WSR 18-19-003
PROPOSED RULES
DEPARTMENT OF LICENSING
[Filed September 7, 2018, 7:35 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-11-033.

Title of Rule and Other Identifying Information: WAC 308-125-040 Examination prerequisite state-certified residential classification, and 308-125-045 Examination prerequisite state-licensed classification, and 308-125-070 Experience requirements.

Hearing Location(s): On October 24, 2018, at 10:30 a.m., at 405 Black Lake Boulevard, Room 2018, Olympia, WA 98502.

Date of Intended Adoption: October 25, 2018.

Submit Written Comments to: Dee Sharp, P.O. Box 9027, Olympia, WA 98507-9027, email DSharp@dol.wa.gov, fax 360-570-7053, by October 23, 2018.

Assistance for Persons with Disabilities: Contact Dee Sharp, phone 360-664-6504, fax 360-570-4981, TTY 711, email dsharp@dol.wa.gov, by October 23, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Replace the existing real estate appraiser certification requirement language in WAC 308-125-040, 308-125-045, and 308-125-070 with language based on the requirements supplied by the appraiser qualifications board.

Reasons Supporting Proposal: Ensure applicants are aware of and can clearly identify the current education and experience requirements to apply for an appraiser credential.

Statutory Authority for Adoption: RCW 18.140.030(1).

Statute Being Implemented: Chapter 18.140 RCW.

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

Name of Proponent: Department of licensing, governmental.

Name of Agency Personnel Responsible for Drafting: Max Weeks, 405 Black Lake Boulevard S.W., Olympia, WA 98502, 360-664-1406; Implementation and Enforcement: Dee Sharp, 405 Black Lake Boulevard S.W., Olympia, WA 98502, 360-664-6501.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The department is exempt under RCW 34.05.328 and this rule making does not qualify as a significant legislative rule or other rule requiring a cost-benefit analysis.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4).

Explanation of exemptions: This rule only affects individual licensees, and does not affect small businesses.

September 7, 2018
Damon Monroe
Rules Coordinator

AMENDATORY SECTION (Amending WSR 16-02-008, filed 12/28/15, effective 1/28/16)

WAC 308-125-040 Examination prerequisite state-certified residential classification. The state-certified residential real estate appraiser classification applies to appraisals of all types of residential property of one to four units without regard to transaction value or complexity and nonresidential property having a transaction value less than two hundred fifty thousand dollars.

(1) As a prerequisite to taking the examination for certification as a state-certified residential real estate appraiser, an applicant shall present evidence satisfactory to the director that he/she has successfully completed not less than two hundred hours in the following core modules:

(a) Basic appraisal principles, thirty hours.

(b) Basic appraisal procedures, thirty hours.

(c) The National USPAP course or equivalent, fifteen hours.

(d) Residential market analysis and highest and best use, fifteen hours.

(e) Residential appraiser site valuation and cost approach, fifteen hours.

(f) Residential sales comparison and income approaches, thirty hours.

(g) Residential appraiser report writing and case studies, fifteen hours.

(h) Statistics, modeling and finance, fifteen hours.

(i) Advanced residential applications and case studies, fifteen hours.

(j) Appraisal subject matter electives, twenty hours.

(2) Credit towards qualifying education requirements may be obtained via the completion of a degree program in real estate from an accredited degree-granting college or university provided the college or university has had its curriculum reviewed and approved by the appraiser qualifications board.

(3) An original certification as a state-certified residential real estate appraiser shall not be issued to any person who does not possess two thousand five hundred hours of appraisal experience obtained continuously over a period of not less than twenty-four months in Washington or in another state having comparable certification requirements.

(4) Applicants for the certified residential appraiser license must satisfy one of the following college education requirement options:

(a) Possess a bachelor's degree or higher in any field of study; or

(b) Possess an associate's degree in a field of study related to business administration, accounting, finance, economics, or real estate; or

(c) Successful completion of thirty semester hours of college level courses in all of the following subject matter areas:

(i) English composition, three hours; and

(ii) Microeconomics, three hours; and

(iii) Macroeconomics, three hours; and

(iv) Finance, three hours; and

(v) Algebra, geometry, or higher mathematics, three hours; and

(vi) Statistics, three hours; and

(vii) Business or real estate law, three hours; and

(viii) Computer science, three hours; and

(ix) Two elective courses in: Accounting, geography, agricultural economics, business management, or real estate, three hours each.

(d) Successful completion of at least thirty semester hours of college level examination program (CLEP) examinations in all of the following subject matter areas:

(i) College algebra, three hours; and

(ii) College composition, six hours; and

(iii) College composition modular, three hours; and

(iv) College mathematics, six hours; and

(v) Principles of macroeconomics, three hours; and

(vi) Principles of microeconomics, three hours; and

(vii) Introductory business law, three hours; and

(viii) Information systems, three hours.

(e) Any thirty semester credit hour combination of (c) and (d) of this subsection that includes at least one course or CLEP exam in each of the following subject matter areas:

(i) Composition; and

(ii) Microeconomics; and

(iii) Macroeconomics; and

(iv) Business law; and

(v) Algebra, geometry or higher mathematics.

(f) No college level education is required to apply for state-certified residential real estate appraiser license for an appraiser that has held a state-licensed real estate appraiser license for a minimum of five years, and satisfies all of the following requirements:

(i) No record of any adverse, final and nonappealable disciplinary action affecting the state-licensed real estate appraiser's legal eligibility to engage in appraisal practice within five years immediately preceding the date of application for a state-certified residential real estate appraiser license; and

(ii) Successful completion of the following core qualifying education modules:

(A) Statistics, modeling, and finance, fifteen hours; and

(B) Advanced residential applications and case studies, fifteen hours; and

(C) Appraisal subject matter electives, twenty hours; and

(iii) Successful completion of the required experience as specified in subsection (3) of this section; and

(iv) Successful completion of the certified residential real property appraiser examination as specified in these rules.

AMENDATORY SECTION (Amending WSR 16-02-008, filed 12/28/15, effective 1/28/16)

WAC 308-125-045 Examination prerequisite state-licensed classification. The state-licensed real estate appraiser classification applies to appraisal of noncomplex one to four residential units having a transaction value less than one million dollars and complex one to four residential units having a transaction value less than two hundred fifty thousand dollars and nonresidential property having a transaction value less than two hundred fifty thousand dollars.

(1) As a prerequisite to taking the examination for certification as a state-licensed real estate appraiser, an applicant shall present evidence satisfactory to the director that he/she has successfully completed not less than one hundred fifty hours in the following core modules:

(a) Basic appraisal principles, thirty hours.

(b) Basic appraisal procedures, thirty hours.

(c) The National USPAP course or equivalent, fifteen hours.

(d) Residential market analysis and highest and best use, fifteen hours.

(e) Residential appraiser site valuation and cost approach, fifteen hours.

(f) Residential sales comparison and income approaches, thirty hours.

(g) Residential appraiser report writing and case studies, fifteen hours.

(2) Credit toward qualifying education requirements may be obtained via the completion of a degree program in real estate from an accredited degree-granting college or university provided the college or university has had its curriculum reviewed and approved by the appraiser qualifications board.

(3) An original certification as a state-licensed real estate appraiser shall not be issued to any person who does not possess two thousand hours of appraisal experience obtained continuously over a period of not less than ((~~twenty-four~~)) twelve months in Washington or in another state having comparable certification requirements.

((~~(4) Applicants for the state-licensed real estate appraiser license must possess an associate's degree or higher in any field of study, or in lieu of the required degree, thirty semester credit hours of college-level education from an accredited college, junior college, community college, or university.~~))

AMENDATORY SECTION (Amending WSR 16-02-008, filed 12/28/15, effective 1/28/16)

WAC 308-125-070 Experience requirements. (1) State licensed applicants must accumulate two thousand hours within a minimum of one year (twelve months) and a maximum of seven years. Certified residential applicants must accumulate two thousand five hundred hours within a minimum of two years (twenty-four months) ((~~full-time experience within five years of application is required for the state licensed and certified residential appraiser~~)) and a maximum of seven years. Certified general applicants must accumulate three thousand hours within a minimum of thirty months and a maximum of seven years. ((~~However, no more than one thousand five hundred hours may be credited in any consecutive twelve months for any of the licensing categories.~~))

(2) Any work product claimed for experience credit dated January 1, 1990, and later shall conform to the Uniform Standards of Professional Appraisal Practice in effect at the time the appraisal is completed.

(a) Reports shall be in writing.

(b) An appraisal work file must be available to the director to substantiate work performed.

(c) Appraisal experience must have been performed as a licensed or certified appraiser or a registered trainee to qualify.

(3) A registered trainee may gain experience under the supervision of no more than six supervisory appraisers during his/her trainee period.

(4) The department may request appraiser work files to verify, confirm, or compare entries made on the experience log. Failure to provide work files to the department upon its request may disqualify the reports as qualifying experience.

(5) An applicant for certification or license shall certify, under penalty of perjury, the completion of the required experience.

(6) Appraisal work qualifying for appraisal experience includes, but is not limited to, the following: Fee and staff appraisal, ad valorem tax appraisal, appraisal review, appraisal analysis, appraisal consulting, highest and best use analysis, feasibility analysis/study.

(7) The department may require a supervisory appraiser to certify, under penalty of perjury, the applicant's work experience.

(8) The department may request written reports or work files to verify an applicant's experience.

WSR 18-19-015
PROPOSED RULES
OFFICE OF THE LIEUTENANT GOVERNOR

[Filed September 7, 2018, 3:50 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-09-004.

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Title of Rule and Other Identifying Information: Copying fees—Payments (related to public records requests).

Hearing Location(s): On October 29, 2018, at 10:00 a.m., at the Senate Rules Room, Legislative (State Capitol) Building, 416 Sid Snyder Avenue S.W., Suite 220-A, Olympia, WA 98501.

Date of Intended Adoption: November 5, 2018.

Submit Written Comments to: Cathleen Bright, Executive Assistant, Office of Lieutenant Governor (OLG), P.O. Box 40400, Olympia, WA 98504, email ltgov@ltgov.wa.gov, by October 24, 2018.

Assistance for Persons with Disabilities: Contact Cathleen Bright, executive assistant, phone 360-786-7700, email cathleen.bright@ltgov.wa.gov, by October 24, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: To meet the requirements described in RCW 42.56.040. Specifically, to publish in the Washington Administrative Code a description of the charges for copying (RCW 42.56.120).

Reasons Supporting Proposal: Comply with statute.

Statutory Authority for Adoption: RCW 42.56.040.

Statute Being Implemented: Chapter 42.56 RCW.

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

Name of Proponent: OLG, governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Cathleen Bright, OLG, Olympia, 360-786-7700; and Enforcement: LaTasha Wortham, OLG, Olympia, 360-786-7700.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. No cost associated with rule. Required by statute.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules relate only to internal governmental operations that are not subject to violation by a nongovernment party.

September 7, 2018
Cathleen Bright
Executive Assistant

NEW SECTION

WAC 241-10-050 Copying fees—Payments. (1) The following copy fees and payment procedures apply to requests to the office under chapter 42.56 RCW and received on or after August XX, 2017.

(2) Pursuant to RCW 42.56.120 (2)(b), the office is not calculating all actual costs for copying records because to do so would be unduly burdensome for the following reasons: (i) The office does not have the resources to conduct a study to determine all its actual copying costs; (ii) to conduct such a study would interfere with other essential agency functions; and, (iii) through the 2017 legislative process, the public and requesters have commented on and been informed of authorized fees and costs, including for electronic records, provided in RCW 42.56.120 (2)(b) and (c), (3) and (4).

(3) The office will charge for copies of records pursuant to the default fees in RCW 42.56.120 (2)(b) and (c). The office will charge for customized services pursuant to 42.56.120(3). Under RCW 42.56.130, the office may charge other copy fees authorized by statutes outside of chapter 42.56 RCW. The office may enter into an alternative fee agreement with a requester under RCW 42.56.120(4). The charges for copying methods used by the office are summarized in the fee schedule available on the office's website at www.atg.wa.gov.

(4) Requesters are required to pay for copies in advance of receiving records. Fee waivers are an exception and are available for some small requests under the following conditions.

(a) It is within the discretion of the public records officer to waive copying fees when: (i) all of the records responsive to an entire request are paper copies only and are twenty-five or fewer pages; or (ii) all of the records responsive to an entire request are electronic and can be provided in a single email with attachments of a size totaling no more than the equivalent of 100 printed pages. If that email for any reason is not deliverable, records will be provided through another

means of delivery, and the requester will be charged in accordance with this rule. `

(b) Fee waivers are not applicable to records provided in installments.

(5) The public records officer may require an advance deposit of ten percent of the estimated fees when the copying fees for an installment or an entire request, or customized service charge, exceeds twenty-five dollars.

(6) All required fees must be paid in advance of release of the copies or an installment of copies, or in advance of when a deposit is required. The office will notify the requester of when payment is due.

(7) Payment should be made by check or money order to the Office of the Lieutenant Governor. The office prefers not to receive cash. For cash payments, it is within the public records officer's discretion to determine the denomination of bills and coins that will be accepted.

(8) The office will close a request when a requester fails by the payment date to pay in the manner prescribed for records, an installment of records, or a required deposit.

WSR 18-19-028
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Developmental Disabilities Administration)

[Filed September 12, 2018, 1:47 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-09-084.

Title of Rule and Other Identifying Information: The department is proposing to create the following new sections in chapter 388-101D WAC, Requirements for providers of residential services and supports: WAC 388-101D-0560 What is a group training home?, 388-101D-0565 What are the physical requirements for a group training home bedroom?, 388-101D-0570 What are the physical requirements for a group training home bathroom?, 388-101D-0575 How must a group training home manage food and maintain its kitchen?, 388-101D-0580 Must the group training home adapt the home to suit a client's needs?, 388-101D-0585 What building codes apply to group training homes?, 388-101D-0590 When must a group training home be inspected by a local building official?, 388-101D-0595 What steps must be taken before moving a client out of the home during construction?, 388-101D-0600 Who is responsible for cleaning and maintaining a group training home?, 388-101D-0605 How must a group training home protect clients from risks associated with bodies of water?, 388-101D-0610 What requirements must a group training home's fireplaces, heaters, and stoves meet?, 388-101D-0615 What requirements must the group training home's smoke detectors and fire extinguishers meet?, 388-101D-0620 How must a group training home prepare for emergency evacuations?, 388-101D-0625 How much emergency food and drinking water must be kept in the group training home?, 388-101D-0630 What must a group training home consider when providing nutritional services?, 388-101D-0635 What requirements must an employee or volunteer meet to prepare meals and snacks in a group training home?, 388-101D-0640 When may a pet live in a group training home?, 388-101D-0645 What infection control practices must a group training home implement?, 388-101F-0650 [388-101D-0650] What must a group training home do to detect and manage tuberculosis?, 388-101D-0655 What type of tuberculin test must a group training home employee complete?, 388-101D-0660 When is a group training home employee not required to complete a tuberculin test?, 388-101D-0665 When must a group training home employee complete a one-step tuberculin test?, 388-101D-0670 When must a group training home employee complete a two-step tuberculin test?, 388-101D-0675 What happens if a group training home employee receives a positive tuberculin test result?, 388-101D-0680 Must a group training home employee complete follow-up testing?, 388-101D-0685 What must a group training home do when a client or employee has tuberculosis symptoms or receives a positive chest x-ray result?, 388-101D-0690 What records must a group training home maintain related to tuberculin testing?, 388-101D-0695 What rights and protections does a client living in a group training home have?, 388-101D-0700 What notice requirements must a group training home meet?, and 388-101D-0705 What requirements under this chapter is a group training home provider exempt from?

Hearing Location(s): On October 23, 2018, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than October 24, 2018.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., October 23, 2018.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by October 9, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The developmental disabilities administration (DDA) is proposing to create these rules to establish requirements for DDA-contracted group training homes.

Reasons Supporting Proposal: Group homes were previously certified and licensed by residential care services. These proposed rules allow a certified and licensed group home to transition to a certified group training home model.

Statutory Authority for Adoption: RCW 71A.12.030.

Statute Being Implemented: RCW 71A.12.120, chapter 71A.22 RCW.

Rule is necessary because of federal law, 42 C.F.R. 441.301 (c)(4).

