WSR 16-23-055
EXPEDITED RULES
DEPARTMENT OF REVENUE
[Filed November 10, 2016, 10:42 a.m.]

November 10, 2016
Kevin Dixon
Rules Coordinator

Title of Rule and Other Identifying Information: WAC 458-61A-202 Inheritance or devise (Rule 61A-202) and 458-61A-210 Irrevocable trusts (Rule 61A-210), describe the required documentation to substantiate an exemption to real estate excise tax when real property is transferred.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Leslie Mullin, Department of Revenue, P.O. Box 47453, Olympia, WA 98504-7453, e-mail LeslieMu@dor.wa.gov, AND RECEIVED BY January 23, 2017.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Rules 61A-202 and 61A-210 are being amended to reflect legislative changes due to the passage of SHB 2539 (2016) which clarified the documentation requirements to qualify for an exemption to real estate excise tax when real property is transferred. The department is proposing revisions to Rules 61A-202 and 61A-210 that include:

- Adding the following definitions:
  - Heir
  - Lack of probate affidavit
  - Nonpro rata distribution.
- Clarifying the types of documents required when real property transfers through a devise by will or inheritance.
- Reorganizing subsections and examples for readability purposes.

Copies of draft rules are available for viewing and printing on our web site at dor.wa.gov.

Reasons Supporting Proposal: Rules 61A-202 and 61A-210 incorporate legislative changes from SHB 2539 passed during the 2016 legislative session.

Statutory Authority for Adoption: RCW 82.45.150 and 82.01.060(2).

Statute Being Implemented: RCW 82.45.197.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of revenue, governmental.

Name of Agency Personnel Responsible for Drafting: Leslie Mullin, 6400 Linderson Way S.W., Tumwater, WA, (360) 534-1589; Implementation and Enforcement: Marcus Glasper, 6400 Linderson Way S.W., Tumwater, WA, (360) 534-1615.

AMENDATORY SECTION (Amending WSR 15-02-018, filed 12/29/14, effective 1/29/15)

WAC 458-61A-202 Inheritance or devise. (1) **Introduction.** Transfers of real property ((~~by inheritance or~~)) through a devise by will or inheritance are not subject to the real estate excise tax. For the purpose of this exemption, it does not matter whether the real property transferred was encumbered by underlying debt at the time it was inherited or devised.

(2) **Definitions.** For the purposes of this rule, the following definitions apply:

(a) "Heir" means a person, including the surviving spouse or surviving domestic partner, who is entitled under the statutes of intestate succession to the real and personal property of a decedent on the decedent's death intestate;

(b) "Lack of probate affidavit" means a signed and notarized document declaring that the affiant or affiants are the rightful heir or heirs to the property and containing the following information:

(i) The names of the affiant or affiants;

(ii) The relationship of the affiant or affiants to the decedent;

(iii) The names of all other heirs of the decedent living at the time of the decedent's death;

(iv) A description of the real property;

(v) Whether the decedent left a will that includes a devise of real property; and

(vi) Any other information the department may require.

(c) "Nonpro rata distribution" is a distribution in which the transfer of real property to the heirs or devisees may not be in proportion to their interests.

(3) **Examples.** This rule contains examples that identify a number of facts and then state a conclusion. These examples should be used only as a general guide. The tax results of other situations must be determined after a review of all of the facts and circumstances.

(4) **Nonpro rata distributions.** A nonpro rata distribution ((~~is one in which the transfer of real property to the heirs or devisees may not be in proportion to their interests. For example, Aunt Mary wills her entire estate equally to her three nieces. The estate consists of her primary residence, a cottage at the ocean, and significant cash assets, among other things. Rather than take title to the two parcels of real estate in all three names, the estate may be distributed by deeding the primary residence to Meg, the oceanfront property to Beth, and the majority of the cash assets to Jo. Such distribution by a personal representative of a probated estate or by the trustee of a trust is not subject to the real estate excise tax if the transfer is authorized under the nonintervention powers of a personal representative under RCW 11.68.090 or under the nonpro rata distribution powers of a trustee under RCW 11.98.070(15), if no consideration is given to the personal representative or the trustee for the transfer. For the purpose of this section, consideration does not include the indebted-~~

~~ness balance of any real property that is encumbered by a security lien.~~

~~(3)~~)) made by a personal representative of a probated estate or by the trustee of a trust is not subject to the real estate excise tax if:

(a) The transfer is authorized under the nonintervention powers of a personal representative under RCW 11.68.090 or under the nonpro rata distribution powers of a trustee under RCW 11.98.070(15); and

(b) If no consideration is given to the personal representative or the trustee for the transfer.

For the purpose of this rule, consideration does not include the indebtedness balance of any real property that is encumbered by a security lien.

(c) **Example 1.** Aunt Mary wills her entire estate equally to her three nieces, Meg, Beth, and Jo. The estate consists of her primary residence, a cottage at the ocean, and significant cash assets, among other things. Rather than take title to the two parcels of real estate in all three names, the estate may be distributed by deeding the primary residence to Meg, the oceanfront property to Beth, and the majority of the cash assets to Jo.

(5) **Subsequent transfers.** A transfer of property from an heir to a third party is subject to the real estate excise tax. ((~~Examples:~~))

(a) **Example 2.** Steve inherits real property from his mother's estate. He sells the property to his son for $50,000. The transfer of the property from the estate to Steve is exempt from real estate excise tax. The subsequent sale of the property to his son is a taxable event, and real estate excise tax is due based upon the full sales price of $50,000.

(b) **Example 3.** Susan inherits real property from her father's estate. She decides to sell it to a friend on a real estate contract for $100,000. Real estate excise tax is due on the $100,000.

(c) **Example 4.** Sheri and her two sisters inherit their father's home, valued at $180,000, in equal portions. Sheri wants sole ownership of the home, but there are not "in-kind" assets of sufficient value to be distributed by the personal representative to her two sisters in a nonpro rata distribution. In order to take title directly from the personal representative, Sheri pays each of her sisters $60,000, and they quitclaim their right to the property under the will. Real estate excise tax is due on the total of $120,000 paid for the property.

(((~~4~~))) (6) **Exemptions and required documentation.** A transfer of real property through a devise by will or inheritance is exempt from the real estate excise tax for the following types of transfers. Refer to WAC 458-61A-303 (Affidavit) to determine if a real estate excise tax affidavit is required to document the exempt transfers. Additional documentation may be required to substantiate each exemption, and must be provided to the county treasurer of the county in which the real property is located and recorded with the county auditor:

(a) **Community property agreement or right of survivorship.** If the transfer of real property to a surviving spouse or surviving domestic partner is in accordance with a community property agreement or ((~~a survivorship clause is not subject to real estate excise tax.~~

~~(5)~~))) right of survivorship clause, copies of the recorded agreement and a certified copy of the death certificate are required.

(b) **Joint tenants with rights of survivorship and remainder interests.** ((~~The transfer of~~)) If real property is transferred upon the death of a joint tenant to the remaining joint tenants under right of survivorship ((~~is not subject to the real estate excise tax.~~

~~(6)~~)), a certified copy of the death certificate is required.

(c) **Life estates and remainder interests.** The transfer of a life estate to the grantor with a remainder interest to another party is not a taxable transfer if no consideration passes. ((~~For example,~~))

Example 5. Nate and Libby convey their property to their son, Rex, and retain a life estate. The transaction is not subject to real estate excise tax because Rex pays no consideration. Upon the deaths of Nate and Libby, the title will vest in Rex and no real estate excise tax is due. However, if Nate and Libby convey their property to Rex, while retaining a life estate, and Rex pays any consideration for his future interest, the transaction is taxable. Real estate excise tax is due on the total consideration paid.

