boat must have live- capture certification.

(2) Deep River Select Area

(a) **Dates:** Monday and Thursday nights immediately through June 13, 2014. Open hours are 7 PM to 7 AM

(b) **Area:** From the markers at USCG navigation marker #16, upstream to the Highway 4 Bridge.

(c) **Gear:** Gillnets. 9 3/4-inch maximum mesh. Nets are restricted to 100 fathoms in length with no weight restriction

on leadline. Use of additional weights or anchors attached directly to the leadline is allowed.

Nets cannot be tied off to stationary structures. Nets may not fully cross navigation channel. It is unlawful to operate in any river, stream or channel any gillnet longer than three-fourths the width of the stream (WAC 220-20-015)(1). It shall be unlawful in any area to use, operate, or carry aboard a commercial fishing vessel a licensed net or combination of such nets, whether fished singly or separately, in excess of the maximum lawful size or length prescribed for a single net in that area, except as otherwise provided for in the rules and regulations of the department (WAC 220-20-010) (17).

(d) **Allowable Possession:** Salmon and shad.

(e) **Miscellaneous:** Transportation or possession of fish outside the fishing area (except to the sampling station) is unlawful until WDFW staff has biologically sampled individual catches. After sampling, fishers will be issued a transportation permit by WDFW staff. A sampling station will be established at WDFW's Oneida Road boat ramp, about 0.5 miles upstream of the lower Deep River area boundary (USCG navigation marker #16).

(3) Tongue Point/South Channel

(a) **Dates:** Monday and Thursday nights from immediately through June 13, 2014 Open hours are 7:00 PM to 7:00 AM, except for the evening of May 8, open hours are reduced to 9:00 PM to 6:00 AM.

(b) **Area:** Tongue Point fishing area includes all waters bounded by a line extended from the upstream (southern most) pier (#1) at the Tongue Point Job Corps facility, through navigation marker #6 to Mott Island; a line from a marker at the southeast end of Mott Island, northeasterly to a marker on the northwest tip of Lois Island; and a line from a marker on the southwest end of Lois Island, westerly to a marker on the Oregon shore.

The South Channel area includes all waters bounded by a line from a marker on John Day Point through the green USCG buoy #7 to a marker on the southwest end of Lois Island, upstream to an upper boundary line from a marker on Settler Point, northwesterly to the flashing red USCG marker #10, and northwesterly to a marker on Burnside Island defining the upstream terminus of South Channel.

c) **Gear:** Gillnets. 9 3/4-inch maximum mesh. In the Tongue Point fishing area, gear restricted to a maximum net length of 250 fathoms, and weight not to exceed two pounds on any one fathom. In the South Channel fishing area, gear restricted to a maximum net length of 250 fathoms, no weight restriction on leadline, and use of additional weights or anchors attached directly to the leadline is allowed.

d) **Allowable Possession:** Salmon and shad.

e) **Miscellaneous:** Fishers are required to call 971-230-8247 and leave a message including name, catch, and where and when fish will be sold. Permanent transportation rules remain in effect.

f) **Observer program**: As a condition of fishing, owners or operators of commercial fishing vessels must cooperate with department observers or observers collecting data for the department, when notified by the observer of his or her intent to board the commercial vessel for observation and sampling during an open fishery. Additionally, cooperation with department personal or observers prior to an open fishery is expected.

(4) Blind Slough/Knappa Slough Select Area

(a) **Dates:** Monday and Thursday nights immediately through June 13, 2014. Open hours are 7:00 PM to 7:00 AM.

(b) **Area:** Blind Slough and Knappa Slough areas are both open. Effective May 8: The lower boundary of the Knappa Slough fishing area is extended downstream to boundary lines defined by markers on the west end of Minaker Island to markers on Karlson Island and the Oregon Shore (fall season boundary).

(c) **Gear:** Gillnets. 9 3/4-inch maximum mesh. Nets are restricted to 100 fathoms in length, with no weight restriction on leadline. Use of additional weights or anchors attached directly to the leadline is allowed.

(d) **Allowable Possession:** Salmon and shad.

(e) **Observer program**: As a condition of fishing, owners or operators of commercial fishing vessels must cooperate with department observers or observers collecting data for the department, when notified by the observer of his or her intent to board the commercial vessel for observation and sampling during an open fishery. Additionally, cooperation with department personal or observers prior to an open fishery is expected.

(5) For all fisheries described above (Sections 1-4):

a) **24-hour** quick reporting is in effect for Washington buyers (WAC 220-69-240 (14)(d)). Permanent transportation rules in effect.

b) **Multi net rule in effect**: Nets not specifically authorized for use in these areas may be onboard a vessel if properly stored (WAC 220-33-001(2)).

c) **Lighted buoys required:** Nets that are fished at any time between official sunset and official sunrise must have lighted buoys on both ends of the net unless the net is attached to the boat. If the net is attached to the boat, then one lighted buoy on the opposite end of the net from the boat is required.

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

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 1:00 p.m. May 7, 2014:

WAC 220-33-01000Q Columbia River seasons below Bonneville. (14-93)