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting: Chantelle Diaz, P.O. Box 45310, Olympia, WA 98504-5310, 360-407-1589; Implementation and Enforcement: Valerie

Kindschy, P.O. Box 45310, Olympia, WA 98504-5310, 360-407-1550.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Chantelle Diaz, P.O. Box 45310, Olympia, WA 98504-5310, phone 360-407-1589, fax 360-407-0955, TTY 1-800-833-6388, email Chantelle.Diaz@dshs.wa.gov.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025, "an agency is not required to prepare a separate small business economic impact statement under RCW 19.85.040 if it prepared an analysis under RCW 34.05.328 that meets the requirements of a small business impact statement and if the agency reduced the costs imposed by the rule on small business to the extent required by RCW 19.85.030(2).

Explanation of exemptions: DDA prepared a cost-benefit analysis under RCW 34.05.328 and reduced the costs to small businesses by allowing entities already licensed and certified as a group home to meet many of the standards they are currently held to rather than requiring them to meet all new standards under the proposed new rules.

September 11, 2018
Katherine I. Vasquez
Rules Coordinator

NEW SECTION

WAC 388-101D-0560 What is a group training home? "Group training home" means a nonprofit facility certified under this chapter and chapter 388-101 WAC. A group training home provides twenty-four-hour community-based instruction and support services to two or more adults.

NEW SECTION

WAC 388-101D-0565 What are the physical requirements for a group training home bedroom? (1) The group training home must ensure each client's bedroom:

(a) Is a private room, unless the client requests to share a room;

(b) Has a window or door that provides natural light, is covered with a screen, and allows for emergency exit;

(c) Has a closet or wardrobe, which must not be considered part of the usable square footage;

(d) Has a locking door, unless the client's person-centered service plan indicates that it is unsafe for the client to have a locking door;

(e) Has direct, unrestricted access to common areas;

(f) Has adequate space for mobility aids, such as a wheelchair, walker, or lifting device; and

(g) Is at least eighty square feet of usable floor space for a single-occupancy room, one hundred and forty square feet for a double-occupancy room.

(2) For a group training home licensed as an adult family home before the effective date of this rule, a double bedroom must be at least one hundred and twenty square feet of usable floor space.

(3) Unless the client chooses to provide their own bed, the home must provide each client:

(a) A clean, comfortable bed that meets the client's needs; and

(b) A waterproof mattress cover if needed or requested by the client.

NEW SECTION

WAC 388-101D-0570 What are the physical requirements for a group training home bathroom? (1) The group training home must provide handwashing sinks with hot and cold running water in the ratio of one for every five clients.

(2) The group training home must provide toilets in the ratio of one for every five clients.

(3) The group training home must provide bathing options, with hot and cold running water, for clients that meet the needs identified in their person-centered service plans.

(4) A client must have access to a toilet and shower or tub without going through another client's room.

NEW SECTION

WAC 388-101D-0575 How must a group training home manage food and maintain its kitchen? A group training home must manage food and maintain its kitchen under chapter 246-215 WAC if the group training home:

(1) Supports more than six clients; and

(2) Was certified after the effective date of this rule.

NEW SECTION

WAC 388-101D-0580 Must the group training home adapt the home to suit a client's needs? If a client's needs change, the group training home must make a reasonable attempt to adapt the home to meet the needs identified in the client's person-centered service plan.

NEW SECTION

WAC 388-101D-0585 What building codes apply to group training homes? (1) A group training home must meet state and local building codes in effect at the time of their:

(a) Initial licensure as an adult family home or assisted living facility; or

(b) Initial certification as a group training home.

(2) A group training home may be required to modify the home to meet current building code requirements if the building poses a health or safety risk to a client.

(3) If a group training home makes any construction changes to the home, the construction must meet current state and local building codes.

NEW SECTION

WAC 388-101D-0590 When must a group training home be inspected by a local building official? The group training home must be inspected by a local building official:

(1) Before initial certification; and

(2) After any construction that:

(a) Affects a client's ability to enter or exit the home; or

(b) Makes a significant structural change to the home.

NEW SECTION

WAC 388-101D-0595 What steps must be taken before moving a client out of the home during construction? (1) Before moving a client out of the group training home during planned construction, the home must provide thirty days' written notice to the client, the client's guardian if they have one, DDA, and residential care services.

(2) The notice must include:

(a) The client's temporary address;

(b) A plan for delivering services to the client while temporarily out of the home;

(c) A transition plan to support the client while moving out of and returning home; and

(d) The projected completion date for the construction project.

NEW SECTION

WAC 388-101D-0600 Who is responsible for cleaning and maintaining a group training home? (1) The group training home's fixtures, furnishings, exterior, and interior, including the client's bedroom, must be safe, sanitary, and well maintained.

(2) The group training home staff must provide housekeeping instruction and support to a client in accordance with the client's person-centered service plan.

NEW SECTION

WAC 388-101D-0605 How must a group training home protect clients from risks associated with bodies of water? (1) Any body of water at the group training home over twenty-four inches deep must be enclosed by a fence at least forty-eight inches high.

(2) Any door or gate that directly leads to the body of water must have an audible alarm.

NEW SECTION

WAC 388-101D-0610 What requirements must a group training home's fireplaces, heaters, and stoves meet? (1) The group training home must not use a space heater unless it has an underwriters laboratories (UL) rating.

(2) Any hot surface, such as a fireplace or wood-burning or pellet stove, must have a stable barrier that prevents accidental client contact.

NEW SECTION

WAC 388-101D-0615 What requirements must the group training home's smoke detectors and fire extinguishers meet? (1) The group training home must install approved automatic smoke detectors:

(a) In every client's bedroom;

(b) On every floor of the home; and

(c) In an interconnected manner so when one alarm is triggered, the whole system reacts.

(2) The approved smoke detectors must:

(a) Be in working condition at all times; and

(b) Meet the specific needs of all clients living in the home.

(3) The group training home must have a five-pound 2A:10B-C fire extinguisher on each floor of the home, unless the local fire authority requires a different type of fire extinguisher.

(4) Each fire extinguisher must be:

(a) Installed according to manufacturer recommendations;

(b) Annually replaced or inspected and serviced;

(c) In proper working order; and

(d) Readily available for use at all times.

(5) The group training home must be located in an area with public fire protection.

(6) A group training home that was a licensed assisted living facility before the effective date of this rule must:

(a) Meet requirements under subsections (1) through (5); or

(b) Annually demonstrate they have passed inspection by the state fire marshal.

NEW SECTION

WAC 388-101D-0620 How must a group training home prepare for emergency evacuations? (1) The group training home must display an emergency evacuation plan in a common area on every floor of the home.

(2) The emergency evacuation plan must include:

(a) A floor plan of the home with clearly marked exits;

(b) Emergency evacuation routes; and

(c) The location for the clients to meet outside the home.

(3) The group training home must be able to evacuate all clients to a safe location outside the home in five minutes or less.

(4) A group training home that was a licensed assisted living facility before the effective date of this rule must:

(a) Meet requirements under subsection (3); or

(b) Annually demonstrate they have passed inspection by the state fire marshal.

(5) If a client requires assistance during an evacuation, the group training home must ensure the client's primary evacuation route does not require the client to evacuate:

(a) Through another person's bedroom; or

(b) Using stairs, an elevator, chairlift, or platform lift.

NEW SECTION

WAC 388-101D-0625 How much emergency food and drinking water must be kept in the group training home? (1) The group training home must keep an emergency food supply on-site to meet the needs of the clients and staff for at least seventy-two hours. The food supply must meet the dietary needs of each client.

(2) The group training home must keep at least three gallons of water on-site for each client and staff member, which must be:

(a) In sealed, food-grade containers;

(b) Stored in a cool, dry location away from direct sunlight; and

(c) Chlorinated or commercially bottled.

(3) Chlorinated water must be replaced every six months.

NEW SECTION

WAC 388-101D-0630 What must a group training home consider when providing nutritional services? (1) The group training home must:

(a) Serve breakfast, lunch, and dinner each day;

(b) Provide twenty-four hour access to snacks and beverages, including nutritious options and options preferred by the client;

(c) Provide a special diet, if ordered by a healthcare professional, such as low sodium, general diabetic, and mechanical soft food diets;

(d) Provide prescribed nutrient concentrates and supplements when prescribed in writing by a healthcare practitioner; and

(e) Maintain a sufficient supply of food at all times.

(2) The group training home must plan meals that accommodate the client's preferences and support the client's choice.

(3) The group training home must provide meals, snacks, and beverages that, if applicable, address each client's:

(a) Nutritional needs;

(b) Food allergies and sensitivities; and

(c) Need for altered diet due to a risk of choking or aspiration.

NEW SECTION

WAC 388-101D-0635 What requirements must an employee or volunteer meet to prepare meals and snacks in a group training home? (1) If a group training home employee prepares food for clients, the employee must:

(a) Complete safe food handling training requirements under chapter 388-829 WAC;

(b) Prepare food for clients in a safe and sanitary manner; and

(c) Have a food worker card under chapter 246-217 WAC.

(2) If a group training home volunteer prepares food for clients, the volunteer must:

(a) Prepare food for clients in a safe and sanitary manner; and

(b) Have a food worker card under chapter 246-217 WAC.

(3) The group training home staff must provide meal preparation instruction and support to the client in accordance with the client's person-centered service plan.

NEW SECTION

WAC 388-101D-0640 When may a pet live in a group training home? A pet living in the group training home must:

(1) Not compromise any client rights, preferences, or medical needs;

(2) Be clean and healthy with proof of current vaccinations; and

(3) Pose no significant health or safety risks to any client residing in the home.

NEW SECTION

WAC 388-101D-0645 What infection control practices must a group training home implement? (1) The group training home must implement occupational safety and health administration (OSHA) universal precautions to limit the spread of infections when:

(a) Providing client care and services;

(b) Cleaning the home;

(c) Washing laundry; and

(d) Managing infectious waste.

(2) The group training home must:

(a) Provide staff with the supplies, equipment, and protective clothing necessary for limiting the spread of infections;

(b) Restrict a staff person's contact with clients when the staff person has an illness that is likely to spread in the group training home by casual contact; and

(c) Report communicable diseases as required under chapter 246-100 WAC.

(3) If a client has a positive tuberculosis test result, the group training home must ensure the client:

(a) Has a chest X-ray no more than seven days after the positive test result;

(b) Is evaluated for signs and symptoms of tuberculosis; and

(c) Follows the recommendation of the client's healthcare provider.

NEW SECTION

WAC 388-101F-0650 What must a group training home do to detect and manage tuberculosis? To detect and manage tuberculosis, a group training home must:

(1) Ensure each employee has a tuberculin test no more than three days after beginning to work with clients unless otherwise exempt under this chapter;

(2) Implement policies and procedures that comply with tuberculosis standards set by the Centers for Disease Control and Prevention and applicable state laws;

(3) Comply with the Washington Industrial Safety and Health Act (WISHA) standards for respiratory protection; and

(4) Comply with chapter 296-842 WAC requirements to protect the health and safety of clients who may come into contact with people who have infectious tuberculosis.

Reviser's note: The above new section was filed by the agency as WAC 388-101F-0650. This section is placed among sections forming new chapter 388-101D WAC, and therefore should be numbered WAC 388-

101D-0650. Pursuant to the requirements of RCW 34.08.040, the section is published in the same form as filed by the agency.

NEW SECTION

WAC 388-101D-0655 What type of tuberculin test must a group training home employee complete? (1) A group training home employee required to complete a tuberculin test must complete:

(a) A tuberculin skin test with results read by a qualified medical professional between forty-eight and seventy-two hours after placing the test; or

(b) Another FDA-approved tuberculin test.

(2) A group training home employee must complete a blood test for tuberculosis if the employee declines a skin test.

NEW SECTION

WAC 388-101D-0660 When is a group training home employee not required to complete a tuberculin test? (1) A group training home employee is not required to complete a tuberculin test if the employee:

(a) Has documentation of an FDA-approved tuberculin test with negative results from within the last twelve months;

(b) Has documentation of a positive FDA-approved tuberculin test with documented evidence of:

(i) Adequate therapy for active disease; or

(ii) Completion of treatment for latent tuberculosis infection preventive therapy;

(c) Self-reports a history of positive test results under subsection (2) or (3) of this section.

(2) If a group training home employee self-reports a history of positive test results with chest x-ray results from the last twelve months, the employee must:

(a) Provide a copy of the normal x-ray results to the group training home; and

(b) Be evaluated for signs and symptoms of tuberculosis.

(3) If a group training home employee self-reports a history of positive test results without chest x-ray results, the employee must:

(a) Be referred to a medical provider;

(b) Complete a chest x-ray within seven days; and

(c) Be cleared by a medical professional before returning to work if the x-ray is abnormal and consistent with tuberculosis.

(4) A group training home volunteer working less than four hours a month is exempt from tuberculin test requirements.

NEW SECTION

WAC 388-101D-0665 When must a group training home employee complete a one-step tuberculin test? A group training home employee must complete a one-step tuberculin test if the employee:

(1) Has a documented history of a negative result from a previous two-step skin test; or

(2) Is tested using an FDA-approved tuberculin test that does not require a two-step testing process.

NEW SECTION

WAC 388-101D-0670 When must a group training home employee complete a two-step tuberculin test? A group training home employee must complete a two-step tuberculosis skin test if the employee:

(1) Has never had a tuberculosis skin test;

(2) Cannot demonstrate proof of a previous negative two-step skin test; or

(3) Completed a one-step skin test more than twelve months ago.

NEW SECTION

WAC 388-101D-0675 What happens if a group training home employee receives a positive tuberculin test result? If a group training home employee receives a positive result to tuberculosis skin or blood testing, the group training home must:

(1) Ensure the employee completes a chest X-ray within seven days;

(2) Evaluate the employee for signs and symptoms of tuberculosis immediately and annually thereafter; and

(3) Follow the recommendations of the employee's medical provider.

NEW SECTION

WAC 388-101D-0680 Must a group training home employee complete follow-up testing? A group training home employee with negative tuberculin test results may be required by a public health provider or licensing authority to complete follow-up testing:

(1) After exposure to active tuberculosis;

(2) When tuberculosis symptoms are present; or

(3) Periodically as determined by the public health provider.

NEW SECTION

WAC 388-101D-0685 What must a group training home do when a client or employee has tuberculosis symptoms or receives a positive chest x-ray result? If a group training home client or employee has tuberculosis symptoms or receives a positive chest x-ray result, the group training home must:

(1) Report the person with tuberculosis symptoms or a positive chest x-ray to an appropriate medical provider or public health provider;

(2) Follow the infection control and safety measures ordered by the person's medical provider or a public health provider;

(3) Implement appropriate infection control measures;

(4) Apply living or work restrictions if the person poses an infection risk to others; and

(5) Ensure an employee caring for a client who has active tuberculosis complies with the Washington Industrial Safety and Health Act (WISHA) standards for respiratory protection under chapter 296-842 WAC.

NEW SECTION

WAC 388-101D-0690 What records must a group training home maintain related to tuberculin testing? A group training home must:

(1) Keep the records of tuberculin test results, reports of X-ray findings, and any medical provider or public health provider orders in the group training home;

(2) Provide the records to a public health provider or licensing agency upon request;

(3) Retain the records for at least two years after the date the employee quits or is terminated; and

(4) Provide an employee a copy of the employee's tuberculin test results.

NEW SECTION

WAC 388-101D-0695 What rights and protections does a client living in a group training home have? (1) In addition to the client rights under WAC 388-101D-0125 and WAC 388-823-1095, a client living in a group training home has the right to:

(a) A locking bedroom door, unless it is unsafe for the client and is documented in their person-centered service plan;

(b) Share their bedroom only if they consent;

(c) Furnish and decorate their bedroom within the terms of their written agreement with the group training home;

(d) Retain and use personal possessions, including furniture and clothing, as space permits;

(e) Control their own schedule, with support if indicated in their person-centered service plan;

(f) Meet privately at any time with visitors of their choosing;

(g) Access and review the group training home's certification review results and corrective action plans;

(h) View copies of the group training home's policies and procedures at any time;

(i) View copies of the certification results, inspection reports, and the group training home's plans of correction at any time;

(j) Receive written notice from the group training home of enforcement action that places a hold on referrals for new clients or is related to provisional certification; and

(k) A setting that meets requirements under 42 C.F.R. 441.301 (c)(4).

(2) Each client must sign a written agreement with the group training home. The written agreement must include the client's notice rights for termination of services. The notice rights must not conflict with requirements under WAC 388-101D-0200.