(((~~7~~))) (d) **Transfer on death deeds.** If the transfer of real property is pursuant to a previously recorded transfer on death deed, upon the death of the transferor to the beneficiary(ies) named in the transfer on death deed ((~~occurs upon the death of the transferor and is generally not subject to the real estate excise tax~~)), a certified copy of the death certificate is required. However, if the transfer of real property pursuant to a transfer on death deed satisfies a contractual obligation of the transferor owed to the beneficiary(ies) designated in the transfer on death deed, real estate excise tax is due on the transfer.

(((~~8) **Documentation.** In order to claim this exemption, the following documentation must be provided:~~

~~(a) **Community property agreement.** If the property is being transferred under the terms of a community property agreement, copies of the recorded agreement and certified copy of the death certificate;~~

~~(b) **Trusts.** If property is being transferred under the terms of a trust instrument, a certified copy of the death certificate, and a copy of the trust instrument showing the authority of the grantor;~~

~~(c)~~)) (e) **Trusts.** If real property is transferred under the terms of a trust instrument, a certified copy of the death certificate and a copy of that portion of the trust instrument showing the authority of the grantor are required. For additional information on the application of real estate excise tax to transfers of real property under the terms of a trust, see WAC 458-61A-210 (Irrevocable trusts) and WAC 458-61A-211 (Mere change in identity or form—Family corporations and partnerships).

(f) **Probate.** ((~~In the case of~~)) For real property transferred under a probated will, a certified copy of the letters testamentary, or in the case of intestate administration, a certified copy of the letters of administration, showing that the grantor is the court appointed executor/executrix or administrator((~~;~~

(d) **Joint tenants with rights of survivorship and remainder interests.** A certified copy of the death certificate is recorded to perfect title;

(e))) is required.

(g) **Court order.** If ((the)) real property is ((being)) transferred pursuant to a court order, a certified copy of the court order requiring the transfer of property((,)) and confirming that the grantor is required to do so under the terms of the order((;

(f) **Transfer on death deeds.** If the property is being transferred pursuant to a transfer on death deed, the beneficiary(ies) of the transfer on death deed must record a certified copy of the death certificate to perfect title.

(g) **Other.**)) is required.

(h) **Community property interest.** If the community property interest of the decedent is ((being)) transferred to a surviving spouse or surviving domestic partner absent the documentation ((set forth in (a) through (f))) described in (a), (b), (e), (f), or (g) of this subsection, a certified copy of the death certificate and a signed lack of probate affidavit from the surviving spouse or surviving domestic partner affirming that he or she is the sole and rightful heir ((of)) to the property are required. Refer to the department's web site at dor.wa.gov for an example of the lack of probate affidavit that may be used.

(i) **Nonprobated will or operation of law.** If the property is transferred to one or more heirs by operation of law, or transferred under a will that has not been probated, but absent the documentation described in (a), (b), (e), (f), or (g) of this subsection, a certified copy of the death certificate and a signed lack of probate affidavit affirming that the affiant or affiants are the sole and rightful heirs to the property are required. When the property is transferred and the decedent-transferor also inherited the property from his or her spouse or domestic partner, but never transferred title to the property into the decedent-transferor's name, the transferee(s) must provide:

(i) A certified copy of the death certificate for the decedent-transferor;

(ii) A certified copy of the death certificate for the spouse or domestic partner from whom the decedent-transferor inherited the real property; and

(iii) A lack of probate affidavit affirming that the affiant or affiants are the rightful heirs to the property.

AMENDATORY SECTION (Amending WSR 14-06-060, filed 2/28/14, effective 3/31/14)

WAC 458-61A-210 Irrevocable trusts. (1) **Introduction.** The distribution of real property to the beneficiaries of an irrevocable trust is not subject to the real estate excise tax if no valuable consideration is given for the transfer and the distribution is made according to the trust instrument.

(2) **Transfer into trust.** A transfer of real property to an irrevocable trust is subject to the real estate excise tax if:

(a) The transfer results in a change in the beneficial interest and not a mere change in identity or ownership; and

(b) There is valuable consideration for the transfer.

(3) **Examples.** The following examples, while not exhaustive, illustrate some of the circumstances in which a transfer of real property to a trust may or may not be exempt from real estate excise tax. The status of each situation must be determined after a review of all the facts and circumstances.

(a) **Example 1.** Eric and Annie, husband and wife, transfer real property valued at $500,000 to an irrevocable trust. The property has an underlying debt of $300,000 that is secured by a deed of trust. Under the terms of the trust, the trustee is required to pay all the income annually to the grantors (Eric and Annie), or to the survivor if one of them dies. Upon the death of both Eric and Annie, the property will be divided equally among their children. The conveyance of the property into the trust is not subject to the real estate excise tax, even if the trust pays the indebtedness, because there has been no change in the present beneficial interest, and Eric and Annie did not receive consideration for the transfer.

(b) **Example 2.** Jim and Jean, husband and wife, own real property valued at $800,000. Upon Jean's death, her one-half interest in the property is transferred to Jean's testamentary trust under the terms of her will. Jim, as trustee, has sole discretion to accumulate income or to pay income to himself, or to their children, or to their grandchildren, or to each. The transfer to the trust is not subject to real estate excise tax. See WAC 458-61A-202.

(c) **Example 3.** Same facts as in Example 2, but upon Jean's death, Jim's remaining half-interest in the property is valued at $400,000, with an underlying debt of $30,000, for which he is personally liable. Jim transfers his half-interest to Jean's testamentary trust, and the trust pays or is obligated to pay the indebtedness. The conveyance of Jim's one-half interest is subject to real estate excise tax, because the transfer involves both a present change in the beneficial interest (after Jean's death, assets in Jean's trust are legally separate from assets belonging to Jim) and there is valuable consideration in the form of relief of liability for the debt. The real estate excise tax is due on the amount of the consideration ($30,000).

(4) **Revocable trusts.** See WAC 458-61A-211 for the taxability of transfers into a revocable trust.

(5) **Documentation.** When real property is transferred to or from a testamentary trust, or real property is transferred to or from an irrevocable trust, the following must be available to the department upon request, and provided to the county treasurer ((or the department upon request)) and recorded with the county auditor:

(a) A certified copy of the death certificate and a copy of that portion of the trust instrument showing the authority of the grantor; or

(b) A statement signed by the trustee or the grantor, or the representative of the trustee or grantor containing the following information:

(i) The name, address, and telephone number of the trustee or grantor, and/or representative of the trustee or grantor who is authorized to represent the trustee or grantor before the department of revenue;

(ii) The character of the trust, e.g., testamentary, irrevocable living trust, etc.;

(iii) The nature of the transfer:

(A) If the transfer is to or from a testamentary trust, the nature of and reason for the transfer.

(B) If the transfer is to or from an irrevocable living trust:

(I) The nature and reason for the transfer;

(II) Whether or not the property is encumbered with debt; and

(III) Whether or not the trustee may, at the time of the transfer, distribute income and/or principal to a person(s) other than the grantor(s).

WSR 16-23-058
EXPEDITED RULES
EMPLOYMENT SECURITY DEPARTMENT

[Filed November 10, 2016, 12:29 p.m.]

Title of Rule and Other Identifying Information: WAC 192-120-030, 192-120-035, 192-130-050, 192-130-080, 192-220-010 and 192-220-080, those subsections that specify the response deadline for various notices issued by the department.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Juanita Myers, Employment Security Department, P.O. Box 9046, Olympia, WA 98507, AND RECEIVED BY January 24, 2017.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The rules are being amended to change "five days" to "five working days" in order to clarify the number of days available to respond to a request for information from the department.

Reasons Supporting Proposal: A settlement agreement signed by the department in 1988 in Thurston County superior court requires the department to provide claimants with reasonable mailing time plus five working days to provide information requested by the department. This settlement remains in effect. The word "working" was inadvertently omitted when the rules were last amended.

Statutory Authority for Adoption: RCW 50.12.010 and 50.12.040.

Statute Being Implemented: Chapter 50.20 RCW.

Rule is necessary because of state court decision, *O'Brien v. Norward Brooks* as Commissioner of the Employment Security Department, Thurston County Superior Court, 1988.