NEW SECTION

WAC 388-101D-0700 What notice requirements must a group training home meet? If a client's group training home services are terminated and the client is evicted, before evicting the client the group training home must follow:

(1) Notice requirements under WAC 388-101D-0200; and

(2) Applicable legal processes, such as unlawful detainer under chapters 59.12 or 59.16 RCW.

NEW SECTION

WAC 388-101D-0705 What requirements under this chapter is a group training home provider exempt from? A group training home provider contracted with DDA before the effective date of this rule is exempt from requirements under WAC 388-101D-0565, 388-101D-0575, 388-101D-0605, 388-101D-0615.

WSR 18-19-030
PROPOSED RULES
SPOKANE REGIONAL CLEAN AIR AGENCY

[Filed September 13, 2018, 7:37 a.m.]

Original Notice.

Proposal is exempt under RCW 70.94.141(1).

Title of Rule and Other Identifying Information: Amend SRCAA Regulation I, Article X: Fees and Charges, Sections 10.02, 10.04, 10.05 and 10.07.

Hearing Location(s): On November 1, 2018, at 9:30 a.m., at Spokane Regional Clean Air Agency (SRCAA), 3104 East Augusta Avenue, Spokane, WA 99207.

Date of Intended Adoption: November 1, 2018.

Submit Written Comments to: Margee Chambers, 3104 East Augusta Avenue, Spokane, WA 99207, email PublicComment@spokanecleanair.org, fax 509-477-6828, by November 1, 2018, close of hearing. Note, please submit written comments by October 30, 2018, for comments to be included in the prehearing presentation.

Assistance for Persons with Disabilities: Contact Mary Kataoka, phone 509-477-4727 ext. #100, fax 509-477-6828, email mkataoka@spokanecleanair.org, by October 30, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: SRCAA is proposing to amend Regulation I, Article X: Fees and Charges; Sections 10.02, 10.04, 10.05 and 10.07. Amendments to Sections 10.02 and 10.05 are to update text for clarification and statutory citing related to the Public Records Act, chapter 42.56 RCW. Updates to Section 10.04 are for clarification purposes. Amendments to Section 10.07 are to update the fee structure for Notice of Construction (NOC) and Notice of Intent (NOI) applications, to move the program towards full cost recovery.

Reasons Supporting Proposal: Amendments to Section 10.02(C) clarify that the public records fees are excluded from the SRCAA round up to the nearest $1 fee calculation because fees are based on state statute and not set by SRCAA. Amendments to Section 10.04 update title information. Section 10.05 amendments are to comply with 2017 legislative amendments that updated the fee structure in the Public Records Act. Revisions to NOC/NOI application fee structure in Section 10.07 will allow for more equitable distribution of fees depending on the complexity of the application. The fee structure revisions allow SRCAA to move the NOC/NOI program towards full cost recovery, as allowed by

the Washington Clean Air Act. NOC/NOI structure updates include base fee classifications, designating number of staff review and processing hours included in base fee, developing hourly fee charged when staff review and processing hours exceed base fee hours, and clarification edits that fees are for new and modified NOC/NOI.

Statutory Authority for Adoption: RCW 70.94.141.

Statute Being Implemented: Chapter 70.94 RCW.

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

Name of Proponent: SRCAA, governmental.

Name of Agency Personnel Responsible for Drafting: Margee Chambers, SRCAA, 509-477-4727; Implementation and Enforcement: April Westby, SRCAA, 509-477-4727.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. SRCAA is a local air pollution control agency. Per RCW 70.94.141, a cost-benefit analysis under RCW 34.05.328 does not apply to local air pollution control agencies.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 70.94.141.

Explanation of exemptions: SRCAA is a local air pollution control agency. Per RCW 70.94.141, a small business economic impact statement does not apply to local air pollution control agencies.

September 13, 2018
Margee Chambers
Rule Writer
SIP Planner

Amendatory Sections
Spokane Regional Clean Air Agency (SRCAA)
Regulation I, Article X: Fees and Charges, Sections 10.02, 10.04, 10.05 and 10.07.

SECTION 10.02 FEES AND CHARGES REQUIRED

(A) Additional Fee for Failure to Pay. Any fee assessed under Article X shall be paid within forty-five (45) days of assessment. Failure to pay an assessed fee in full within ninety (90) days of assessment will result in the imposition of an additional fee equal to three (3) times the amount of the original fee assessed.

(B) Revenues Collected per RCW 70.94.161. Revenues collected per RCW 70.94.161 shall be deposited in the operating permit program dedicated account and shall be used exclusively for the program.

(C) Method of Calculating Fees in Article X. Invoice totals will be rounded-up to the nearest one (1) dollar, except for ((~~photocopy and postage~~)) public records fees per Section 10.05(A).

(D) Periodic Fee Review. The Board shall periodically review all agency fees in the Fee Schedule and determine if the total projected fee revenue to be collected is sufficient to fully recover direct and indirect program costs. If the Board determines that the total projected fee revenue significantly exceeds or is insufficient for the program costs, then the Board shall amend the Fee Schedule to more accurately recover program costs. Any proposed fee revisions shall include opportunity for public review and comment.

SECTION 10.04 ((~~RESERVED~~)) FEE WAIVER (Repealed 10/7/10, Res. 10-15)

SECTION 10.05 GENERAL ADMINISTRATIVE FEES

(A) ((~~Photocopy~~)) Public Records Fees. ((~~A fee of $0.15 per page for photocopies shall be charged (RCW 42.56.120)~~)) The Agency charges the standard fees and costs authorized in RCW 42.56.120.

((~~(B) Postage. The actual cost of postage shall be charged for all material requested to be mailed [RCW 42.56.070 (7)(a)].~~))

((~~C~~)) (B) Other Services. For other administrative services requested and performed by Agency staff, which are not provided to the public generally, the Control Officer shall determine such charge as reasonably reimburses the Agency for time and materials expended in providing the service.

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules. The rule published above varies from its predecessor in certain respects not indicated by the use of these markings.

SECTION 10.07 APPLICATION AND PERMIT FEES FOR NOTICE OF CONSTRUCTION AND APPLICATION FOR APPROVAL (NOC) AND FOR NOTICE OF INTENT (NOI) TO INSTALL AND OPERATE A TEMPORARY STATIONARY SOURCE

(A) NOC and ((~~Notice of Intent~~)) NOI Fees.

(1) NOC/NOI Class, Base Fee, Fee for Additional NOC/NOI Review Hours, SEPA Fee, and Fee Determination.

((~~(a)~~)) For each project required by Regulation I, Article V, to file a NOC or a ((~~Notice of Intent, the applicant~~)) NOI application, the owner or operator ((~~shall~~)) must pay ((~~a base fee per the Fee Schedule. Base fee classes are listed below~~)) the following applicable fees in (b) through (d) below:

(a) NOC/NOI Class. Each NOC/NOI application will be assigned a Class, as follows:

1. Class I - ((~~Notice of Intent. Notice of Intent~~)) NOI to install and operate portable stationary sources and temporary stationary sources include the following:

Article IV Source/Source Category Description	
Asphalt plant	
Concrete production operation/ready mix plant	
Rock crusher	
((~~Article IV Source/Source Category Description~~	((~~Article IV, Exhibit R Category~~
~~Asphalt plant~~	~~15~~
~~Concrete batch plant/ready mix plant~~	~~22~~
~~Rock crusher~~))	((~~36~~))

2. Class II - ((~~Simple NOC.~~)) Simple NOCs include the following:

Article IV Source/Source Category Description

Coffee roaster
Degreaser/solvent cleaner (not subject to 40 CFR Part 63, Subpart T) subject to Article IV
Dry cleaner (non halogenated solvent)
Evaporator subject to Article IV
Gasoline dispensing facility with maximum annual gasoline throughput ≤ 1.5 million gallons
Graphic art system, including lithographic and screenprinting operation, subject to Article IV
Material handling operation that exhausts > 1,000 and < 10,000 acfm to the ambient air
Organic vapor collection system within commercial or industrial facility that is subject to Article IV
Rock, asphalt, or concrete crusher
Spray booth/surface coating operation that exhausts ≤ 10,000 acfm to the ambient air
Sterilizer subject to Article IV
Wood furniture stripping operation subject to Article IV

((~~Article IV Source/Source Category Description~~	((~~Article IV, Exhibit R Category~~
~~Boiler and other fuel-burning equipment~~	~~27~~
~~Coffee roaster~~	~~20~~
~~Concrete batch plant/ready mix plant~~	~~22~~
~~Dry cleaner~~	~~23~~
~~Emergency generator~~	~~52~~
~~Gasoline dispensing facility~~	~~28~~
~~Lithographic printing/screen printing~~	~~9.e.5~~
~~Material handling that exhausts > 1,000 acfm~~	~~24~~
~~Rock crusher~~	~~36~~
~~Spray booth/surface coating operation~~	~~57~~
~~Stationary internal combustion engine~~	~~53~~
~~Sterilizer~~	~~9.e.8~~
~~Stump/wood waste grinder~~))	~~54~~))

3. Class III - ((~~Standard NOC.~~)) Standard NOCs include the following:

Article IV Source/Source Category Description
Soil and groundwater remediation operation subject to Article IV
Bakery subject to Article IV
Bed lining or undercoating operation subject to Article IV
Boiler and other fuel-burning equipment with maximum per unit heat input < 100 MMBtu/hr
Brick and clay products manufacturing operations
Burn out, kiln, and curing oven
Chrome plating operation
Concrete production operation
Dry cleaner (halogenated solvent)
Gasoline dispensing facility with maximum annual gasoline throughput > 1.5 million gallons
Grain handling; seed, pea and lentil processing facility
Incinerator/crematory
Internal combustion engine used for standby, back-up operations rated ≥ 500 bhp
Internal combustion engine, other than engines used for standby or backup operation rated ≥ 100 bhp
Material handling operation that exhausts ≥ 10,000 acfm to the ambient air
Metal casting facility/foundry
Metal plating or anodizing operation
Metallurgical processing operation
Mill; lumber, plywood, shake, shingle, woodchip, veneer operation, dry kiln, wood products, grain, seed, feed, or flour
Plastic and fiberglass operations using ≥ 55 gallons per year of all VOC and toxic air pollutant containing materials
Spray booth/surface coating operation that exhausts > 10,000 acfm to the ambient air
Storage tank for organic liquid with capacity > 20,000 gallons
Stump/woodwaste grinder
Tire recapping operation

((~~Article IV Source/Source Category Description~~	((~~Article IV, Exhibit R Category~~
~~Soil and groundwater remediation operation~~	~~9.e.7~~
~~Burn out oven~~	~~43~~
~~Chrome plating~~	~~35~~
~~Incinerator / crematory~~))	~~31~~))

4. Class IV - ~~Complex NOC.~~ Complex NOCs include the following:

Article IV Source/Source Category Description
Asphalt plant
Boiler and other fuel-burning equipment with maximum per unit heat input ≥ 100 MMBtu/hr
Bulk gasoline and aviation gas terminal, plant, or terminal
Cattle feedlot subject to Article IV
Chemical manufacturing operation
Composting operation
Natural gas transmission and distribution facility

Paper manufacturing operation, except Kraft and sulfite paper mills
Petroleum refinery
Pharmaceutical production operation
Refuse systems
Rendering operation
Semiconductor manufacturing operation
Sewerage systems
Wholesale meat/fish/poultry slaughter and packing plant

((~~Article IV Source/Source Category Description~~	((~~Article IV, Exhibit R Category~~
~~Asphalt plant~~	~~15~~
~~Composting~~	~~21~~
~~Refuse systems~~	~~48~~
~~Rendering~~	~~49~~
~~Sewerage systems~~))	~~50~~))

5. ((~~(b)~~)) For sources/source categories not listed in Section 10.07 (A)(1)(a), each NOC/NOI ((~~Notice of Intent and NOC~~)) application ((~~review~~)) will be assigned to Class I, II, III or IV by the Control Officer on a case-by-case basis.

(b) Base fee. A base fee must be paid to the Agency with the submission of each completed NOC/NOI application. The base fee applicable for each NOC/NOI Class is listed in the Fee Schedule.

1. For each NOC/NOI application, the base fee covers staff time spent in reviewing and processing the application up to the listed number of base-fee hours provided in the Fee Schedule for each class of NOC/NOI.

((~~(c)~~)) 2. For sources with one or more emission points under one NOC application, as allowed in Article V, Section 5.02.G, a separate base fee applies to each emissions unit, or each group of like-kind emissions units, being installed or modified. A group of emissions units will be considered as like-kind if the same set of emission calculations can be used to characterize emissions from each of the emissions units.

(c) Fee for Additional NOC/NOI Review Hours. When the staff time hours spent reviewing and processing a NOC/NOI application exceeds the listed number of base-fee hours provided in the Fee Schedule for the applicable class of NOC/NOI, an additional fee will be charged. The additional fee is calculated by multiplying the total staff time spent in reviewing and processing the NOC/NOI application that exceeds the listed number of review hours (rounded up to the nearest half-hour) by the hourly rate as listed in the Fee Schedule.

(d) SEPA Review Fee. Where submittal of an Environmental Checklist, is required per the State Environmental Policy Act (SEPA) Chapter 197-11 WAC is required in association with a NOC or a NOI, and SRCAA is the lead agency, the applicant must pay a SEPA review fee as listed in the Fee Schedule. The SEPA review fee must be paid with the submission of the Environmental Checklist to the Agency.

(e) Fee Determinations.

1. The base fee is calculated by multiplying the number of base-fee hours for the NOC/NOI class by the hourly rate listed in the Fee Schedule.

2. Hourly Rate. The hourly rate is calculated by:

$$\text{Hourly Rate} = \frac{\text{Total NOC and NOI Program Costs}}{\text{Total NOC and NOI Program Hours}}$$

3. Hourly Rate Revision. Revisions to the hourly rate are based on a three (3) year average of the three (3) most representative fiscal years out of the four (4) recent fiscal years, rounded-up to the nearest one (1) dollar.

(2) Fees for Replacement or Substantial Alteration of Control Technology and for Changes to an Order of Approval or Permission to Operate.

(a) The following NOC applications or requested changes to an Order of Approval or Permission to Operate must pay a fee as listed in the Fee Schedule. The fee will be assessed each time a request is submitted and will be invoiced to the owner or operator with the final determination.

1. NOC applications for replacement or substantial alteration of control technology under WAC 173-400-114.

2. An owner or operator requesting a modification, revision, and/or change in conditions of an approved Order of Approval or Permission to Operate, under Article V, Section 5.10.C.((~~, shall pay a revision fee as listed in the Fee Schedule. The revision fee will be assessed each time a request is submitted and will be invoiced to the owner or operator, or both with the final determination.~~))

(b) The ((~~revision~~)) fee is calculated by adding all the applicable fees described below:

1. Minimum Fee. The minimum fee, as listed in the Fee Schedule, will be assessed for all NOCs reviewed under WAC 173-400-114 and revision request reviews. The minimum fee includes the first three (3) hours of staff time spent in reviewing and processing the request; and

2. Hourly Fee. The hourly fee is calculated by multiplying the total staff time spent in reviewing and processing the request beyond the first three (3) hours covered in 10.07 (A)(2)(b)1. (rounded-up to the nearest half-hour), by the hourly rate as listed in the Fee Schedule.

(c) Fee Determinations.

1. Flat Fee. The revision flat fee is calculated by multiplying three (3) hours by the hourly rate listed in the Fee Schedule.

2. Hourly Rate. The hourly rate is calculated by:

$$\text{Hourly Rate} = \frac{\text{Total NOC and NOI Program Costs}}{\text{Total NOC and NOI Program Hours}}$$

3. Hourly Rate Revision. Revisions to the hourly rate are based on a three (3) year average of the three (3) most representative fiscal years out of the four (4) recent fiscal years, rounded-up to the nearest one (1) dollar.