Name of Proponent: Employment security department, governmental.

Name of Agency Personnel Responsible for Drafting: Juanita Myers, 212 Maple Park, Olympia, (360) 902-9665; Implementation and Enforcement: Neil Gorrell, 212 Maple Park, Olympia, (360) 902-9303.

November 9, 2016
Lisa Marsh
Deputy Commissioner

AMENDATORY SECTION (Amending WSR 16-21-013, filed 10/7/16, effective 11/14/16)

WAC 192-120-030 Will I be told if my eligibility for benefits is questioned? Whenever we have a question regarding whether you (the claimant) are eligible for benefits, we will give you adequate notice before making a decision. "Adequate notice" means we will tell you:

(1) Why we question your eligibility for benefits;

(2) That you have the right to a fact-finding interview about your eligibility for benefits and that the interview will be conducted by telephone except:

(a) When you specifically ask to be interviewed in person; or

(b) In unusual circumstances where we decide an in-person interview is necessary.

(3) That you can have someone, including an attorney, assist you at the interview;

(4) That you can have witnesses on your behalf, provide evidence, and cross-examine other witnesses or parties;

(5) That, prior to the interview, you may ask for copies of any records or documents we have that we will consider in making a decision about your eligibility for benefits;

(6) The date by which you must reply to the notice (which will be no earlier than five working days plus reasonable mailing time, if any); and

(7) That if you do not respond to the notice by the date shown, your benefits may be denied and you may have to repay any benefits already paid to you.

AMENDATORY SECTION (Amending WSR 16-21-013, filed 10/7/16, effective 11/14/16)

WAC 192-120-035 How will adequate notice be provided? When you file your weekly claim for benefits by telephone, you will receive a verbal notice if there is a question about your eligibility for benefits. When you file your weekly claim for benefits by using the department's online services, a statement will be displayed online that there is a question about your eligibility for benefits. You will be provided a minimum of five working days, plus reasonable mailing time, if any, to respond to the notice or statement.

AMENDATORY SECTION (Amending WSR 16-21-013, filed 10/7/16, effective 11/14/16)

WAC 192-130-050 Notice of filing of application—RCW 50.20.150. Whenever an individual files an initial application for unemployment benefits, or reopens a claim after subsequent employment, a notice will be sent to the applicant's most recent employer as stated by the applicant. Any employer who receives such a notice and has information which might make the applicant ineligible for benefits must report this information to the department as indicated on the notice. The information must be reported within five working days, plus reasonable mailing time, if any, beginning on the date the notice was sent. If the employer does not reply

within this time frame, the department may allow benefits to the individual, if he or she is otherwise eligible.

AMENDATORY SECTION (Amending WSR 16-21-013, filed 10/7/16, effective 11/14/16)

WAC 192-130-080 Procedure—Separation issues. (1) The department will not make a decision on a separation issue (RCW 50.20.050 or 50.20.066) until both the employer and the claimant have had an opportunity to present information and rebuttal, if necessary and appropriate, about the separation.

(2) If an employer does not respond to the notice within five working days, plus reasonable mailing time, if any, as required by WAC 192-130-060, the department may make a decision at that time based on available information.

(3) If the employer sends separation information to the department after the end of the response period, but before the decision has been made, the department will consider that information before making a decision.

(4) If the employer sends separation information to the department within thirty days after a decision has been sent, the department will consider that information for the purposes of a redetermination under RCW 50.20.160 or as an appeal of the decision.

(5) Any information received within thirty days of the date the notice required by WAC 192-130-060 was sent will be considered a request for relief of benefit charges under RCW 50.29.021.

AMENDATORY SECTION (Amending WSR 16-21-013, filed 10/7/16, effective 11/14/16)

WAC 192-220-010 Will I be notified about a potential overpayment? (1) If a potential overpayment exists, the department will provide you with a written overpayment advice of rights explaining the following:

(a) The reasons you may have been overpaid;

(b) The amount of the possible overpayment as of the date the notice is sent;

(c) The fact that the department will collect overpayments as provided in WAC 192-230-100;

(d) The fact that final overpayments are legally enforceable debts which must be repaid whether or not you are claiming unemployment benefits;

(e) The fact that these debts can be the basis for warrants which can result in liens, notices to withhold and deliver personal properties, possible sale of real and personal properties, and garnishment of salaries;

(f) An explanation that if you are not at fault, you may request a waiver of the overpayment; and

(g) A statement that you have five working days plus reasonable mailing time, if any, to submit information about the possible overpayment and whether you are at fault. If you do not provide the information within this time frame, the department will make a decision based on available information about the overpayment and your eligibility for waiver.

(2) Any amounts deducted from your benefit payments for federal income taxes or child support are considered paid to you and will be included in the overpayment.

AMENDATORY SECTION (Amending WSR 16-21-013, filed 10/7/16, effective 11/14/16)

WAC 192-220-080 How do I obtain a waiver? (1) When a decision is issued that creates an overpayment, the department will send you an application for waiver if you are potentially eligible.

(2) The waiver application asks for information concerning your financial condition and other circumstances which will help the department determine if the overpayment should be waived.

(3) The financial information requested includes documentation for the previous month, current month, and following month of your:

(a) Income and, to the extent available, the income of other household members who contribute financially to the household;

(b) Expenses; and

(c) Readily available liquid assets including, but not limited to, checking and savings account balances, stocks, bonds, and cash on hand.

(4) The completed application and supporting documents must be returned to the department by the response deadline indicated in the notice, which will be no less than five working days plus reasonable mailing time, if any. If you do not provide the information by the deadline, the department will make a decision about your eligibility for waiver based on available information.

(5) A waiver cannot exceed the total amount of benefits available on your claim. The department will not waive the overpayment in such a way as to allow you to receive either a greater weekly benefit amount or a greater total benefit amount than you were originally eligible to receive. Any benefits waived are considered paid to you.

Example: You misplace a benefit check and request a replacement from the department. You subsequently cash both the original check and the replacement. Waiver will not be approved under these circumstances because you have been paid twice for the same week.

(6) If a waiver is approved based on information that is later found to be false or misleading, the amount waived will be restored to your overpayment balance.

WSR 16-23-091
EXPEDITED RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed November 16, 2016, 12:29 p.m.]

Title of Rule and Other Identifying Information: Amends WAC 181-79A-128 to clarify length of a permit. Language said "minimum" and changed to "up to" a year.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE

RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO David Brenna, Professional Educator Standards Board, 600 Washington Street South, Room 400, Olympia, WA 98504, AND RECEIVED BY January 24, 2017.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Corrects and clarifies language related to the length of permits.

Reasons Supporting Proposal: Clarity of length of permit.

Statutory Authority for Adoption: RCW 28A.410.210.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Professional educator standards board, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: David Brenna, 600 Washington Street South, Olympia, WA 98504, (360) 725-6238.

November 16, 2016
David Brenna
Senior Policy Analyst

AMENDATORY SECTION (Amending WSR 15-14-065, filed 6/26/15, effective 7/27/15)

WAC 181-79A-128 Temporary permits. Temporary permits may be issued by the superintendent of public instruction and designated agents under the following conditions:

(1) Temporary permits may be issued under this section to those persons who have filed an application for a certificate; who, based on available documentation, including affidavits or other evidence that appears reliable which substantiates the existence of missing documentation, appear to have completed all requirements for certification; and who do not disclose any information which indicates that such applicant fails to meet the character requirement of WAC 181-79A-150(2).

(2) An individual may apply for a permit directly to the superintendent of public instruction or designated agents—i.e., educational service districts or Washington state institutions of higher education.

(3) A permit entitles the holder to serve as a teacher, educational staff associate or administrator consistent with the endorsement(s) on his/her permit.

(4) A permit is valid for ((~~a minimum of~~)) up to one year unless prior to the expiration date the superintendent of public instruction determines the applicant is ineligible to receive a valid certificate or endorsement. In such cases, the temporary permit shall expire on the date notice of cancellation is received by the applicant and/or the employer.

(5) The temporary permit may be reissued only upon demonstration that the applicant has made a good faith effort to secure the missing documentation; provided, that an individual affected by WAC 181-79A-132 may obtain one additional permit to meet additional endorsement requirements.

(6) Issuing authority. The superintendent of public instruction either directly or through a designated agent shall issue all permits and shall provide institutions of higher education and educational service districts with forms and instructions relevant to application for a permit.

WSR 16-23-095
EXPEDITED RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed November 16, 2016, 1:40 p.m.]

Title of Rule and Other Identifying Information: Amends WAC 181-79A-270 to clarify requirement for foreign teacher renewal. Requires district sponsorship.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO David Brenna, Professional Educator Standards Board, 600 Washington Street South, Room 400, Olympia, WA 98504, AND RECEIVED BY January 24, 2017.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Clarifies the districts responsibility to sponsor exchange and visiting teacher program certificate renewal.

Reasons Supporting Proposal: Clarity for districts sponsorship.

Statutory Authority for Adoption: RCW 28A.410.210.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Professional educator standards board, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: David Brenna, 600 Washington Street South, Olympia, WA 98504, (360) 725-6238.

November 16, 2016
David Brenna
Senior Policy Analyst

AMENDATORY SECTION (Amending WSR 06-02-051, filed 12/29/05, effective 1/1/06)

WAC 181-79A-270 Teacher, principal, and educational staff associate exchange permits. Teacher, principal, and educational staff associate exchange permits may be issued by the superintendent of public instruction to an individual admitted to the United States for the purpose of serving as an exchange teacher, principal, or educational staff

associate. Such teacher, principal, or educational staff associate exchange permits shall be valid for one year and may be renewed ((~~once~~)) while being sponsored by a school district in the exchange and visiting teacher program.

WSR 16-23-097
EXPEDITED RULES
DEPARTMENT OF HEALTH

[Filed November 16, 2016, 4:57 p.m.]

Title of Rule and Other Identifying Information: WAC 246-310-010 Certificate of need—Definitions, the department of health (department) intends to delete subsection (54) that refers to the "sale, purchase, or lease" of part or all of any existing hospital in order to comply with a 2015 Washington state supreme court (court) ruling.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Janis Sigman, Manager, Department of Health, Certificate of Need Program, P.O. Box 47850, Tumwater, WA 98504-7850, AND RECEIVED BY January 23, 2017.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed change will delete WAC 246-310-010(54) within the Certificate of need—Definitions section of rule. On July 9, 2015, the court ruled the department exceeded its statutory authority in adopting this particular definition of "sale, purchase, or lease" citing the new rule was invalid because it interpreted terms in RCW 70.38.105 (4)(b) in a manner that was "too broad to be consistent with the statute." The court concluded that the department's new rule was consequentially invalid. The purpose of this proposal is to delete the subsection in its entirety to comply with the court's ruling.

Reasons Supporting Proposal: It is necessary for the department to delete WAC 246-310-010(54) to comply with the court's 2015 judgment and ruling, No. 90486-3. This rule change qualifies for expedited rule making under RCW 34.05.353 (2)(c) because it is no longer necessary because of changed circumstances.

Statutory Authority for Adoption: RCW 70.38.115 and 70.38.135.

Statute Being Implemented: RCW 70.38.105.

Rule is necessary because of state court decision, *WSHA v. DOH*, No. 90486-3.

Name of Proponent: Washington state department of health, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Janis Sigman, 111 Israel Road S.E., Tumwater, WA 98501, (360) 236-2956.

November 16, 2016
John Wiesman, DrPH, MPH
Secretary

AMENDATORY SECTION (Amending WSR 14-02-040, filed 12/23/13, effective 1/23/14)

WAC 246-310-010 Definitions. For the purposes of chapter 246-310 WAC, the following words and phrases have the following meanings unless the context clearly indicates otherwise.

(1) "Acute care facilities" means hospitals and ambulatory surgical facilities.

(2) "Affected person" means an interested person who:

(a) Is located or resides in the applicant's health service area;

(b) Testified at a public hearing or submitted written evidence; and

(c) Requested in writing to be informed of the department's decision.

(3) "Alterations," see "construction, renovation, or alteration."

(4) "Ambulatory care facility" means any place, building, institution, or distinct part thereof not a health care facility as defined in this section and operated for the purpose of providing health services to individuals without providing such services with board and room on a continuous twenty-four-hour basis. The term "ambulatory care facility" includes the offices of private physicians, whether for individual or group practice.

(5) "Ambulatory surgical facility" means any free-standing entity, including an ambulatory surgery center that operates primarily for the purpose of performing surgical procedures to treat patients not requiring hospitalization. This term does not include a facility in the offices of private physicians or dentists, whether for individual or group practice, if the privilege of using the facility is not extended to physicians or dentists outside the individual or group practice.

(6) "Applicant," means:

(a) Any person proposing to engage in any undertaking subject to review under chapter 70.38 RCW; or

(b) Any person or individual with a ten percent or greater financial interest in a partnership or corporation or other comparable legal entity engaging in any undertaking subject to review under chapter 70.38 RCW.

(7) "Bed banking" means the process of retaining the rights to nursing home bed allocations which are not licensed as outlined in WAC 246-310-395.

(8) "Bed supply" means within a geographic area the total number of:

(a) Nursing home beds which are licensed or certificate of need approved but not yet licensed or beds banked under RCW 70.38.111 (8)(a) or where the need is deemed met under RCW 70.38.115 (13)(b), excluding:

(i) Those nursing home beds certified as intermediate care facility for the mentally retarded (ICF-MR) the operators of which have not signed an agreement on or before July 1,

1990, with the department of social and health services department of social and health services to give appropriate notice prior to termination of the ICF-MR service;

(ii) New or existing nursing home beds within a CCRC which are approved under WAC 246-310-380(5); or

(iii) Nursing home beds within a CCRC which is excluded from the definition of a health care facility per RCW 70.38.025(6); and

(iv) Beds banked under RCW 70.38.115 (13)(b) where the need is not deemed met.

(b) Licensed hospital beds used for long-term care or certificate of need approved hospital beds to be used for long-term care not yet in use, excluding swing-beds.

(9) "Bed-to-population ratio" means the nursing home bed supply per one thousand persons of the estimated or forecasted resident population age seventy and older.

(10) "Capital expenditure": Except for WAC 246-310-280, capital expenditure means an expenditure, including a force account expenditure (i.e., an expenditure for a construction project undertaken by a nursing home facility as its own contractor), which, under generally accepted accounting principles, is not properly chargeable as an expense of operation or maintenance. The costs of any studies, surveys, designs, plans, working drawings, specifications, and other activities (including staff effort, consulting and other services which, under generally accepted accounting principles, are not properly chargeable as an expense of operation and maintenance) shall be considered capital expenditures. Where a person makes an acquisition under lease or comparable arrangement, or through donation, which would have required certificate of need review if the acquisition had been made by purchase, this acquisition shall be deemed a capital expenditure. Capital expenditures include donations of equipment or facilities to a nursing home facility, which if acquired directly by the facility, would be subject to review under this chapter and transfer of equipment or facilities for less than fair market value if a transfer of the equipment or facilities at fair market value would be subject to the review.

(11) "Certificate of need" means a written authorization by the secretary's designee for a person to implement a proposal for one or more undertakings.

(12) "Certificate of need program" means that organizational program of the department responsible for the management of the certificate of need program.

(13) "Commencement of the project" means whichever of the following occurs first: In the case of a construction project, giving notice to proceed with construction to a contractor for a construction project provided applicable permits have been applied for or obtained within sixty days of the notice; beginning site preparation or development; excavating or starting the foundation for a construction project; or beginning alterations, modification, improvement, extension, or expansion of an existing building. In the case of other projects, initiating a health service.