((~~(3) Additional Fees (for each application).~~

~~(a) SEPA Review Fee. Where review of an Environmental Impact Statement (EIS), Environmental Checklist, or an Addendum to, or adoption of, an existing environmental document per the State Environmental Policy Act (SEPA) Chapter 197-11 WAC is required, in association with a NOC or a Notice of Intent, the applicant shall pay a SEPA or EIS review fee per the Fee Schedule.~~

~~(b) Toxics Review Fee. For any new source of air pollution which requires review per Chapter 173-460 WAC, a toxic air pollutant review fee shall be paid. For sources with one or more emission points under one NOC application, as allowed in Article V, Section 5.02.G, a separate toxic air pollutant review fee applies to each emissions unit, or each group of like-kind emissions units, being installed or modified. A group of emissions units shall be considered as like-kind if the same set of emission calculations can be used to characterize emissions from each of the emissions units. The toxic air pollutant review fee shall be as follows:~~

~~1. Small Quantity Emission Rate (SQER). For a new source using WAC 173-460-080 (2)(b), SQER, to demonstrate that ambient impacts are sufficiently low to protect human health and safety, as required WAC 173-460-070 & WAC 173-460, the applicant shall pay a SQER review fee per the Fee Schedule.~~

~~2. Dispersion Modeling. For a new source using dispersion screening models (e.g., EPA SCREEN or TSCREEN) under WAC 173-460-080 (2)(a) to demonstrate that ambient impacts are sufficiently low to protect human health and safety, as required WAC 173-460-070, the applicant shall pay a dispersion modeling review fee per the Fee Schedule.~~

~~3. Advanced Modeling. For a new source using more refined dispersion models (e.g., EPA ISC3) under WAC 173-460-080 (2)(a) to demonstrate that ambient impacts are sufficiently low to protect human health and safety, as required WAC 173-460-070; or for a new or modified source using a second tier analysis under WAC 173-460-090 or a risk management decision under WAC 173-460-100 to demonstrate that ambient impacts are sufficiently low to protect human health and safety, as required WAC 173-460-070, the applicant shall pay the advanced modeling review fee per the Fee Schedule.~~

~~(c) New Source Performance Standards (NSPS) Review Fee.~~

~~Applicants of any new air pollution source subject to WAC 173-400-115 (NSPS) and 40 CFR Parts 60 shall pay a NSPS review fee per the Fee Schedule.~~

~~(d) National Emission Standard for Hazardous Air Pollutants (NESHAP) Review Fee. Applicants of any new air pollution source subject to WAC 173-400-075 (NESHAP) and 40 CFR Parts 61 and 63 shall pay a NESHAP fee per the Fee Schedule.~~

~~(e) Best Available Control Technology (BACT) Review Fee.~~

~~1. Generic BACT. Where no BACT review is required (e.g., the applicant demonstrates there is an established and/or recognized BACT standard for the source category type), a BACT review fee is not applicable.~~

~~2. Non-Generic BACT Review. A non-generic BACT review is one where a generic BACT standard is not applicable and a top-down BACT review is not required. Applicants of any new air pollution source subject to a non-generic BACT review shall pay a non-generic BACT review fee per the Fee Schedule.~~

~~3. Top-Down BACT Review (as described in EPA's Draft New Source Review Workshop Manual from October 1990 and as summarized here). A top-down BACT review requires the ranking of available control technologies in descending order of control effectiveness. Applicants of any new air pollution source subject to a top-down BACT review shall pay a top-down BACT review fee per the Fee Schedule.~~))

(B) Payment of Fees.

(1) Upon Submission of Application. The base fee and SEPA fee (if applicable) ((~~shall~~)) must be paid at the time the NOI/NOC application is submitted to the Agency. Review of the NOI/NOC application will not commence until the ((~~applicable~~)) base fee and SEPA fee (if applicable) is received.

(2) After Application.

(a) Complete Applications. The Agency will invoice the owner, operator, or both, for ((~~all other applicable fees~~)) Fees for Additional NOC/NOI Review Hours, if applicable. The fees ((~~shall~~)) must be paid whether the application is approved or denied.

(b) Incomplete Applications.

1. If an owner, operator, or both, notifies the Agency in writing that an application will not be completed or cancels the application; or the application remains incomplete for more than three (3) months; the Agency will invoice the owner, operator, or both, for payment of applicable fees.

2. Applications not accompanied by the base fee and SEPA fee (if applicable) will be considered incomplete. If information requested by the Agency is not provided, the application will be considered incomplete and review of the application will be suspended. Review of the application will commence, or recommence, when all required fees and information requested by the Agency is received. An application will be cancelled if it remains incomplete for more than eighteen (18) months from initial receipt. For review of the cancelled application to resume, the applicant must pay all outstanding invoice fees((~~,~~)) (if applicable), and resubmit the ((~~applicable~~)) base fee and SEPA fee (if applicable).

(C) Compliance Investigation Fee. When a compliance investigation is conducted per Article V, Section 5.12, the compliance investigation fee shall be assessed per the Fee Schedule. The fee shall be assessed for each emissions unit, or group of like-kind emissions units, being installed or modified. A group of emissions units shall be considered as like-kind if the same set of calculations can be used to characterize emissions from each of the emissions units.

Reviser's note: The typographical errors in the above material occurred in the copy filed by the Spokane Regional Clean Air Agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

WSR 18-19-035
WITHDRAWL OF PROPOSED RULES
COLUMBIA RIVER GORGE COMMISSION
(By the Code Reviser's Office)
[Filed September 13, 2018, 12:34 p.m.]

Amendments proposed by the Columbia River Gorge Commission in WSR 17-24-105, appearing in issue 18-02 of the Washington State Register, which was distributed on January 17, 2018, is withdrawn by the office of the code reviser

under RCW 34.05.335(3), since the proposal was not adopted within the one hundred eighty day period allowed by the statute.

Kerry S. Radcliff, Editor
Washington State Register

WSR 18-19-044
PROPOSED RULES
PARKS AND RECREATION COMMISSION

[Filed September 14, 2018, 7:03 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-16-032.

Title of Rule and Other Identifying Information: Chapter 352-80 WAC, No child left inside (aka outdoor education and recreation grant program.

Hearing Location(s): On November 15, 2018, at 9 a.m., at Auburn City Hall, Council Chambers, 25 West Main Street, Auburn, WA 98001. Actual hearing time will occur anytime between 9 a.m. and 5 p.m.

Date of Intended Adoption: November 15, 2018.

Submit Written Comments to: Steve Brand, 1111 Israel Road, Tumwater, WA, 98504, email Steve.brand@parks.wa.gov, https://www.rco.wa.gov/grants/ncli.shtml, by November 9, 2018.

Assistance for Persons with Disabilities: Contact Becki Ellison, phone 360-902-8502, fax 360-664-8112, TTY 800-833-6388, email beckii.ellison@parks.wa.gov, by October 23, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: To provide for a more efficient process of evaluating applications and clarify criteria for awarding grants.

Reasons Supporting Proposal: Greater likelihood of achieving the program objectives and a more efficient implementation of the no child left inside program.

Statutory Authority for Adoption: RCW 79A.05.351 Outdoor education and recreation grant program and chapter 79A.05 RCW.

Statute Being Implemented: RCW 79A.05.351.

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

Name of Proponent: Washington state parks and recreation commission, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Steve Brand, Tumwater, Washington, 360-902-8651.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. No new cost to program implementation.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules only correct typographical errors, make address or name changes, or clarify language of a rule without changing its effect.

September 14, 2018
Valeria Veasley
Management Analyst

AMENDATORY SECTION (Amending WSR 08-06-013, filed 2/21/08, effective 3/23/08)

WAC 352-80-030 Eligibility. Public agencies, private nonprofit organizations, formal school programs, informal after school programs, and community based programs within Washington state are eligible to apply for grants under this chapter. ((~~Programs that provide outdoor education opportunities to schools must be fully aligned with the state's essential academic learning requirements.~~))

AMENDATORY SECTION (Amending WSR 08-06-013, filed 2/21/08, effective 3/23/08)

WAC 352-80-080 Evaluation criteria and process. ((~~The following criteria are used to evaluate applications:~~

~~(1) Proposals that provide for public/private partnerships;~~

~~(2) Proposals that provide for innovative ways to increase the availability and use of outdoor recreation facilities;~~

~~(3) Proposals which show consideration for the economics of installation or implementation to provide greatest cost benefit ratio, for example, where private parties contribute more than the minimum amount;~~

~~(4) Proposals which contribute to the statewide network of facilities or programs;~~

~~(5) Proposals which demonstrate their compatibility with the legislative intent of RCW 79A.05.351;~~

~~(6) Programs that contribute to the reduction of academic failure and drop out rates;~~

~~(7) Programs that make use of research-based, effective environmental, ecological, agricultural, or other natural resource based educational curriculum;~~

~~(8) Proposals which encourage sound environmental practices through changing education or recreational behavior;~~

~~(9) Proposals which target geographic areas as defined in RCW 79A.05.351;~~

~~(10) Proposals which encourage community involvement;~~

~~(11) Proposals which demonstrate innovative approaches to education or information;~~

~~(12) Programs that will commit matching and in-kind resources;~~

~~(13) Proposals that contribute to healthy lifestyles through outdoor recreation and sound nutrition;~~

~~(14) Proposals that use state park and other natural resource venues and personnel as a resource;~~

~~(15) Proposals that maximize the number of participants that can be served;~~

~~(16) Proposals that provide an opportunity to experience the out-of-doors directly and understand nature and the natural world; and~~

~~(17) Proposals that include ongoing program evaluation, assessment and reporting of their effectiveness.~~)) (1) The director shall adopt a competitive evaluation process to guide the allocation of grant funds.

(2) The director shall set priorities and develop criteria for awarding grants considering the following:

(a) Be developed, to a reasonable extent, through the participation of a grant program advisory committee;

(b) Be published in the grant program manual;

(c) Be designed for use by an advisory committee selected for this purpose;

(d) Be in accord with RCW 79A.05.351 and all other applicable statutes and federal laws and rules.

WSR 18-19-049
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed September 14, 2018, 11:45 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-11-040.

Title of Rule and Other Identifying Information: The department is proposing to amend WAC 388-106-0045 When will the department authorize my long-term care services? and 388-106-0047 When can the department terminate or deny long-term care services to me?

Hearing Location(s): On October 23, 2018, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than October 24, 2018.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., October 23, 2018.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by October 9, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend these rules in order to clarify that client services may be authorized prior to the client's signature on the service summary and that services are not required to be terminated when the department is unable to obtain the client's signature on the service summary.

Reasons Supporting Proposal: The amendments clarify client services.

Statutory Authority for Adoption: RCW 74.08.090.

Statute Being Implemented: RCW 74.09.520.

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

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Barbara Hannemann, P.O. Box 45600, Olympia, WA 98504-5600, 360-725-2525.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Rules are exempt per RCW 34.05.328 (5)(b)(v), rules the content of which is explicitly and specifically dictated by statute.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 34.05.328 (5)(b)(vii).

Explanation of exemptions: Rules of DSHS relating only to client medical or financial eligibility and rules concerning liability for care of dependents.

September 12, 2018
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 16-04-020, filed 1/22/16, effective 2/22/16)

WAC 388-106-0045 When will the department authorize my long-term care services? The department will authorize long-term care services when you:

(1) Are assessed using CARE;

(2) Are found financially and functionally eligible for services including, if applicable, the determination of the amount of participation toward the cost of your care and/or the amount of room and board that you must pay;

(3) Have given ((~~written~~)) consent for services and approved your plan of care; and

(4) Have chosen a provider(s), qualified for payment.

AMENDATORY SECTION (Amending WSR 16-04-020, filed 1/22/16, effective 2/22/16)

WAC 388-106-0047 When can the department terminate or deny long-term care services to me? (1) The department will deny or terminate long-term care services if you are not eligible for long-term care services pursuant to WAC 388-106-0210, 388-106-0277, 388-106-0310, or 388-106-0610.

(2) The department may deny or terminate long-term care services to you if, after exhaustion of standard case management activities and the approaches delineated in the department's challenging cases protocol, which must include an attempt to reasonably accommodate your disability or disabilities, any of the following conditions exist:

(a) After a department representative reviews with you your rights and responsibilities as a client of the department, per WAC 388-106-1300 and 388-106-1303, you refuse to accept those long-term care services identified in your plan of care that are vital to your health, welfare or safety;

(b) You choose to receive services in your own home and you or others in your home demonstrate behaviors that are substantially likely to cause serious harm to you or your care provider;

(c) You choose to receive services in your own home and hazardous conditions in or immediately around your home jeopardize the health, safety, or welfare of you or your provider. Hazardous conditions include but are not limited to the following:

(i) Threatening, uncontrolled animals (e.g., dogs);

(ii) The manufacture, sale, or use of illegal drugs;

(iii) The presence of hazardous materials (e.g., exposed sewage, evidence of a methamphetamine lab).

(3) The department ((~~will~~)) may terminate long-term care services if you do not sign and return your service summary document within sixty days of your assessment completion date.

WSR 18-19-050
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed September 14, 2018, 12:01 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-15-093.

Title of Rule and Other Identifying Information: The department is proposing to amend WAC 388-106-0905 Am I eligible to receive medical care services (MCS) residential care services?

Hearing Location(s): On October 23, 2018, at 10:00 a.m., at Office Building 2, Department of Social and Health and Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than October 24, 2018.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., October 23, 2018.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by October 9, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend WAC 388-106-0905(3) to correct an eligibility error for MCS that occurred during the implementation of the community first choice (CFC) program. At the time of the implementing the CFC program, the department changed the eligibility for medical personal care to exclude nursing facility level of care (NFLOC), which inadvertently changed eligibility for MCS. The department filed an emergency rule as WSR 18-14-009 on June 22, 2018, that restores NFLOC eligibility for MCS.

Reasons Supporting Proposal: Without the rule change, vulnerable people with no other options for care may be harmed.

Statutory Authority for Adoption: RCW 74.08.090.

Statute Being Implemented: RCW 74.09.520.

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

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Jamie Tong, P.O. Box 45600, Olympia, WA 98504-5600, 360-725-3293.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Rules are exempt per RCW 34.05.328 (5)(b)(v), rules the content of which is explicitly and specifically dictated by statute.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 34.05.328 (5)(b)(vii).

Explanation of exemptions: Rules of DSHS relating only to client medical or financial eligibility and rules concerning liability for care of dependents.

September 12, 2018
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 15-03-038, filed 1/12/15, effective 2/12/15)

WAC 388-106-0905 Am I eligible to receive medical care services (MCS) residential care services? You are eligible to receive MCS-funded residential care services if:

(1) You meet financial eligibility requirements for medical care services (MCS), described in WAC 182-508-0005;

(2) You are not eligible for services under COPES, or MPC; and

(3) You are assessed in CARE and meet the functional criteria outlined in WAC ((~~388-106-0210(2)~~)) 388-106-0210(3) or WAC 388-106-0355(1).

WSR 18-19-052
PROPOSED RULES
DEPARTMENT OF HEALTH

[Filed September 14, 2018, 1:55 p.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Title of Rule and Other Identifying Information: WAC 246-330-199 Fees—License, change of ownership, refund process, proposing increased initial license and renewal fees for ambulatory surgical facilities (ASF).

Hearing Location(s): On October 30, 2018, at 11:00 a.m., at the Department of Health, Town Center 2, 111 Israel Road S.E., Room 158, Tumwater, WA 98501.

Date of Intended Adoption: November 6, 2018.

Submit Written Comments to: Sherry Thomas, Policy Coordinator, P.O. Box 47850, Olympia, WA 98504-7850,

email https://fortress.wa.gov/doh/policyreview, fax 360-236-2901, by October 30, 2018.

Assistance for Persons with Disabilities: Contact Sherry Thomas, phone 360-236-4612, fax 360-236-2901, TTY 360-833-6388 or 711, email sherry.thomas@doh.wa.gov, by October 16, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Current revenue from ASF licensing fees generates approximately thirty-seven percent of the funding needed to support all legislatively mandated activities. These activities include prelicensure and ongoing health and safety inspections to confirm compliance with minimum standards and identify deficiencies that pose patient safety risks.

Based on revenue levels and projected expenditures necessary to conduct the required inspections, the department anticipates an average annual funding gap of about $539,000 for a total of $1,616,000 over three years. Several factors have contributed to this funding gap. The department's calculations when first setting the fees were based on an estimate of an average four-hour on-site inspection time, however, inspections are actually averaging nearly twelve hours each for a single operating room facility. The types of surgeries performed, patient acuity level, and level of potential health and safety patient risk in modern ASFs is far more complex than originally anticipated when the authorizing legislation passed in 2007. In addition, the job classification for the department's surveyors received a twenty-seven percent salary increase in 2017, which was unanticipated by the department.

Legislation has restricted the department from raising ASF fees since 2015 (through a budget proviso in ESSB 6052 and SSB 5778 in 2016). SSB 5778 also required the department to compare Washington's system for regulating ASFs to the systems of other states and make recommendations that could be implemented in Washington to reduce licensing fees. The department's report provided potential options for the legislature to consider, including reducing the frequency of state inspections and allowing medicare certification and/or accreditation to fully satisfy the state inspection requirement. However, all of the options represented greater patient safety risks because it would take longer to identify and correct unsafe practices. In addition, seventy-three percent of inspections the department has conducted on behalf of medicare during the current federal fiscal year revealed system-level findings. These included either a number of deficient practices or a single deficient practice so severe it posed an immediate risk of harm to patients, or a number of deficient practices in one area of the regulation that led to a determination that the entire system was noncompliant. Many of these were repeat findings.

The department estimates expenses over a three-year licensing cycle budget to be $2,574,000. This amount is based on the assumptions that the number of licensed ASFs will remain the same at one hundred eighty through one hundred ninety and we will conduct all statutorily required inspections, which will average eighty surveys per year. The department is proposing to increase initial and renewal licensing fees for ASFs. The department anticipates the proposed fee increases will adequately fund the required inspection activities and bring year-end reserves to the desired fund balance of 12.5 percent (a desired fund balance is a reserve available for unanticipated expenditures like costly disciplinary cases or other increases in operating costs).

Reasons Supporting Proposal: RCW 70.230.050 requires ASFs to demonstrate that they comply with standards in statute and rule for both initial licensure and license renewal, and to pay initial and renewal license fees. RCW 43.70.250 requires licensing fees to fully cover the costs of administering a licensing program. Current fees do not meet these statutory requirements.

The department anticipates that the proposed fee increases will bring licensing fee revenues more in alignment with the actual costs of regulating ASFs, while bringing year-end reserves to the desired fund balance over a six year period. This will allow the department to complete its statutory obligations and increase patient safety.

Statutory Authority for Adoption: RCW 43.70.250 and 43.70.280.

Statute Being Implemented: RCW 43.70.250, 70.230.-100, and 43.70.280.

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

Name of Proponent: Department of health, governmental.

Name of Agency Personnel Responsible for Drafting and Implementation: Sherry Thomas, 111 Israel Road S.E., Tumwater, WA 98501, 360-236-4612; and Enforcement: John Hilger, 111 Israel Road S.E., Tumwater, WA 98501, 360-236-2929.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The agency did not complete a cost-benefit analysis under RCW 34.05.328. RCW 34.05.328 (5)(b)(vi) exempts rules that set or adjust fees or rates pursuant to legislative standards.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules set or adjust fees under the authority of RCW 19.02.075 or that set or adjust fees or rates pursuant to legislative standards, including fees set or adjusted under the authority of RCW 19.80.045.

September 14, 2018
John Wiesman, DrPH, MPH
Secretary

AMENDATORY SECTION (Amending WSR 12-10-010, filed 4/19/12, effective 6/1/12)

WAC 246-330-199 Fees—License, change of ownership, refund process. This section establishes the initial and renewal license fees, change of ownership fee, late fee, and request for refund of an initial license fee for an ambulatory surgical facility (ASF).

(1) Initial and renewal license fees. An initial license or a renewal license and fee are valid for three years from date

of issuance. An applicant for an initial or renewal license must submit one of the following fees to the department:

AMBULATORY SURGICAL FACILITY INITIAL AND RENEWAL FEES

Fee Type	Fees		
Initial and Renewal License	Performs 1,000 or Fewer Surgical Procedures on an Annual Basis	Performs 1,001 - 5,000 Surgical Procedures on an Annual Basis	Performs More than 5,000 Surgical Procedures on an Annual Basis
((~~Accredited~~	~~$3,630~~	~~$4,447~~	~~$5,410~~))
Accredited or Medicare Certified	$((~~4,781~~)) 12,900	$((~~5,925~~)) 16,000	$((~~7,273~~)) 19,650
State Licensed Only	$((~~6,507~~)) 17,550	$((~~8,142~~)) 22,000	$((~~10,068~~)) 27,200

(a) Accredited means an ASF is accredited by one of the organizations identified in WAC 246-330-025 (1)(b).

(b) Medicare certified means an ASF is certified by the Centers for Medicare and Medicaid Services (CMS).

(c) State licensed only means an ASF that is not accredited and is not medicare certified.

(2) Late fee. A licensee must send the department a late fee in the amount of fifty dollars per day, not to exceed one thousand dollars, whenever the renewal fee is not paid by thirty days before the license expiration (date as indicated by the postmark).

(3) Change of ownership. The change of ownership fee is good for that transaction and does not change the original license ending date. The person purchasing or taking over ownership of a licensed ASF must:

(a) Send the department a change of ownership fee in the amount of five hundred dollars thirty days before the change of ownership becomes final (date as indicated by the postmark); and

(b) Receive from the department a new license valid for the remainder of the current license period.

(4) An applicant may request a refund for initial licensure as follows:

(a) Two-thirds of the initial fee paid after the department has received an application but has not conducted an on-site survey or provided technical assistance and has not issued a license; or

(b) One-third of the initial fee paid after the department has received an application and has conducted either an on-site survey or provided technical assistance but not issued a license.

WSR 18-19-070
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed September 17, 2018, 2:52 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-05-078.

Title of Rule and Other Identifying Information: The department is proposing to amend WAC 388-450-0185 What income deductions does the department allow when determining if I am eligible for food benefits and the amount of my monthly benefits?, 388-450-0190 How does the department figure my shelter cost income deduction for basic food?, 388-450-0195 Does the department use my utility costs when calculating my basic food or WASHCAP benefits?, and 388-478-0060 What are the income limits and maximum benefit amounts for basic food?

Hearing Location(s): On October 23, 2018, at 10:00 a.m., at Office Building 2, Department of Social and Health and Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than October 24, 2018.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., October 23, 2018.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by October 9, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed amendments will do the following: Increase the maximum basic food allotments; increase the basic food standard deduction for one to three persons to $164, four persons to $174, five persons to $204, and six or more persons to $234; increase the maximum shelter deduction to $552; increase the standard utility allowance to $430, limited utility allowance to $336, and telephone utility allowance to $58; and increase the maximum gross monthly income and maximum net monthly income limit for household[s] that are not categorically eligible for basic food.

Reasons Supporting Proposal: The proposed amendments adopt basic food standards for federal fiscal year 2019 to comply with requirements of the United States Department of Agriculture (USDA), Food and Nutrition Service (FNS), per 7 C.F.R. § 273.9 (a)(3), USDA, FNS, SNAP—Fiscal Year 2018 Cost-of-Living Adjustments (July 27, 2018), and USDA, FNS, Standard utility allowance approval letter (August 23, 2018).

Statutory Authority for Adoption: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090, 74.08A.120, 7 C.F.R. 273.9 (d)(iii)(B).

Rule is necessary because of federal law, 7 C.F.R. 273.1.

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Holly St. John, P.O. Box 45470, Olympia, WA 98504-5470, 360-725-4895.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. These amendments are exempt as allowed under

RCW 34.05.328 (5)(b)(vii) which states in part, "this section does not apply to … rules of the department of social and health services relating only to client medical or financial eligibility and rules concerning liability for care of dependents."

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Citation of the specific federal statute or regulation and description of the consequences to the state if the rule is not adopted: 7 C.F.R. 273.1 (if the rule is not adopted the state will be out of compliance with federal regulations).

Is exempt under RCW 19.85.061.

Explanation of exemptions: 7 C.F.R. 273.1 (if the rule is not adopted the state will be out of compliance with federal regulations).

September 13, 2018
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-02-043, filed 12/26/17, effective 1/26/18)

WAC 388-450-0185 What income deductions does the department allow when determining if I am eligible for food benefits and the amount of my monthly benefits? (1) We determine if your assistance unit (AU) is eligible for basic food and calculate your monthly benefits according to requirements of the Food and Nutrition Act of 2008 and federal regulations related to the supplemental nutrition assistance program (SNAP).

(2) Under these federal laws, we subtract the following amounts from your AU's total monthly income to determine your countable monthly income under WAC 388-450-0162:

(a) A standard deduction based on the number of eligible people in your AU under WAC 388-408-0035:

Eligible AU members	Standard deduction
((~~1~~)) 3 or less	((~~$160~~)) $164
((~~2~~))	((~~$160~~))
((~~3~~))	((~~$160~~))
4	((~~$170~~)) $174
5	((~~$199~~)) $204
6 or more	((~~$228~~)) $234

(b) Twenty percent of your AU's gross earned income (earned income deduction);

(c) Your AU's expected monthly dependent care expense needed for an AU member to:

(i) Keep work, look for work, or accept work;

(ii) Attend training or education to prepare for employment; or

(iii) Meet employment and training requirements under chapter 388-444 WAC;

(d) Medical expenses over thirty-five dollars a month owed or anticipated by an elderly or disabled person in your AU as allowed under WAC 388-450-0200; and

(e) A portion of your shelter costs as described in WAC 388-450-0190.

AMENDATORY SECTION (Amending WSR 18-02-043, filed 12/26/17, effective 1/26/18)

WAC 388-450-0190 How does the department figure my shelter cost income deduction for basic food? The department calculates your shelter cost income deduction for basic food as follows:

(1) First, we add up the amounts your assistance unit (AU) must pay each month for shelter. We do not count any overdue amounts, late fees, penalties, or mortgage payments you make ahead of time as allowable shelter costs. We count the following expenses as an allowable shelter cost in the month the expense is due:

(a) Monthly rent, lease, and mortgage payments;

(b) Property taxes;

(c) Homeowner's association or condo fees;

(d) Homeowner's insurance for the building only;

(e) Utility allowance your AU is eligible for under WAC 388-450-0195;

(f) Out-of-pocket repairs for the home if it was substantially damaged or destroyed due to a natural disaster such as a fire or flood;

(g) Expense of a temporarily unoccupied home because of employment, training away from the home, illness, or abandonment caused by a natural disaster or casualty loss if your:

(i) AU intends to return to the home;

(ii) AU has current occupants who are not claiming the shelter costs for basic food purposes; and

(iii) AU's home is not being leased or rented during your AU's absence.

(2) Second, we subtract all deductions your AU is eligible for under WAC 388-450-0185 (2)(a) through (2)(d) from your AU's gross income. The result is your AU's countable income.

(3) Finally, we subtract one-half of your AU's countable income from your AU's total shelter costs. The result is your excess shelter costs. Your AU's shelter cost deduction is the excess shelter costs:

(a) Up to a maximum of five hundred ((~~thirty-five~~)) fifty-two dollars if no one in your AU is elderly or disabled; or

(b) The entire amount if an eligible person in your AU is elderly or disabled, even if the amount is over five hundred ((~~thirty-five~~)) fifty-two dollars.

AMENDATORY SECTION (Amending WSR 18-02-043, filed 12/26/17, effective 1/26/18)

WAC 388-450-0195 Does the department use my utility costs when calculating my basic food or WASHCAP benefits? (1) The department uses utility allowances instead of the actual utility costs your assistance unit (AU) pays when we determine your:

(a) Monthly benefits under WAC 388-492-0070 if you receive Washington state combined application project (WASHCAP); or

(b) Shelter cost income deduction under WAC 388-450-0190 for basic food.

(2) We use the following amounts if you have utility costs separate from your rent or mortgage payment:

(a) If your AU has heating or cooling costs or receives more than twenty dollars in low income home energy assistance program (LIHEAP) benefits each year, you get a standard utility allowance (SUA) of four hundred twenty-one dollars.

(b) If your household does not receive a LIHEAP payment and the reason is solely because of your immigration status, you get a SUA of four hundred ((~~twenty-one~~)) thirty dollars.

(c) If your AU does not qualify for the SUA and you have any two utility costs listed in subsection (3) of this section, you get a limited utility allowance (LUA) of three hundred ((~~twenty-eight~~)) thirty-six dollars.

(d) If your AU has only telephone costs and no other utility costs, you get a telephone utility allowance (TUA) of ((~~fifty-seven~~)) fifty-eight dollars.

(3) "Utility costs" include the following:

(a) Heating or cooling fuel;

(b) Electricity or gas;

(c) Water;

(d) Sewer;

(e) Well installation/maintenance;

(f) Septic tank installation/maintenance;

(g) Garbage/trash collection; and

(h) Telephone service.

(4) If you do not have a utility cost separate from your rent or mortgage payment and do not receive low income energy assistance program (LIHEAP), you do not receive a utility allowance.

AMENDATORY SECTION (Amending WSR 18-02-043, filed 12/26/17, effective 1/26/18)

WAC 388-478-0060 What are the income limits and maximum benefit amounts for basic food? (1) If your assistance unit (AU) meets all other eligibility requirements for basic food, your AU must have income at or below the limits in columns B and C of this subsection to get basic food, unless you meet one of the exceptions listed below in subsection (2) of this section. The maximum monthly food assistance benefit your AU could receive is listed in column D of this subsection.

EFFECTIVE ((~~10/1/2017~~)) 10/1/2018

Column A Number of Eligible AU Members	Column B Maximum Gross Monthly Income	Column C Maximum Net Monthly Income	Column D Maximum Allotment	Column E 165% of Poverty Level
1	((~~$1,307~~)) $1,316	((~~$1,005~~)) $1,012	$192	((~~$1,659~~)) $1,670
2	((~~1,760~~)) 1,784	((~~1,354~~)) 1,352	((~~352~~)) 353	((~~2,233~~)) 2,264
3	((~~2,213~~)) 2,252	((~~1,702~~)) 1,732	((~~504~~)) 505	((~~2,808~~)) 2,858
4	((~~2,665~~)) 2,720	((~~2,050~~)) 2,092	((~~640~~)) 642	((~~3,383~~)) 3,452
5	((~~3,118~~)) 3,188	((~~2,399~~)) 2,452	((~~760~~)) 762	((~~3,958~~)) 4,046
6	((~~3,571~~)) 3,656	((~~2,747~~)) 2,812	((~~913~~)) 914	((~~4,532~~)) 4,640
7	((~~4,024~~)) 4,124	((~~3,095~~)) 3,172	((~~1,009~~)) 1,011	((~~5,107~~)) 5,234
8	((~~4,477~~)) 4,592	((~~3,444~~)) 3,532	((~~1,153~~)) 1,155	((~~5,682~~)) 5,828
9	((~~4,930~~)) 5,060	((~~3,793~~)) 3,892	((~~1,297~~)) 1,299	((~~6,257~~)) 6,422
10	((~~5,383~~)) 5,528	((~~4,142~~)) 4,252	((~~1,441~~)) 1,443	((~~6,832~~)) 7,016
Each Additional Member	((~~+453~~)) +468	((~~+349~~)) +360	+144	((~~+575~~)) +594

(2) Exceptions:

(a) If your AU is categorically eligible as under WAC 388-414-0001, your AU does not have to meet the gross or net income standards in columns B and C of subsection (1) of this section. We budget your AU's income to decide the amount of basic food your AU will receive.

(b) If your AU includes a member who is sixty years of age or older or has a disability, your AU's income must be at or below the limit in column C of subsection (1) of this section.

(c) If you are sixty years of age or older and cannot buy and cook your own meals because of a permanent disability, we will use column E of subsection (1) of this section to decide if you can be a separate AU.

(d) If your AU has zero income, your benefits are the maximum allotment in column D of subsection (1) of this section, based on the number of eligible members in your AU.

WSR 18-19-071
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed September 17, 2018, 3:16 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-15-096.

Title of Rule and Other Identifying Information: The department is proposing to amend WAC 388-418-0005 How will I know what changes to report?, 380-470-0005 How do resources affect my eligibility for cash assistance and basic food?, and 388-470-0070 How vehicles are counted toward the resource limit for cash assistance.

Hearing Location(s): On October 23, 2018, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than October 24, 2018.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAURulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., October 23, 2018.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by October 9, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend WAC 388-418-0005, 388-470-0005, and 388-470-0070 to increase the resource limits used to determine cash assistance eligibility to $6,000 and the vehicle equity limit to $10,000.

Reasons Supporting Proposal: The department must make this amendment to comply with legislation (ESSHB [E2SHB] 1831, chapter 40, Laws of 2018).

Statutory Authority for Adoption: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.08.090.

Statute Being Implemented: RCW 74.04.005.

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

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Jared Beard, P.O. Box 45470, Olympia, WA 98504-5470, 360-725-4617.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. This amendment is exempt as allowed under RCW 34.05.328 (5)(b)(vii) which states in part, "[t]his section does not apply to … rules of the department of social and health services relating only to client medical or financial eligibility and rules concerning liability for care of dependents."

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rule content is explicitly and specifically dictated by statute.