(14) "Construction, renovation, or alteration" means the erection, building, remodeling, modernization, improvement, extension, or expansion of a physical plant of a health care facility, or the conversion of a building or portion thereof to a health care facility.

(15) "Continuing care contract" means a contract providing a person, for the duration of that person's life or for a term in excess of one year, shelter along with nursing, medical, health-related, or personal care services. The contract is conditioned on the transfer of property, the payment of an entrance fee to the provider of the services, or the payment of periodic charges for the care and services involved. A continuing care contract is not excluded from this definition because the contract is mutually terminable or because shelter and services are not provided at the same location.

(16) "Continuing care retirement community (CCRC)" means any of a variety of entities, unless excluded from the definition of health care facility under RCW 70.38.025(6), which provides shelter and services based on continuing care contracts with its residents which:

Maintains for a period in excess of one year a CCRC contract with a resident which provides or arranges for at least the following specific services:

(a) Independent living units;

(b) Nursing home care with no limit on the number of medically needed days;

(c) Assistance with activities of daily living;

(d) Services equivalent in scope to either state chore services or medicaid home health services;

(e) Continues a contract, if a resident is no longer able to pay for services;

(f) Offers services only to contractual residents with limited exception during a transition period; and

(g) Holds the medicaid program harmless from liability for costs of care, even if the resident depletes his or her personal resources.

(17) "Days" means calendar days. Days are counted starting the day after the date of the event from which the designated period of time begins to run. If the last day of the period falls on a Saturday, Sunday, or legal holiday observed by the state of Washington, a designated period runs until the end of the first working day following the Saturday, Sunday, or legal holiday.

(18) "Department" means the Washington state department of health.

(19) "Effective date of facility closure" means:

(a) The date on which the facility's license was relinquished, revoked or expired; or

(b) The date the last resident leaves the facility, whichever comes first.

(20) "Enhance the quality of life for residents" means, for the purposes of voluntary bed banking, those services or facility modifications which have a direct and immediate benefit to the residents. These include, but are not limited to: Resident activity and therapy facilities; family visiting rooms; spiritual rooms and dining areas. These services or facility modifications shall not include those that do not have direct and immediate benefit to the residents, such as: Modifications to staff offices; meeting rooms; and other staff facilities.

(21) "Established ratio" means a bed-to-population ratio of forty beds per one thousand persons of the estimated or forecast resident population age seventy and older established for planning and policy-making purposes. The depart-

ment may revise this established ratio using the process outlined in WAC 246-310-370.

(22) "Estimated bed need" means the number of nursing home beds calculated by multiplying the planning area's forecasted resident population by the established ratio for the projection year.

(23) "Estimated bed projection" means the number of nursing home beds calculated by the department statewide or within a planning area, by the end of the projection period.

(24) "Ex parte contact" means any oral or written communication between any person in the certificate of need program or any other person involved in the decision regarding an application for, or the withdrawal of, a certificate of need and the applicant for, or holder of, a certificate of need, any person acting on behalf of the applicant or holder, or any person with an interest regarding issuance or withdrawal of a certificate of need.

(25) "Expenditure minimum" means one million dollars for the twelve-month period beginning with July 24, 1983, adjusted annually by the department according to WAC 246-310-900.

(26) "Health care facility" means hospitals, psychiatric hospitals, nursing homes, kidney disease treatment centers including freestanding dialysis units, ambulatory surgical facilities, continuing care retirement communities, hospices and home health agencies, and includes the facilities when owned and operated by a political subdivision or instrumentality of the state and other facilities as required by federal law and rules, but does not include any health facility or institution conducted by and for those who rely exclusively upon treatment by prayer or spiritual means in accordance with the creed or tenets of any well-recognized church or religious denomination, or any health facility or institution operated for the exclusive care of members of a convent as defined in RCW 84.36.800 or rectory, monastery, or other institution operated for the care of members of the clergy.

(a) In addition, the term "health care facility" does not include any nonprofit hospital:

(i) Operated exclusively to provide health care services for children;

(ii) Which does not charge fees for the services; and

(iii) If not contrary to federal law as necessary to the receipt of federal funds by the state.

(b) In addition, the term "health care facility" does not include a continuing care retirement community which:

(i) Offers services only to contractual residents;

(ii) Provides its residents a contractually guaranteed range of services from independent living through skilled nursing, including some form of assistance with activities of daily living;

(iii) Contractually assumes responsibility for costs of services exceeding the resident's financial responsibility as stated in contract, so that, with the exception of insurance purchased by the retirement community or its residents, no third party, including the medicaid program, is liable for costs of care even if the resident depletes personal resources;

(iv) Offers continuing care contracts and operates a nursing home continuously since January 1, 1988, or obtained a certificate of need to establish a nursing home;

(v) Maintains a binding agreement with the department of social and health services assuring financial liability for services to residents, including nursing home services, shall not fall upon the department of social and health services;

(vi) Does not operate, and has not undertaken, a project resulting in a number of nursing home beds in excess of one for every four living units operated by the continuing care retirement community, exclusive of nursing home beds; and

(vii) Has undertaken no increase in the total number of nursing home beds after January 1, 1988, unless a professional review of pricing and long-term solvency was obtained by the retirement community within the prior five years and fully disclosed to residents.

(27) "Health maintenance organization" means a public or private organization, organized under the laws of the state, which:

(a) Is a qualified health maintenance organization under Title XIII, Section 1310(d) of the Public Health Service Act; or

(b) Provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: Usual physician services, hospitalization, laboratory, X ray, emergency and preventive services, and out-of-area coverage;

(c) Is compensated (except for copayments) for the provision of the basic health care services listed in this subsection to enrolled participants by a payment made on a periodic basis without regard to the date the health care services are provided and fixed without regard to the frequency, extent, or kind of health service actually provided; and

(d) Provides physicians' services primarily:

(i) Directly through physicians who are either employees or partners of the organization; or

(ii) Through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

(28) "Health service area" means a geographic region appropriate for effective health planning including a broad range of health services.

(29) "Health services" means clinically related (i.e., preventive, diagnostic, curative, rehabilitative, or palliative) services and includes alcoholism, drug abuse, and mental health services.

(30) "Home health agency" means an entity which is, or has declared its intent to become, certified as a provider of home health services in the medicaid or medicare program.

(31) "Hospice" means an entity which is, or has declared its intent to become, certified as a provider of hospice services in the medicaid or medicare program.

(32) "Hospital" means any institution, place, building or agency or distinct part thereof which qualifies or is required to qualify for a license under chapter 70.41 RCW, or as a psychiatric hospital licensed under chapter 71.12 RCW.

(33) "Inpatient" means a person receiving health care services with board and room in a health care facility on a continuous twenty-four-hour-a-day basis.

(34) "Interested persons" means:

(a) The applicant;

(b) Health care facilities and health maintenance organizations providing services similar to the services under review and located in the health service area;

(c) Third-party payers reimbursing health care facilities in the health service area;

(d) Any agency establishing rates for health care facilities and health maintenance organizations in the health service area where the proposed project is to be located;

(e) Health care facilities and health maintenance organizations which, in the twelve months prior to receipt of the application, have submitted a letter of intent to provide similar services in the same planning area;

(f) Any person residing within the geographic area to be served by the applicant; and

(g) Any person regularly using health care facilities within the geographic area to be served by the applicant.

(35) "Licensee" means an entity or individual licensed by the department of health or the department of social and health services. For the purposes of nursing home projects, licensee refers to the operating entity and those persons specifically named in the license application as defined under chapter 388-97 WAC.

(36) "Net estimated bed need" means estimated bed need of a planning area changed by any redistribution as follows:

(a) Adding nursing home beds being redistributed from another nursing home planning area or areas; or

(b) Subtracting nursing home beds being redistributed to another nursing home planning area or areas.