September 13, 2018
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-09-017, filed 4/10/18, effective 7/1/18)

WAC 388-418-0005 How will I know what changes to report? (1) You must report changes to the department based on the kinds of assistance you receive. We inform you of your reporting requirements on letters we send you about your benefits. Follow the steps below to determine the types of changes you must report:

(a) If you receive **cash** benefits, you need to tell us if:

(i) You move;

(ii) Someone moves out of your home;

(iii) Your total gross monthly income goes over the:

(A) Payment standard under WAC 388-478-0033 if you receive ABD cash; or

(B) Earned income limit under WAC 388-478-0035 and 388-450-0165 for all other programs;

(iv) You have liquid resources more than ((~~four~~)) six thousand dollars; or

(v) You have a change in employment, you need to tell us if:

(A) You get a job or change employers;

(B) Your schedule changes from part-time to full-time or full-time to part-time;

(C) You have a change in your hourly wage rate or salary; or

(D) You stop working.

(b) If you are a relative or nonrelative caregiver and receive cash benefits on behalf of a child in your care but not for yourself or other adults in your household, you need to tell us if:

(i) You move;

(ii) The child you are caring for moves out of the home;

(iii) Anyone related to the child you are caring for moves into or out of the home;

(iv) There is a change in the recipient child's earned or unearned income unless they are in school full-time as described in WAC 388-450-0070;

(v) The recipient child has liquid resources more than ((~~four~~)) six thousand dollars;

(vi) A recipient child in the home becomes a foster child; or

(vii) You legally adopt the recipient child.

(2) If you do not receive cash assistance but you do receive benefits from basic food, you must report changes for the people in your assistance unit under chapter 388-408 WAC, and tell us if:

(a) Your total monthly income is more than the maximum gross monthly income as described in WAC 388-478-0060; or

(b) Anyone who receives food benefits in your assistance unit and who must meet work requirements under WAC 388-444-0030 has their hours at work go below twenty hours per week.

AMENDATORY SECTION (Amending WSR 18-02-043, filed 12/26/17, effective 1/26/18)

WAC 388-470-0005 How do resources affect my eligibility for cash assistance and basic food? (1) The following definitions apply to this chapter:

(a) **"We"** means the department of social and health services.

(b) **"You"** means a person applying for or getting benefits from the department.

(c) **"Fair market value"** or **"FMV"** means the price at which you could reasonably sell the resource.

(d) **"Equity value"** means the FMV minus any amount you owe on the resource.

(e) **"Community property"** means a resource in the name of the husband, wife, or both.

(f) **"Separate property"** means a resource of a married person that one of the spouses:

(i) Had possession of and paid for before they were married;

(ii) Acquired and paid for entirely out of income from separate property; or

(iii) Received as a gift or inheritance.

(2) We count a resource to decide if your assistance unit (AU) is eligible for cash assistance or basic food when:

(a) It is a resource we must count under WAC 388-470-0045 for cash assistance or WAC 388-470-0055 for basic food;

(b) You own the resource and we consider you to own a resource if:

(i) Your name is on the title to the property; or

(ii) You have property that does not have a title;

(c) You have control over the resource, which means the resource is actually available to you; and

(d) You could legally sell the resource or convert it into cash within twenty days.

(3) For cash assistance, you must try to make your resources available even if it will take you more than twenty days to do so, unless:

(a) There is a legal barrier; or

(b) You must petition the court to release part or all of a resource.

(4) When you apply for assistance, we count your resources as of:

(a) The date of your interview, if you are required to have an interview; or

(b) The date of your application, if you are not required to have an interview.

(5) If your total countable resources are over the resource limit in subsection (6) through (13) of this section, you are not eligible for benefits.

(6) For cash assistance, ((~~we use the~~)) there is an equity value ((~~as the value of your resources.~~)) resource limit of six

(((~~(a) Applicants may have countable resources up to one~~)) thousand dollars.

(((~~(b) Recipients of cash assistance may have an additional three thousand dollars in a savings account.~~))

(7) If your AU is categorically eligible (CE) as described in WAC 388-414-0001, you do not have a resource limit for Basic Food.

(8) If your AU is not CE under WAC 388-414-0001, your AU may have countable resources up to the following amount and be eligible for basic food:

(a) Three thousand five hundred dollars if your AU has either an elderly or disabled individual; or

(b) Two thousand two hundred fifty dollars for all other AUs.

(9) If you own a countable resource with someone who is not in your AU, we count the portion of the resource that you own. If we cannot determine how much of the resource is yours:

(a) For cash assistance, we count an equal portion of the resource that belongs to each person who owns it.

(b) For basic food, we count the entire amount unless you can prove that the entire amount is not available to you.

(10) We assume that you have control of community property and you can legally sell the property or convert it to cash unless you can show that you do not.

(11) We may not consider an item to be separate property if you used both separate and community funds to buy or improve it.

(12) We do not count the resources of victims of family violence when:

(a) The resource is owned jointly with members of the former household;

(b) Availability of the resource depends on an agreement of the joint owner; or

(c) Making the resource available would place the client at risk of harm.

(13) You may give us proof about a resource anytime, including when we ask for it or if you disagree with a decision we made, about:

(a) Who owns a resource;

(b) Who has legal control of a resource;

(c) The value of a resource;

(d) The availability of a resource; or

(e) The portion of a property you or another person owns.

AMENDATORY SECTION (Amending WSR 13-18-005, filed 8/22/13, effective 10/1/13)

WAC 388-470-0070 How vehicles are counted toward the resource limit for cash assistance. (1) A vehicle is any device for carrying persons and objects by land, water, or air.

(2) The entire value of a licensed vehicle needed to transport a physically disabled assistance unit member is excluded.

(3) The equity value of one vehicle up to ((~~five~~)) ten thousand dollars is excluded when the vehicle is used by the assistance unit or household as a means of transportation.

WSR 18-19-072
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)
[Filed September 17, 2018, 4:04 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-15-045.

Title of Rule and Other Identifying Information: The department is proposing to amend WAC 388-478-0055 How much do I get from my state supplemental payments (SSP)?

Hearing Location(s): On October 23, 2018, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than October 24, 2018.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., October 23, 2018.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by October 9, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing to amend WAC 388-478-0055 to update the monthly SSP rate for those in medical institutions effective January 1, 2019, from $27.28 to $40.00. The maximum personal needs allowance (PNA) standard has increased to seventy dollars for those in medical institutions and residential settings. PNA is comprised of a social security withholding of $30.00 and the remainder of PNA is supplemented with SSP.

Reasons Supporting Proposal: This amendment is necessary in order to comply with SHB 2651 (chapter 137, Laws of 2018), which increases the PNA standard for those in medical and residential settings.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.057, 74.09.340, 74.08.090.

Statute Being Implemented: RCW 74.09.340.

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

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Jared Beard, P.O. Box 45470, Olympia, WA 98504-5470, 360-725-4617.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. This amendment is exempt as allowed under RCW 34.05.328 (5)(b)(vii) which states in part, "[t]his section does not apply to … rules of the department of social and health services relating only to client medical or financial eligibility and rules concerning liability for care of dependents."

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rule content is explicitly and specifically dictated by statute.

Is exempt under RCW 34.05.310.

Explanation of exemptions: The department is required to amend WAC 388-478-0055 per RCW 74.09.340.

September 13, 2018
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-22-037, filed 10/31/13, effective 12/1/13)

WAC 388-478-0055 How much do I get from my state supplemental payments (SSP)? (1) The SSP is a payment from the state to certain SSI eligible people (((~~see~~)) as described in WAC 388-474-0012((~~,~~)).

(2) If you converted to the federal SSI program from state assistance in January 1974((~~,~~)) because you were aged, blind, or disabled, and have remained continuously eligible for SSI since January 1974, the department calls you a grandfathered client. Social Security calls you a ((~~mandatory~~)) minimum income level (MIL) client.

A change in living situation, cost-of-living adjustment (COLA), or federal ((~~payment level (FPL)~~)) benefit rate (FBR) can affect a grandfathered (((~~MIL~~))) MIL client. A grandfathered (((~~MIL~~))) MIL client gets a federal SSI payment and a SSP payment, which totals the higher of one of the following:

(a) The state assistance standard set in December 1973, unless you lived in a medical institution at the time of conversion, plus the federal ((~~cost-of-living adjustments (COLA)~~)) COLA since then; or

(b) The current payment standard.

(3) The monthly SSP rate standards for eligible persons under WAC 388-474-0012 and individuals residing in an institution are:

SSP eligible persons	Standard
Individual (aged 65 and older)	$40.00
Individual (blind as determined by SSA)	$40.00
Individual with an ineligible spouse	$40.00
Grandfathered (MIL)	Varies by individual based on federal requirements. Payments range between $0.54 and $199.77.

Medical institution	Monthly SSP Rate
Individual	((~~$27.28~~)) $40.00

(4) We may adjust the SSP rate standards at the end of the calendar year to comply with WAC 388-478-0057.

WSR 18-19-075
PROPOSED RULES
OFFICE OF FINANCIAL MANAGEMENT
[Filed September 18, 2018, 8:06 a.m.]

Supplemental Notice to WSR 18-15-062.

Preproposal statement of inquiry was filed as WSR 18-09-028.

Title of Rule and Other Identifying Information: Amending chapter 82-75 WAC, related to the statewide all-payer health care claims database (WA-APCD). Specifically, the rules will address activities related to ensuring that there is compliance with the following requirements: Submission, release of data, use of data and destruction of data. The office of financial management (OFM) held a hearing on August 21, 2018. In response to the hearing notice, OFM received written and verbal comments. After considering the comments, OFM made significant changes to the rules subject to that hearing, to incorporate this feedback. The rules, as amended, are the subject of this second hearing

Hearing Location(s): On October 23, 2018, at 9:30 a.m., at 302 Sid Snyder Avenue S.W., Fourth Floor, The HIVE, Olympia, WA 98501.

Date of Intended Adoption: November 5, 2018.

Submit Written Comments to: Thea Mounts, 106 11th Avenue S.W., P.O. Box 43124, Olympia, WA 98504, email apcd@ofm.wa.gov, by October 23, 2018.

Assistance for Persons with Disabilities: Contact OFM, phone 360-902-3092, TTY 360-753-4107, email hayden.mackley@ofm.wa.gov, by October 19, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of the rule is to establish a clear and fair process to ensure that statutory requirements related to the submission of data into the WA-APCD, release of data out of the WA-APCD, use of the data released from the WA-APCD and destruction of data once the use has been fulfilled.

Reasons Supporting Proposal: Chapter 43.371 RCW directs OFM to establish a WA-APCD to support transparent public reporting of health care information. The chapter requires specified providers to submit claims data pursuant to the schedule developed by OFM and the data submission guide. There are also strict requirements regarding the release, use and destruction of the data from APCD. In order to ensure that the statutory and regulatory provisions are being followed, it is imperative that OFM develop an audit program.

Statutory Authority for Adoption: RCW 43.371.070.

Statute Being Implemented: Chapter 43.371 RCW.

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

Name of Proponent: OFM, governmental.

Name of Agency Personnel Responsible for Drafting: Roselyn Marcus, Insurance Building, Olympia, Washington, 360-902-0434; Implementation and Enforcement: Thea Mounts, Helen Sommers Building, Olympia, Washington, 360-902-0552.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. OFM is not a listed agency in RCW 34.05.328 (5)(a)(i).

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rule content is explicitly and specifically dictated by statute.

September 18, 2018
Roselyn Marcus
Assistant Director for
Legal and Legislative Affairs

AUDITS

NEW SECTION

WAC 82-75-700 Purpose of audits. There are two primary areas for which audits may be performed to ensure compliance with laws and rules related to the WA-APCD.

(1) Audits may be performed to determine if data suppliers are in compliance with the requirements for the submission of data to the WA-APCD including, but not limited to:

(a) Compliance with the data submission guide including, but not limited to, accuracy of financial fields;

(b) Data integrity, as opposed to data quality checks that the data vendor performs using thresholds and variances;

(c) Finding data that is missing or being withheld from submission into the WA-APCD; and

(d) Documenting the process for determining the number of Washington covered persons for each line of business in order to ensure that data suppliers are not artificially creating lines of business with small numbers of covered lives in order to meet the minimum threshold for exclusion to report.

(2) Audits can be performed to determine whether requestors who receive data from the WA-APCD are in com-

pliance with the data release requirements or agreements, whether provided datasets or licenses to the data enclave including, but not limited to:

(a) For physical datasets, compliance with data use agreements, confidentiality agreements, compliance with collecting, storing, analyzing, and destroying the data; and

(b) For data enclave licenses, compliance with data use agreements, confidentiality agreements, compliance with analyzing, storing, destroying, and user license access to the data.

(3) For purposes of this section, the following definitions apply:

(a) "Data quality checks" means the extent to which data is missing or the data conforms with the data format requirements; and

(b) "Data integrity checks" means the completeness and validity of the submitted data, whether the submitted values are consistent with the instructions and intent of the data submission guide.

NEW SECTION

WAC 82-75-705 When an audit may be commenced. (1) The office may initiate a random audit to ensure compliance with data release requirements. A data requestor may not be subject to a random audit more frequently than once every three years.

(2) The office may initiate an audit of a data supplier or data requestor upon notice that one of the following events has occurred:

(a) Reports from the data vendor that there is a material change, without justification or a reasonable basis for the change provided by the data supplier, in the number of claims submitted from a data supplier. Before submitting a report under this subsection, the data vendor should have worked with the data supplier to cure any inadvertent data submission issues.

(b) Reports from the data vendor that certain types of claims are missing for a data supplier.

(c) Notice that the data requestor or data user is publishing data in reports that are not compliant with data use agreements. Violations of the data use agreements are subject to penalties in accordance with the process set forth in chapter 82-75 WAC.

(d) Notice that the data requestor or data user is publishing PFI or PHI not in compliance with state or federal requirements.

(e) Other occurrence that could indicate that the data supplier or data requestor is not in compliance with the requirements in law or rule regarding the WA-APCD.

NEW SECTION

WAC 82-75-710 Audit process. (1) Once the office determines an audit will be conducted, either as a random audit or based on a triggering event set forth in WAC 82-75-705(2), the office shall provide written notice to the subject of the audit at least thirty days before the start of the audit. The notice must include the name of the company or individuals who will be conducting the audit and the subject of the audit, including the time period for which the audit covers, which time period must be no longer than the prior three years. If the audit is the result of a triggering event, the notice will include information regarding the triggering event. The notice will also include information regarding the audit entrance conference that has been scheduled to take place within fourteen days before the audit will begin. The notice will include the location, date and time and contact person for the entrance conference and such other information as required. The office will work with the subject of the audit to ensure sufficient time is provided between providing the written notice, the date of the entrance conference, and the start of the audit.

(2) The subject of the audit is required to cooperate with the auditor, providing the information as requested. If there is a dispute during the audit, the issue should be brought to the attention of the WA-APCD program director, who will resolve the dispute. Both the auditor and the subject of the audit will be provided an opportunity to present its issues regarding the dispute, either in writing or in person. The WA-APCD program director may engage a mediator to help resolve the dispute.

(3) The auditor will be required to prepare an audit report. A draft of the audit report shall be provided to the subject of the audit for review and comments. The subject of the audit should be provided no less than thirty days to provide comment to the draft report.

(4) After receiving and reviewing any comments, and revising the draft audit report as deemed necessary, the auditor shall schedule an exit conference with the subject of the audit to review the audit and final audit report. The subject of the audit shall be provided an opportunity to submit comments or responses to the findings in the audit. The auditor shall provide a deadline, not less than thirty days after the exit conference for submission of any response to the audit.

(5) The auditor shall issue a final audit report no later than thirty days after the deadline for submission of any response. The report shall be provided to the office and the subject of the audit. The final report shall include any response provided by the subject of the audit. The office shall publish the final report on the agency web site.

(6) The auditor shall be required to sign a confidentiality/nondisclosure agreement if the auditor will have access to any confidential or proprietary information.

NEW SECTION

WAC 82-75-715 Audit guide. (1) The office shall develop the audit guide with input from the data vendor, lead organization, and stakeholders. The audit guide shall include, but is not limited to, the following topics:

(a) The audit standards that will be used for all audits to ensure compliance with generally accepted auditing practices;

(b) The process that will be used to select an auditor, including the auditor qualifications, process to identify and address conflicts of interest;

(c) Specific contract terms that should be included in any contract with an auditor including retention and destruction process for working papers.

(2) The office shall develop a process to allow for stakeholder review and comment on drafts of the audit guide and all subsequent changes to the guide. Prior to final adoption, the DPC shall be given an opportunity to review and provide comments on the draft audit guide to the office. The office shall have final approval authority over the adoption of the audit guide and all subsequent changes.

(3) The office shall conduct an annual review of the audit guide. The office will post notice that the review is being conducted and provide a time period for stakeholder to submit comments and changes to the audit guide. The office will follow the process developed pursuant to subsection (2) of this section for review and comment on draft changes to the guide.

(4) The office shall notify data suppliers before changes to the audit guide are final. Notification shall occur no less than one hundred twenty calendar days prior to the effective date of any change.

(5) The version of the audit guide that is in effect must be posted on the OFM web site. Notice should be given through the office listserv when a new audit guide is posted.

NEW SECTION

WAC 82-75-720 Audit findings of a violation. (1) If the audit finds that any person has violated laws, rules or data use agreements, the WA-APCD program director shall require an investigation be conducted in accordance with WAC 82-75-615. If the investigation determines that a violation or violations have occurred, the office will take appropriate action as set forth in chapter 82-75 WAC.

(2) In addition to any other penalties authorized by law or rule, the audited party may be required to pay the cost of the audit if, after an investigation conducted pursuant to chapter 82-75 WAC, a violation is found. The subject of the audit may contest the requirement to pay the cost of the audit or the amount requested using the appeal process set forth in chapter 82-75 WAC for the appeal of penalties.

WSR 18-19-079
WITHDRAWL OF PROPOSED RULES
SECRETARY OF STATE
(By the Code Reviser's Office)
[Filed September 18, 2018, 9:58 a.m.]

WAC 434-261-050, proposed by the secretary of state in WSR 18-06-087, appearing in issue 18-06 of the Washington State Register, which was distributed on March 21, 2018, is withdrawn by the office of the code reviser under RCW 34.05.335(3), since the proposal was not adopted within the one hundred eighty day period allowed by the statute.

Kerry S. Radcliff, Editor
Washington State Register

WSR 18-19-080
WITHDRAWL OF PROPOSED RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION
(By the Code Reviser's Office)
[Filed September 18, 2018, 9:59 a.m.]

WAC 392-401-012, proposed by the superintendent of public instruction in WSR 18-06-104, appearing in issue 18-06 of the Washington State Register, which was distributed on March 21, 2018, is withdrawn by the office of the code reviser under RCW 34.05.335(3), since the proposal was not adopted within the one hundred eighty day period allowed by the statute.

Kerry S. Radcliff, Editor
Washington State Register

WSR 18-19-081
PROPOSED RULES
DEPARTMENT OF LABOR AND INDUSTRIES
[Filed September 18, 2018, 10:25 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-13-096.

Title of Rule and Other Identifying Information: 2019 Industrial insurance premium rates, chapter 296-17 WAC, General reporting rules, audit and recordkeeping, rates and rating system for Washington workers' compensation insurance and chapter 296-17B WAC, Retrospective rating for workers' compensation insurance.

Hearing Location(s): On October 30, 2018, at 9:00 a.m., at the Department of Labor and Industries (L&I) Headquarters, Auditorium, 7273 Linderson Way S.W., Tumwater, WA 98501; on October 30, 2018, at 1:00 p.m., at L&I Tukwila Location, Room C30, 12806 Gateway Drive South, Tukwila, WA 98168; and on October 31, 2018, at 9:00 a.m., at Spokane CenterPlace, Auditorium, 2426 North Discover [Discovery] Place, Spokane Valley, WA 99216.

Date of Intended Adoption: November 30, 2018.

Submit Written Comments to: Jo Anne Attwood, P.O. Box 44148, Olympia, WA 98504-4148, email JoAnne. Attwood@lni.wa.gov, fax 360-402-4988, by November 2, 2018, 5:00 p.m.

Assistance for Persons with Disabilities: Contact Jo Anne Attwood, phone 360-902-4777, fax 360-902-4988, TTY 360-902-5797, email JoAnne.Attwood@lni.wa.gov, by October 16, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This rule proposal will amend the tables of classification base premium rates, experience rating plan parameters, experience modification factor calculation limitations, and retrospective rating plan size groupings for the workers' compensation insurance program for calendar year 2019. Classification base rates were amended for updated loss and payroll experience. The depart-

ment proposes a five percent overall average premium rate decrease.

This proposal is also notice that the director intends to transfer the amount of the accident and medical-aid funds combined that exceed ten percent of funded liabilities as required by RCW 51.44.023.

Amendments are also being proposed to align with the risk classification changes associated with rule making adopted on February 20, 2018, effective January 1, 2019, that repeals risk classification 6304 Department stores.

Amending WAC 296-17-855 Experience modification, 296-17-875 Table I, 296-17-880 Table II, 296-17-885 Table III, 296-17-890 Table IV, 296-17-895 Industrial insurance accident fund base rates, stay at work and medical aid base rates by class of industry, 296-17-89502 Industrial insurance accident fund, stay at work, medical aid and supplemental pension rates by class of industry for nonhourly rated classifications, 296-17-89507 Horse racing rates, 296-17-901 Risk classification hazard group table (remove repealed 6304 effective January 1, 2019), 296-17-920 Assessment for supplemental pension fund, 296-17B-540 Determining loss incurred for each claim, and 296-17B-900 Retrospective rating plans standard premium size ranges.

Reasons Supporting Proposal: The department's decision to decrease rates by an overall average of five percent is intended to ensure adequate premiums to cover expected losses for 2019 claims and to maintain the contingency reserves at adequate levels. Washington law provides that rates should be adjusted annually to reflect the hazards of each industry and in accordance with recognized workers' compensation insurance principles.

Statutory Authority for Adoption: RCW 51.16.035 (base rates), 51.32.073 (supplemental pension), 51.18.010 (retrospective rating), and 51.04.020(1) (general authority).

Statute Being Implemented: RCW 51.16.035, 51.32.073, and 51.18.010.

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

Name of Proponent: L&I, governmental.

Name of Agency Personnel Responsible for Drafting: Jo Anne Attwood, Tumwater, Washington, 360-902-4777; Implementation: Mike Ratko, Tumwater, Washington, 360-902-6369; and Enforcement: Victoria Kennedy, Tumwater, Washington, 360-902-4997.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. A cost-benefit analysis is not required per RCW 34.05.328 (5)(b)(vi), as the proposed rules are adjusting rates pursuant to legislative standards.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules set or adjust fees under the authority of RCW 19.02.075 or that set or adjust fees or rates pursuant to legislative standards, including fees set or adjusted under the authority of RCW 19.80.045.

September 18, 2018
Joel Sacks
Director

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17-855 Experience modification. The basis of the experience modification shall be a comparison of the actual losses charged to an employer during the experience period with the expected losses for an average employer reporting the same exposures in each classification. The comparison shall contain actuarial refinements designed to weigh the extent to which the actual experience is credible, due consideration being given to the volume of the employer's experience. Except for those employers who qualify for an adjusted experience modification as specified in WAC 296-17-860 or 296-17-865, the experience modification factor shall be calculated from the formula:

EXPERIENCE MODIFICATION FACTOR	=	(Credible Actual Primary Loss + Credible Actual Excess Loss)/Expected Loss
Where		
Credible Actual Primary Loss	=	Actual Primary Loss x Primary Credibility
	+	Expected Primary Loss x (100% - Primary Credibility)
Credible Actual Excess Loss	=	Actual Excess Loss x Excess Credibility
	+	Expected Excess Loss x (100% - Excess Credibility)

The meaning and function of each term in the formula is specified below.

For each claim, the actual primary loss is the first dollar portion of the claim costs, which has been shown in actuarial studies, to have the greater credibility in predicting future experience. These amounts are summed over all claims. For each claim in excess of $20,112 the actual primary loss shall be determined from the formula:

$$\text{ACTUAL PRIMARY LOSS} = \frac{50{,}280}{(\text{Total loss} + 30{,}168)} \times \text{total loss}$$

For each claim, less than $20,112 the full value of the claim shall be considered a primary loss.

For each claim, the excess actual loss is the remaining portion of the claim costs, which have been shown in actuarial studies to have less credibility in predicting future experience. The excess actual loss for each claim shall be determined by subtracting the primary loss from the total loss. These amounts are summed over all claims.

For any claim without disability benefits (time loss, partial permanent disability, total permanent disability or death) either actually paid or estimated to be paid, the total actual losses for calculating the primary loss and excess loss shall first be reduced by the lesser of $((~~2,930~~)) 3,050 or the total cost of the claim. Here are some examples for these claims:

Total Loss	Type of Claim	Total Loss (after deduction)	Primary Loss	Excess Loss
((~~300~~	~~Medical Only~~	~~0~~	~~0~~	~~0~~
~~3,000~~	~~Medical Only~~	~~70~~	~~70~~	~~0~~
~~3,000~~	~~Time Loss~~	~~3,000~~	~~3,000~~	~~0~~
~~30,000~~	~~Medical Only~~	~~27,070~~	~~23,779~~	~~3,291~~
~~30,000~~	~~Time Loss~~	~~30,000~~	~~25,070~~	~~4,930~~
~~130,000~~	~~PPD~~	~~130,000~~	~~40,810~~	~~89,190~~
~~500,000~~	~~TPD Pension~~	~~277,022~~	~~45,342~~	~~231,680~~
~~2,000,000~~	~~TPD Pension~~	~~277,022~~	~~45,342~~	~~231,680~~))
300	Medical Only	0	0	0
4,000	Medical Only	950	950	0
4,000	Timeloss	4,000	4,000	0
30,000	Medical Only	26,950	23,724	3,226
30,000	Timeloss	30,000	25,070	4,930
130,000	PPD	130,000	40,810	89,190
500,000	TPD Pension	286,074	45,484	240,590
2,000,000	TPD Pension	286,074	45,484	240,590

Note: The deduction, $((~~2,930~~)) 3,050, is twice the average case incurred cost of these types of claims occurring during the three-year period used for experience rating. On average this results in reducing the average actual loss about seventy percent for these types of claims adjusted. This is done to help make the transition between the two different experience rating methods better by helping make the change in experience factor reasonable for small changes to the actual losses.

For each employer, the primary credibility and the excess credibility determines the percentage weight given to the corresponding actual primary losses and the actual excess losses, included in the calculation of the experience modification, based on the volume of expected losses. Primary credibility and excess credibility values are set forth in Table II.

An employer's expected losses shall be determined by summing the expected loss for each of the three years of the experience period, which are calculated by multiplying the reported exposure in each classification during the year by the corresponding classification expected loss rate and rounding the result to the nearest cent. Classification expected loss rates by year are set forth in Table III.

Expected losses in each classification shall be multiplied by the classification "Primary-Ratio" to obtain "expected primary losses" which shall be rounded to the nearest cent. Expected excess losses shall then be calculated by subtracting expected primary losses from expected total losses rounded to the nearest cent. Primary-Ratios are also set forth in Table III.

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17-875 Table I.

Primary Losses for Selected Claim Values
Effective January 1, ((~~2018~~)) 2019

TOTAL LOSS AFTER DEDUCTION		PRIMARY LOSS
5,000		5,000
10,000		10,000
15,000		15,000
20,112		20,112
29,834		25,000
44,627		30,000
69,102		35,000
100,000		38,627
117,385		40,000
200,000		43,690
((~~277,022~~	~~**~~	~~45,342~~))
286,074	**	45,484

** Maximum claim value

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17-880 Table II.

PRIMARY AND EXCESS CREDIBILITY VALUES
Effective January 1, ((~~2018~~)) 2019

Maximum Claim Value = $((~~277,022~~)) 286,074
Average Death Value = $((~~277,022~~)) 286,074

Expected Losses			Primary Credibility	Excess Credibility
((~~0~~	~~-~~	~~6,416~~	~~12%~~	~~7%~~
~~6,417~~	~~-~~	~~6,849~~	~~13%~~	~~7%~~
~~6,850~~	~~-~~	~~7,287~~	~~14%~~	~~7%~~
~~7,288~~	~~-~~	~~7,730~~	~~15%~~	~~7%~~
~~7,731~~	~~-~~	~~8,178~~	~~16%~~	~~7%~~
~~8,179~~	~~-~~	~~8,632~~	~~17%~~	~~7%~~
~~8,633~~	~~-~~	~~9,092~~	~~18%~~	~~7%~~
~~9,093~~	~~-~~	~~9,558~~	~~19%~~	~~7%~~
~~9,559~~	~~-~~	~~10,028~~	~~20%~~	~~7%~~
~~10,029~~	~~-~~	~~10,507~~	~~21%~~	~~7%~~
~~10,508~~	~~-~~	~~10,992~~	~~22%~~	~~7%~~
~~10,993~~	~~-~~	~~11,484~~	~~23%~~	~~7%~~
~~11,485~~	~~-~~	~~11,983~~	~~24%~~	~~7%~~
~~11,984~~	~~-~~	~~12,491~~	~~25%~~	~~7%~~
~~12,492~~	~~-~~	~~13,008~~	~~26%~~	~~7%~~
~~13,009~~	~~-~~	~~13,530~~	~~27%~~	~~7%~~
~~13,531~~	~~-~~	~~14,063~~	~~28%~~	~~7%~~
~~14,064~~	~~-~~	~~14,604~~	~~29%~~	~~7%~~

Expected Losses			Primary Credibility	Excess Credibility
14,605	-	15,156	30%	7%
15,157	-	15,721	31%	7%
15,722	-	16,292	32%	7%
16,293	-	16,878	33%	7%
16,879	-	17,476	34%	7%
17,477	-	18,087	35%	7%
18,088	-	18,712	36%	7%
18,713	-	19,352	37%	7%
19,353	-	20,013	38%	7%
20,014	-	20,686	39%	7%
20,687	-	21,382	40%	7%
21,383	-	22,098	41%	7%
22,099	-	22,838	42%	7%
22,839	-	23,603	43%	7%
23,604	-	24,397	44%	7%
24,398	-	25,222	45%	7%
25,223	-	26,086	46%	7%
26,087	-	26,989	47%	7%
26,990	-	27,943	48%	7%
27,944	-	28,955	49%	7%
28,956	-	30,032	50%	7%
30,033	-	31,197	51%	7%
31,198	-	32,473	52%	7%
32,474	-	33,894	53%	7%
33,895	-	34,039	54%	7%
34,040	-	35,532	54%	8%
35,533	-	37,534	55%	8%
37,535	-	56,805	56%	8%
56,806	-	62,610	57%	8%
62,611	-	89,430	57%	9%
89,431	-	92,111	57%	10%
92,112	-	116,415	58%	10%
116,416	-	127,415	58%	11%
127,416	-	143,568	59%	11%
143,569	-	162,722	59%	12%
162,723	-	170,884	60%	12%
170,885	-	198,029	60%	13%
198,030	-	198,375	61%	13%
198,376	-	226,036	61%	14%
226,037	-	233,333	61%	15%
233,334	-	253,870	62%	15%
253,871	-	268,640	62%	16%
268,641	-	281,877	63%	16%
281,878	-	303,946	63%	17%
303,947	-	310,062	64%	17%
310,063	-	338,424	64%	18%
338,425	-	339,250	64%	19%
339,251	-	366,969	65%	19%
366,970	-	374,557	65%	20%
374,558	-	395,691	66%	20%
395,692	-	409,863	66%	21%
409,864	-	424,597	67%	21%
424,598	-	445,169	67%	22%
445,170	-	453,689	68%	22%
453,690	-	480,472	68%	23%
480,473	-	482,967	69%	23%
482,968	-	512,433	69%	24%
512,434	-	515,778	69%	25%
515,779	-	542,089	70%	25%
542,090	-	551,086	70%	26%
551,087	-	571,938	71%	26%
571,939	-	586,392	71%	27%
586,393	-	601,981	72%	27%
601,982	-	621,697	72%	28%
621,698	-	632,219	73%	28%
632,220	-	657,003	73%	29%
657,004	-	662,654	74%	29%
662,655	-	692,309	74%	30%
692,310	-	693,292	75%	30%
693,293	-	724,128	75%	31%
724,129	-	727,615	75%	32%
727,616	-	755,170	76%	32%
755,171	-	762,921	76%	33%
762,922	-	786,415	77%	33%
786,416	-	798,226	77%	34%
798,227	-	817,872	78%	34%
817,873	-	833,532	78%	35%
833,533	-	849,535	79%	35%
849,536	-	868,838	79%	36%
868,839	-	881,411	80%	36%
881,412	-	904,142	80%	37%
904,143	-	913,502	81%	37%
913,503	-	939,450	81%	38%
939,451	-	945,808	82%	38%