(37) "New nursing home bed" means a nursing home bed never licensed by the state or beds banked under RCW 70.38.115(13), where the applicant must demonstrate need for the previously licensed nursing home beds. This term does not include beds banked under RCW 70.38.111(8).

(38) "Nursing home" means any entity licensed or required to be licensed under chapter 18.51 RCW or distinct part long-term care units located in a hospital and licensed under chapter 70.41 RCW.

(39) "Obligation," when used in relation to a capital expenditure, means the following has been incurred by or on behalf of a health care facility:

(a) An enforceable contract has been entered into by a health care facility or by a person on behalf of the health care facility for the construction, acquisition, lease, or financing of a capital asset; or

(b) A formal internal commitment of funds by a health care facility for a force account expenditure constituting a capital expenditure; or

(c) In the case of donated property, the date on which the gift is completed in accordance with state law.

(40) "Offer," when used in connection with health services, means the health facility provides one or more specific health services.

(41) "Over the established ratio" means the bed-to-population ratio is greater than the statewide current established ratio.

(42) "Person" means an individual, a trust or estate, a partnership, any public or private corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.

(43) "Planning area" means each individual county designated by the department as the smallest geographic area for which nursing home bed need projections are developed, except as follows:

(a) Clark and Skamania counties shall be one planning area.

(b) Chelan and Douglas counties shall be one planning area.

(44) "Predevelopment expenditures" means capital expenditures, the total of which exceeds the expenditure minimum, made for architectural designs, plans, drawings, or specifications in preparation for the acquisition or construction of physical plant facilities. "Predevelopment expenditures" exclude any obligation of a capital expenditure for the acquisition or construction of physical plant facilities and any activity which the department may consider the "commencement of the project" as this term is defined in this section.

(45) "Professional review of continuing care retirement community pricing and long-term solvency" means prospective financial statements, supported by professional analysis and documentation, which:

(a) Conform to Principles and Practices Board Statement Number 9 of the Healthcare Financial Management Association, "Accounting and Reporting Issues Related to Continuing Care Retirement Communities"; and

(b) Project the financial operations of the continuing care retirement community over a period of ten years or more into the future; and

(c) Are prepared and signed by a qualified actuary as defined under WAC 284-05-060 or an independent certified public accountant, or are prepared by management of the continuing care retirement community and reviewed by a qualified actuary or independent certified public accountant who issues a signed examination or compilation report on the prospective financial statements; and

(d) Include a finding by management that the intended expansion project of the continuing care retirement project is financially feasible.

(46) "Project" means all undertakings proposed in a single certificate of need application or for which a single certificate of need is issued.

(47) "Project completion" for projects requiring construction, means the date the facility is licensed. For projects not requiring construction, project completion means initiating the health service.

(48) "Projection period" means the three-year time interval following the projection year.

(49) "Projection year" for nursing home purposes, means the one-year time interval preceding the projection period.

(50) "Public comment period" means the time interval during which the department shall accept comments regarding a certificate of need application.

(51) "Redistribution" means the shift of nursing home bed allocations between two or more planning areas or the shift of nursing home beds between two or more nursing homes.

(52) "Replacement authorization" means a written authorization by the secretary's designee for a person to

implement a proposal to replace existing nursing home beds in accordance with the eligibility requirements in WAC 246-310-044 and notice requirements in WAC 246-310-396.

(53) "Resident population" for purposes of nursing home projects, means the number of residents sixty-five years of age and older living within the same geographic area which:

(a) Excludes contract holders living within a recognized CCRC:

(i) With approval for new nursing home beds under WAC 246-310-380(4); or

(ii) Excluded from the definition of a health care facility per RCW 70.38.025(6);

(b) Is calculated using demographic data obtained from:

(i) The office of financial management; and

(ii) Certificate of need applications and exemption requests previously submitted by a CCRC.

(54) ((~~"Sale, purchase, or lease" means any transaction in which the control, either directly or indirectly, of part or all of any existing hospital changes to a different person including, but not limited to, by contract, affiliation, corporate membership restructuring, or any other transaction.~~

~~(55)~~)) "Secretary" means the secretary of the Washington state department of health or the secretary's designee.

(((~~56~~))) (55) "State Health Planning and Resources Development Act" means chapter 70.38 RCW.

(((~~57~~))) (56) "Statewide current ratio" means a bed-to-population ratio computed from the most recent statewide nursing home bed supply and the most recent estimate of the statewide resident population.

(((~~58~~))) (57) "Swing beds" means up to the first five hospital beds designated by an eligible rural hospital which are available to provide either acute care or nursing home services.

(((~~59~~))) (58) "Tertiary health service" means a specialized service meeting complicated medical needs of people and requires sufficient patient volume to optimize provider effectiveness, quality of service, and improved outcomes of care.

(((~~60~~))) (59) "Transition period" means the period of time, not exceeding five years, between the date a CCRC is inhabited by a member, and the date it fully meets the requirements of a CCRC.

(((~~61~~))) (60) "Under the established ratio" means the bed-to-population ratio is less than the statewide current established ratio.

(((~~62~~))) (61) "Undertaking" means any action subject to the provisions of chapter 246-310 WAC.

(((~~63~~))) (62) "Working days" excludes Saturdays, Sundays, and legal holidays observed by the state of Washington. Working days are counted in the same way as calendar days.

WSR 16-23-155

EXPEDITED RULES

HEALTH CARE AUTHORITY

(Washington Apple Health)

[Filed November 22, 2016, 3:15 p.m.]

Title of Rule and Other Identifying Information: WAC 182-531-0300 Anesthesia providers and covered physician-related services, 182-531-0400 Client responsibility for reimbursement for physician-related services, 182-531-0650 Hospital physician-related services not requiring authorization when provided in department-approved centers of excellence or hospitals authorized to provide the specific services, 182-531-1100 Out-of-state physician services, 182-531-1450 Radiology physician-related services, 182-531-1700 Surgical physician-related services, 182-531-1750 Transplant coverage for physician-related services, 182-531-1800 Transplant coverage—Medical criteria to receive transplants, and 182-531-1850 Payment methodology for physician-related services—General and billing modifiers.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Wendy Barcus, Rules Coordinator, Health Care Authority (HCA), P.O. Box 42716, Olympia, WA 98504-2716, or deliver to Cherry Street Plaza, 626 8th Avenue S.E., Olympia, WA 98504, e-mail arc@hca.wa.gov, fax (360) 586-9727, AND RECEIVED BY January 23, 2017.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA is making these amendments to correct agency names and WAC citations within the rules.

Reasons Supporting Proposal: See Purpose above.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Melinda Froud, P.O. Box 42716, Olympia, WA 98504, (360) 725-1408; Implementation and Enforcement: Tonja Nichols, P.O. Box 45502, Olympia, WA 98504, (360) 725-1658.

November 22, 2016

Wendy Barcus

Rules Coordinator

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

WAC 182-531-0300 Anesthesia providers and covered physician-related services. The ((~~department~~)) medicaid agency bases coverage of anesthesia services on medicare policies and the following rules:

(1) The ((~~department~~)) agency reimburses providers for covered anesthesia services performed by:

(a) Anesthesiologists;

(b) Certified registered nurse anesthetists (CRNAs);

(c) Oral surgeons with a special agreement with the ((~~department~~)) agency to provide anesthesia services; and

(d) Other providers who have a special agreement with the ((~~department~~)) agency to provide anesthesia services.

(2) The ((~~department~~)) agency covers and reimburses anesthesia services for children and noncooperative clients in those situations where the medically necessary procedure cannot be performed if the client is not anesthetized. A statement of the client-specific reasons why the procedure could not be performed without specific anesthesia services must be kept in the client's medical record. Examples of such procedures include:

(a) Computerized tomography (CT);

(b) Dental procedures;

(c) Electroconvulsive therapy; and

(d) Magnetic resonance imaging (MRI).

(3) The ((~~department~~)) agency covers anesthesia services provided for any of the following:

(a) Dental restorations and/or extractions:

(b) Maternity per subsection (9) of this section. See WAC ((~~388-531-1550~~)) 182-531-1550 for information about sterilization/hysterectomy anesthesia;

(c) Pain management per subsection (5) of this section;

(d) Radiological services as listed in WAC ((~~388-531-1450~~)) 182-531-1450; and

(e) Surgical procedures.

(4) For each client, the anesthesiologist provider must do all of the following:

(a) Perform a preanesthetic examination and evaluation;

(b) Prescribe the anesthesia plan;

(c) Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

(d) Ensure that any procedures in the anesthesia plan that the provider does not perform, are performed by a qualified individual as defined in the program operating instructions;

(e) At frequent intervals, monitor the course of anesthesia during administration;

(f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provide indicated post anesthesia care.

(5) The ((~~department~~)) agency does not allow the ((~~anaesthesiologist~~)) anesthesiologist provider to:

(a) Direct more than four anesthesia services concurrently; and

(b) Perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by medicare instructions.

(6) The ((~~department~~)) agency requires the anesthesiologist provider to document in the client's medical record that the medical direction requirements were met.

(7) General anesthesia:

(a) When a provider performs multiple operative procedures for the same client at the same time, the ((~~department~~)) agency reimburses the base anesthesia units (BAU) for the major procedure only.

(b) The ((~~department~~)) agency does not reimburse the attending surgeon for anesthesia services.

(c) When more than one anesthesia provider is present on a case, the ((~~department~~)) agency reimburses as follows:

(i) The supervisory anesthesiologist and certified registered nurse anesthetist (CRNA) each receive fifty percent of the allowed amount.

(ii) For anesthesia provided by a team, the ((~~department~~)) agency limits reimbursement to one hundred percent of the total allowed reimbursement for the service.

(8) Pain management:

(a) The ((~~department~~)) agency pays CRNAs or anesthesiologists for pain management services.

(b) The ((~~department~~)) agency allows two postoperative or pain management epidurals per client, per hospital stay plus the two associated E&M fees for pain management.

(9) Maternity anesthesia:

(a) To determine total time for obstetric epidural anesthesia during normal labor and delivery and c-sections, time begins with insertion and ends with removal for a maximum of six hours. "Delivery" includes labor for single or multiple births, and/or cesarean section delivery.

(b) The ((~~department~~)) agency does not apply the six-hour limit for anesthesia to procedures performed as a result of post-delivery complications.

(c) See WAC ((~~388-531-1550~~)) 182-531-1550 for information on anesthesia services during a delivery with sterilization.

(d) See chapter ((~~388-533~~)) 182-533 WAC for more information about maternity-related services.

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

WAC 182-531-0400 Client responsibility for reimbursement for physician-related services. Clients may be responsible to reimburse the provider, as described under WAC ((~~388-501-0100~~)) 182-501-0100, for noncovered services as defined in WAC ((~~388-501-0050~~)) 182-501-0050 or for services excluded from the client's benefits package as defined under WAC ((~~388-501-0060~~)) 182-501-0060. Clients whose care is provided under CHIP may be responsible for copayments as outlined in chapter ((~~388-542~~)) 182-542 WAC. Also, see WAC ((~~388-502-0160,~~)) 182-502-0160 Billing the client.

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

WAC 182-531-0650 Hospital physician-related services not requiring authorization when provided in ((~~department-approved~~)) agency-approved centers of excellence or hospitals authorized to provide the specific

services. The ((~~department~~)) medicaid agency covers the following services without prior authorization when provided in ((~~department-approved~~)) agency-approved centers of excellence. The ((~~department~~)) agency issues periodic publications listing centers of excellence. These services include the following:

(1) All transplant procedures specified in WAC ((~~388-550-1900~~)) 182-550-1900;

(2) Chronic pain management services, including outpatient evaluation and inpatient treatment, as described under WAC ((~~388-550-2400~~)) 182-550-2400. See also WAC ((~~388-531-0700~~)) 182-531-0700;

(3) Sleep studies including, but not limited to, polysomnograms for clients one year of age and older. The ((~~department~~)) agency allows sleep studies only in outpatient hospital settings as described under WAC ((~~388-550-6350~~)) 182-550-6350. See also WAC ((~~388-531-1500~~)) 182-531-1500; and

(4) Diabetes education, in a DOH-approved facility, per WAC ((~~388-550-6300~~)) 182-550-6300.

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

WAC 182-531-1100 Out-of-state physician services. (1) The ((~~department~~)) medicaid agency covers medical services provided to eligible clients who are temporarily located outside the state, subject to the provisions of this chapter and WAC ((~~388-501-0180~~)) 182-501-0180.

(2) Out-of-state border areas as described under WAC ((~~388-501-0175~~)) 182-501-0175 are not subject to out-of-state limitations. The ((~~department~~)) agency considers physicians in border areas as providers in the state of Washington.

(3) In order to be eligible for reimbursement, out-of-state physicians must meet all criteria for, and must comply with all procedures required of in-state physicians, in addition to other requirements of this chapter.

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

WAC 182-531-1450 Radiology physician-related services. (1) The ((~~department~~)) medicaid agency reimburses radiology services subject to the limitations in this section and under WAC ((~~388-531-0300~~)) 182-531-0300.

(2) The ((~~department~~)) agency does not make separate payments for contrast material. The exception is low osmolar contrast media (LOCM) used in intrathecal, intravenous, and intra-arterial injections. Clients receiving these injections must have one or more of the following conditions:

(a) A history of previous adverse reaction to contrast material. An adverse reaction does not include a sensation of heat, flushing, or a single episode of nausea or vomiting;

(b) A history of asthma or allergy;

(c) Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmias, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension;

(d) Generalized severe debilitation;

(e) Sickle cell disease;

(f) Preexisting renal insufficiency; and/or

(g) Other clinical situations where use of any media except LOCM would constitute a danger to the health of the client.

(3) The ((~~department~~)) agency reimburses separately for radiopharmaceutical diagnostic imaging agents for nuclear medicine procedures. Providers must submit invoices for these procedures when requested by the ((~~department~~)) agency, and reimbursement is at acquisition cost.

(4) The ((~~department~~)) agency reimburses general anesthesia for radiology procedures. See WAC ((~~388-531-0300~~)) 182-531-0300.

(5) The ((~~department~~)) agency reimburses radiology procedures in combination with other procedures according to the rules for multiple surgeries. See WAC ((~~388-531-1700~~)) 182-531-1700. The procedures must meet all of the following conditions:

(a) Performed on the same day;

(b) Performed on the same client; and

(c) Performed by the same physician or more than one member of the same group practice.

(6) The ((~~department~~)) agency reimburses consultation on X-ray examinations. The consulting physician must bill the specific radiological X-ray code with the appropriate professional component modifier.

(7) The ((~~department~~)) agency reimburses for portable X-ray services furnished in the client's home or in nursing facilities, limited to the following:

(a) Chest or abdominal films that do not involve the use of ((~~contract [contrast]~~)) contrast media;

(b) Diagnostic mammograms; and

(c) Skeletal films involving extremities, pelvis, vertebral column or skull.

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

WAC 182-531-1700 Surgical physician-related services. (1) The ((~~department's~~)) agency's global surgical reimbursement for all covered surgeries includes all of the following:

(a) The operation itself;

(b) Postoperative dressing changes, including:

(i) Local incision care and removal of operative packs;

(ii) Removal of cutaneous sutures, staples, lines, wire, tubes, drains, and splints;

(iii) Insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; or

(iv) Change and removal of tracheostomy tubes.

(c) All additional medical or surgical services required because of complications that do not require additional operating room procedures.

(2) The ((~~department's~~)) agency's global surgical reimbursement for major surgeries, includes all of the following:

(a) Preoperative visits, in or out of the hospital, beginning on the day before surgery; and

(b) Services by the primary surgeon, in or out of the hospital, during a standard ninety-day postoperative period.

(3) The ((~~department's~~)) agency's global surgical reimbursement for minor surgeries includes all of the following:

(a) Preoperative visits beginning on the day of surgery; and

(b) Follow-up care for zero or ten days, depending on the procedure.

(4) When a second physician provides follow-up services for minor procedures performed in hospital emergency departments, the ((~~department~~)) agency does not include these services in the global surgical reimbursement. The physician may bill these services separately.

(5) The ((~~department's~~)) agency's global surgical reimbursement for multiple surgical procedures is as follows:

(a) Payment for multiple surgeries performed on the same client on the same day equals one hundred percent of the ((~~department's~~)) agency's allowed fee for the highest value procedure. Then,

(b) For additional surgical procedures, payment equals fifty percent of the ((~~department's~~)) agency's allowed fee for each procedure.

(6) The ((~~department~~)) agency allows separate reimbursement for any of the following:

(a) The initial evaluation or consultation;

(b) Preoperative visits more than one day before the surgery;

(c) Postoperative visits for problems unrelated to the surgery; and

(d) Postoperative visits for services that are not included in the normal course of treatment for the surgery.

(7) The ((~~department's~~)) agency's reimbursement for endoscopy is as follows:

(a) The global surgical reimbursement fee includes follow-up care for zero or ten days, depending on the procedure.

(b) Multiple surgery rules apply when a provider bills multiple endoscopies from different endoscopy groups. See subsection (4) of this section.

(c) When a physician performs more than one endoscopy procedure from the same group on the same day, the ((~~department~~)) agency pays the full amount of the procedure with the highest maximum allowable fee.

(d) The ((~~department~~)) agency pays the procedure with the second highest maximum allowable fee at the maximum allowable fee minus the base diagnostic endoscopy procedure's maximum allowed amount.

(e) The ((~~department~~)) agency does not pay when payment for other codes within an endoscopy group is less than the base code.

(8) The ((~~department~~)) agency restricts reimbursement for surgery assists to selected procedures as follows:

(a) The ((~~department~~)) agency applies multiple surgery reimbursement rules for surgery assists ((~~apply~~)). See subsection (4) of this section.

(b) Surgery assists are reimbursed at twenty percent of the maximum allowable fee for the surgical procedure.

(c) A surgical assist fee for a registered nurse first assistant (RNFA) is reimbursed if the nurse has been assigned a provider number.

(d) A provider must use a modifier on the claim with the procedure code to identify surgery assist.

(9) The ((~~department~~)) agency bases payment splits between preoperative, intraoperative, and postoperative services on medicare determinations for given surgical procedures or range of procedures. The ((~~department~~)) agency pays any procedure that does not have an established medicare payment split according to a split of ten percent - eighty percent - ten percent respectively.

(10) For preoperative and postoperative critical care services provided during a global period refer to WAC ((~~388-531-0450~~)) 182-531-0450.

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

WAC 182-531-1750 Transplant coverage for physician-related services. The ((~~department~~)) medicaid agency covers transplants when performed in ((~~a department-approved~~)) an agency-approved center of excellence. See WAC ((~~388-550-1900~~)) 182-550-1900 for information regarding transplant coverage.

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

WAC 182-531-1800 Transplant coverage—Medical criteria to receive transplants. See WAC ((~~388-550-2000~~)) 182-550-2000 for information about medical criteria to receive transplants.

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

WAC 182-531-1850 Payment methodology for physician-related services—General and billing modifiers.

GENERAL PAYMENT METHODOLOGY

(l) The ((~~department~~)) medicaid agency bases the payment methodology for most physician-related services on medicare's RBRVS. The ((~~department~~)) agency obtains information used to update the ((~~department's~~)) agency's RBRVS from the MPFSPS.

(2) The ((~~department~~)) agency updates and revises the following RBRVS areas each January prior to the ((~~department's~~)) agency's annual update.

(3) The ((~~department~~)) agency determines a budget-neutral conversion factor (CF) for each RBRVS update, by:

(a) Determining the units of service and expenditures for a base period. Then,

(b) Applying the latest medicare RVU obtained from the MPFSDB, as published in the MPFSPS, and GCPI changes to obtain projected units of service for the new period. Then,

(c) Multiplying the projected units of service by conversion factors to obtain estimated expenditures. Then,

(d) Comparing expenditures obtained in (c) of this subsection with base period expenditure levels. Then,

(e) Adjusting the dollar amount for the conversion factor until the product of the conversion factor and the projected units of service at the new RVUs equals the base period amount.

(4) The ((~~department~~)) agency calculates maximum allowable fees (MAFs) in the following ways:

(a) For procedure codes that have applicable medicare RVUs, the three components (practice, malpractice, and work) of the RVU are:

(i) Each multiplied by the statewide GPCI. Then,

(ii) The sum of these products is multiplied by the applicable conversion factor. The resulting RVUs are known as RBRVS RVUs.

(b) For procedure codes that have no applicable medicare RVUs, RSC RVUs are established in the following way:

(i) When there are three RSC RVU components (practice, malpractice, and work):

(A) Each component is multiplied by the statewide GPCI. Then,

(B) The sum of these products is multiplied by the applicable conversion factor.

(ii) When the RSC RVUs have just one component, the RVU is not GPCI adjusted and the RVU is multiplied by the applicable conversion factor.

(c) For procedure codes with no RBRVS or RSC RVUs, the ((~~department~~)) agency establishes maximum allowable fees, also known as "flat" fees.

(i) The ((~~department~~)) agency does not use the conversion factor for these codes.

(ii) The ((~~department~~)) agency updates flat fee reimbursement only when the legislature authorizes a vendor rate increase, except for the following categories which are revised annually during the update:

(A) Immunization codes are reimbursed at EAC. (See WAC ((~~388-530-1050~~)) 182-530-1050 for explanation of EAC.) When the provider receives immunization materials from the department of health, the ((~~department~~)) agency pays the provider a flat fee only for administering the immunization.

(B) A cast material maximum allowable fee is set using an average of wholesale or distributor prices for cast materials.

(iii) Other supplies are reimbursed at physicians' acquisition cost, based on manufacturers' price sheets. Reimbursement applies only to supplies that are not considered part of the routine cost of providing care (e.g., intrauterine devices (IUDs)).

(d) For procedure codes with no RVU or maximum allowable fee, the ((~~department~~)) agency reimburses "by report." By report codes are reimbursed at a percentage of the amount billed for the service.

(e) For supplies that are dispensed in a physician's office and reimbursed separately, the provider's acquisition cost when flat fees are not established.

(f) The ((~~department~~)) agency reimburses at acquisition cost those HCPCS J and Q codes that do not have flat fees established.

(5) The technical advisory group reviews RBRVS changes.

(6) The ((~~department~~)) agency also makes fee schedule changes when the legislature grants a vendor rate increase and the effective date of that increase is not the same as the ((~~department's~~)) agency's annual update.

(7) If the legislatively authorized vendor rate increase, or other increase, becomes effective at the same time as the annual update, the ((~~department~~)) agency applies the increase after calculating budget-neutral fees. The ((~~department~~)) agency pays providers a higher reimbursement rate for primary health care E&M services that are provided to children age twenty and under.

(8) The ((~~department~~)) agency does not allow separate reimbursement for bundled services. However, the ((~~department~~)) agency allows separate reimbursement for items considered prosthetics when those items are used for a permanent condition and are furnished in a provider's office.

(9) Variations of payment methodology which are specific to particular services and which differ from the general payment methodology described in this section are included in the sections dealing with those particular services.

CPT/HCFA MODIFIERS

(10) A modifier is a code a provider uses on a claim in addition to a billing code for a standard procedure. Modifiers eliminate the need to list separate procedures that describe the circumstance that modified the standard procedure. A modifier may also be used for information purposes.

(11) Certain services and procedures require modifiers in order for the ((~~department~~)) agency to reimburse the provider. This information is included in the sections dealing with those particular services and procedures, as well as the fee schedule.