Expected Losses			Primary Credibility	Excess Credibility
~~945,809~~	~~-~~	~~974,756~~	~~82%~~	~~39%~~
~~974,757~~	~~-~~	~~978,334~~	~~83%~~	~~39%~~
~~978,335~~	~~-~~	~~1,010,062~~	~~83%~~	~~40%~~
~~1,010,063~~	~~-~~	~~1,011,079~~	~~84%~~	~~40%~~
~~1,011,080~~	~~-~~	~~1,044,047~~	~~84%~~	~~41%~~
~~1,044,048~~	~~-~~	~~1,045,365~~	~~84%~~	~~42%~~
~~1,045,366~~	~~-~~	~~1,077,239~~	~~85%~~	~~42%~~
~~1,077,240~~	~~-~~	~~1,080,672~~	~~85%~~	~~43%~~
~~1,080,673~~	~~-~~	~~1,110,662~~	~~86%~~	~~43%~~
~~1,110,663~~	~~-~~	~~1,115,979~~	~~86%~~	~~44%~~
~~1,115,980~~	~~-~~	~~1,144,312~~	~~87%~~	~~44%~~
~~1,144,313~~	~~-~~	~~1,151,284~~	~~87%~~	~~45%~~
~~1,151,285~~	~~-~~	~~1,178,196~~	~~88%~~	~~45%~~
~~1,178,197~~	~~-~~	~~1,186,591~~	~~88%~~	~~46%~~
~~1,186,592~~	~~-~~	~~1,212,313~~	~~89%~~	~~46%~~
~~1,212,314~~	~~-~~	~~1,221,895~~	~~89%~~	~~47%~~
~~1,221,896~~	~~-~~	~~1,246,670~~	~~90%~~	~~47%~~
~~1,246,671~~	~~-~~	~~1,257,202~~	~~90%~~	~~48%~~
~~1,257,203~~	~~-~~	~~1,281,263~~	~~91%~~	~~48%~~
~~1,281,264~~	~~-~~	~~1,292,506~~	~~91%~~	~~49%~~
~~1,292,507~~	~~-~~	~~1,316,099~~	~~92%~~	~~49%~~
~~1,316,100~~	~~-~~	~~1,327,814~~	~~92%~~	~~50%~~
~~1,327,815~~	~~-~~	~~1,351,180~~	~~93%~~	~~50%~~
~~1,351,181~~	~~-~~	~~1,363,119~~	~~93%~~	~~51%~~
~~1,363,120~~	~~-~~	~~1,386,510~~	~~94%~~	~~51%~~
~~1,386,511~~	~~-~~	~~1,398,424~~	~~94%~~	~~52%~~
~~1,398,425~~	~~-~~	~~1,422,088~~	~~95%~~	~~52%~~
~~1,422,089~~	~~-~~	~~1,433,730~~	~~95%~~	~~53%~~
~~1,433,731~~	~~-~~	~~1,457,918~~	~~96%~~	~~53%~~
~~1,457,919~~	~~-~~	~~1,469,036~~	~~96%~~	~~54%~~
~~1,469,037~~	~~-~~	~~1,494,004~~	~~97%~~	~~54%~~
~~1,494,005~~	~~-~~	~~1,504,341~~	~~97%~~	~~55%~~
~~1,504,342~~	~~-~~	~~1,530,347~~	~~98%~~	~~55%~~
~~1,530,348~~	~~-~~	~~1,539,647~~	~~98%~~	~~56%~~
~~1,539,648~~	~~-~~	~~1,566,951~~	~~99%~~	~~56%~~
~~1,566,952~~	~~-~~	~~1,574,952~~	~~99%~~	~~57%~~
~~1,574,953~~	~~-~~	~~1,603,819~~	~~100%~~	~~57%~~
~~1,603,820~~	~~-~~	~~1,640,954~~	~~100%~~	~~58%~~
~~1,640,955~~	~~-~~	~~1,678,358~~	~~100%~~	~~59%~~
~~1,678,359~~	~~-~~	~~1,716,033~~	~~100%~~	~~60%~~
~~1,716,034~~	~~-~~	~~1,753,984~~	~~100%~~	~~61%~~
~~1,753,985~~	~~-~~	~~1,792,213~~	~~100%~~	~~62%~~
~~1,792,214~~	~~-~~	~~1,830,724~~	~~100%~~	~~63%~~
~~1,830,725~~	~~-~~	~~1,869,518~~	~~100%~~	~~64%~~
~~1,869,519~~	~~-~~	~~1,908,600~~	~~100%~~	~~65%~~
~~1,908,601~~	~~-~~	~~1,947,972~~	~~100%~~	~~66%~~
~~1,947,973~~	~~-~~	~~1,987,640~~	~~100%~~	~~67%~~
~~1,987,641~~	~~-~~	~~2,027,605~~	~~100%~~	~~68%~~
~~2,027,606~~	~~-~~	~~2,067,870~~	~~100%~~	~~69%~~
~~2,067,871~~	~~-~~	~~2,108,438~~	~~100%~~	~~70%~~
~~2,108,439~~	~~-~~	~~2,149,316~~	~~100%~~	~~71%~~
~~2,149,317~~	~~-~~	~~2,190,505~~	~~100%~~	~~72%~~
~~2,190,506~~	~~-~~	~~2,232,006~~	~~100%~~	~~73%~~
~~2,232,007~~	~~-~~	~~2,273,828~~	~~100%~~	~~74%~~
~~2,273,829~~	~~-~~	~~2,315,968~~	~~100%~~	~~75%~~
~~2,315,969~~	~~-~~	~~2,358,438~~	~~100%~~	~~76%~~
~~2,358,439~~	~~-~~	~~2,401,234~~	~~100%~~	~~77%~~
~~2,401,235~~	~~-~~	~~2,444,365~~	~~100%~~	~~78%~~
~~2,444,366~~	~~-~~	~~2,487,833~~	~~100%~~	~~79%~~
~~2,487,834~~	~~-~~	~~2,531,642~~	~~100%~~	~~80%~~
~~2,531,643~~	~~-~~	~~2,575,799~~	~~100%~~	~~81%~~
~~2,575,800~~	~~-~~	~~2,620,301~~	~~100%~~	~~82%~~
~~2,620,302~~	~~-~~	~~2,665,159~~	~~100%~~	~~83%~~
~~2,665,160~~	~~-~~	~~2,710,371~~	~~100%~~	~~84%~~
~~2,710,372~~	~~-~~	~~2,755,950~~	~~100%~~	~~85%~~
~~2,755,951~~		~~and higher~~	~~100%~~	~~86%~~))
0	-	6,095	12%	7%
6,096	-	6,507	13%	7%
6,508	-	6,923	14%	7%
6,924	-	7,343	15%	7%
7,344	-	7,769	16%	7%
7,770	-	8,200	17%	7%
8,201	-	8,637	18%	7%
8,638	-	9,080	19%	7%
9,081	-	9,527	20%	7%
9,528	-	9,982	21%	7%
9,983	-	10,442	22%	7%
10,443	-	10,910	23%	7%
10,911	-	11,384	24%	7%
11,385	-	11,866	25%	7%
11,867	-	12,358	26%	7%
12,359	-	12,853	27%	7%
12,854	-	13,360	28%	7%
13,361	-	13,874	29%	7%

Expected Losses			Primary Credibility	Excess Credibility
13,875	-	14,398	30%	7%
14,399	-	14,935	31%	7%
14,936	-	15,477	32%	7%
15,478	-	16,034	33%	7%
16,035	-	16,602	34%	7%
16,603	-	17,183	35%	7%
17,184	-	17,776	36%	7%
17,777	-	18,384	37%	7%
18,385	-	19,012	38%	7%
19,013	-	19,652	39%	7%
19,653	-	20,313	40%	7%
20,314	-	20,993	41%	7%
20,994	-	21,696	42%	7%
21,697	-	22,423	43%	7%
22,424	-	23,177	44%	7%
23,178	-	23,961	45%	7%
23,962	-	24,782	46%	7%
24,783	-	25,640	47%	7%
25,641	-	26,546	48%	7%
26,547	-	27,507	49%	7%
27,508	-	28,530	50%	7%
28,531	-	29,637	51%	7%
29,638	-	30,849	52%	7%
30,850	-	32,199	53%	7%
32,200	-	32,337	54%	7%
32,338	-	33,755	54%	8%
33,756	-	35,657	55%	8%
35,658	-	53,965	56%	8%
53,966	-	59,479	57%	8%
59,480	-	84,958	57%	9%
84,959	-	87,505	57%	10%
87,506	-	110,594	58%	10%
110,595	-	121,044	58%	11%
121,045	-	136,390	59%	11%
136,391	-	154,586	59%	12%
154,587	-	162,340	60%	12%
162,341	-	188,128	60%	13%
188,129	-	188,456	61%	13%
188,457	-	214,734	61%	14%
214,735	-	221,666	61%	15%
221,667	-	241,176	62%	15%
241,177	-	255,208	62%	16%
255,209	-	267,783	63%	16%
267,784	-	288,749	63%	17%
288,750	-	294,559	64%	17%
294,560	-	321,503	64%	18%
321,504	-	322,287	64%	19%
322,288	-	348,621	65%	19%
348,622	-	355,829	65%	20%
355,830	-	375,906	66%	20%
375,907	-	389,370	66%	21%
389,371	-	403,367	67%	21%
403,368	-	422,911	67%	22%
422,912	-	431,005	68%	22%
431,006	-	456,448	68%	23%
456,449	-	458,819	69%	23%
458,820	-	486,811	69%	24%
486,812	-	489,989	69%	25%
489,990	-	514,985	70%	25%
514,986	-	523,532	70%	26%
523,533	-	543,341	71%	26%
543,342	-	557,072	71%	27%
557,073	-	571,882	72%	27%
571,883	-	590,612	72%	28%
590,613	-	600,608	73%	28%
600,609	-	624,153	73%	29%
624,154	-	629,521	74%	29%
629,522	-	657,694	74%	30%
657,695	-	658,627	75%	30%
658,628	-	687,922	75%	31%
687,923	-	691,234	75%	32%
691,235	-	717,411	76%	32%
717,412	-	724,775	76%	33%
724,776	-	747,094	77%	33%
747,095	-	758,315	77%	34%
758,316	-	776,978	78%	34%
776,979	-	791,855	78%	35%
791,856	-	807,058	79%	35%
807,059	-	825,396	79%	36%
825,397	-	837,340	80%	36%
837,341	-	858,935	80%	37%
858,936	-	867,827	81%	37%
867,828	-	892,477	81%	38%
892,478	-	898,518	82%	38%

Expected Losses			Primary Credibility	Excess Credibility
898,519	-	926,018	82%	39%
926,019	-	929,417	83%	39%
929,418	-	959,559	83%	40%
959,560	-	960,525	84%	40%
960,526	-	991,845	84%	41%
991,846	-	993,097	84%	42%
993,098	-	1,023,377	85%	42%
1,023,378	-	1,026,638	85%	43%
1,026,639	-	1,055,129	86%	43%
1,055,130	-	1,060,180	86%	44%
1,060,181	-	1,087,096	87%	44%
1,087,097	-	1,093,720	87%	45%
1,093,721	-	1,119,286	88%	45%
1,119,287	-	1,127,261	88%	46%
1,127,262	-	1,151,697	89%	46%
1,151,698	-	1,160,800	89%	47%
1,160,801	-	1,184,336	90%	47%
1,184,337	-	1,194,342	90%	48%
1,194,343	-	1,217,200	91%	48%
1,217,201	-	1,227,881	91%	49%
1,227,882	-	1,250,294	92%	49%
1,250,295	-	1,261,423	92%	50%
1,261,424	-	1,283,621	93%	50%
1,283,622	-	1,294,963	93%	51%
1,294,964	-	1,317,184	94%	51%
1,317,185	-	1,328,503	94%	52%
1,328,504	-	1,350,984	95%	52%
1,350,985	-	1,362,043	95%	53%
1,362,044	-	1,385,022	96%	53%
1,385,023	-	1,395,584	96%	54%
1,395,585	-	1,419,304	97%	54%
1,419,305	-	1,429,124	97%	55%
1,429,125	-	1,453,830	98%	55%
1,453,831	-	1,462,665	98%	56%
1,462,666	-	1,488,603	99%	56%
1,488,604	-	1,496,204	99%	57%
1,496,205	-	1,523,628	100%	57%
1,523,629	-	1,558,906	100%	58%
1,558,907	-	1,594,440	100%	59%
1,594,441	-	1,630,231	100%	60%
1,630,232	-	1,666,285	100%	61%
1,666,286	-	1,702,602	100%	62%
1,702,603	-	1,739,188	100%	63%
1,739,189	-	1,776,042	100%	64%
1,776,043	-	1,813,170	100%	65%
1,813,171	-	1,850,573	100%	66%
1,850,574	-	1,888,258	100%	67%
1,888,259	-	1,926,225	100%	68%
1,926,226	-	1,964,476	100%	69%
1,964,477	-	2,003,016	100%	70%
2,003,017	-	2,041,850	100%	71%
2,041,851	-	2,080,980	100%	72%
2,080,981	-	2,120,406	100%	73%
2,120,407	-	2,160,137	100%	74%
2,160,138	-	2,200,170	100%	75%
2,200,171	-	2,240,516	100%	76%
2,240,517	-	2,281,172	100%	77%
2,281,173	-	2,322,147	100%	78%
2,322,148	-	2,363,441	100%	79%
2,363,442	-	2,405,060	100%	80%
2,405,061	-	2,447,009	100%	81%
2,447,010	-	2,489,286	100%	82%
2,489,287	-	2,531,901	100%	83%
2,531,902	-	2,574,852	100%	84%
2,574,853	-	2,618,152	100%	85%
2,618,153		and higher	100%	86%

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17-885 Table III.

Expected Loss Rates and Primary Ratios
by Risk Classification and Fiscal Year
Expected Loss Rates in Dollars Per Worker Hour
Effective January 1, ((~~2018~~)) 2019

((~~Class~~	~~2014~~	~~2015~~	~~2016~~	~~Primary Ratio~~
~~0101~~	~~0.9336~~	~~0.7691~~	~~0.6157~~	~~0.444~~
~~0103~~	~~1.4302~~	~~1.1909~~	~~0.9719~~	~~0.435~~
~~0104~~	~~0.8770~~	~~0.7257~~	~~0.5855~~	~~0.436~~
~~0105~~	~~1.0855~~	~~0.9004~~	~~0.7271~~	~~0.546~~
~~0106~~	~~2.0438~~	~~1.7009~~	~~1.3851~~	~~0.486~~
~~0107~~	~~0.8784~~	~~0.7247~~	~~0.5816~~	~~0.422~~
~~0108~~	~~0.8770~~	~~0.7257~~	~~0.5855~~	~~0.436~~
~~0112~~	~~0.6812~~	~~0.5672~~	~~0.4626~~	~~0.439~~
~~0201~~	~~1.3612~~	~~1.1198~~	~~0.8946~~	~~0.430~~

((Class	2014	2015	2016	Primary Ratio	((Class	2014	2015	2016	Primary Ratio
0202	1.9984	1.6504	1.3291	0.402	1006	0.1860	0.1534	0.1226	0.578
0210	0.7181	0.5927	0.4760	0.429	1007	0.2551	0.2108	0.1696	0.476
0212	1.0493	0.8658	0.6955	0.438	1101	0.9019	0.7462	0.6015	0.507
0214	1.2260	1.0078	0.8034	0.463	1102	1.3640	1.1220	0.8969	0.455
0217	1.1566	0.9577	0.7733	0.462	1103	1.0431	0.8640	0.6979	0.500
0219	0.8110	0.6690	0.5372	0.419	1104	0.6015	0.5018	0.4094	0.525
0301	0.7432	0.6223	0.5114	0.496	1105	0.7266	0.6018	0.4858	0.495
0302	1.9293	1.5777	1.2475	0.438	1106	0.3080	0.2592	0.2143	0.538
0303	1.7997	1.4852	1.1940	0.426	1108	0.4496	0.3748	0.3053	0.511
0306	0.7645	0.6284	0.5003	0.484	1109	1.2494	1.0371	0.8405	0.519
0307	0.7922	0.6541	0.5252	0.478	1301	0.5270	0.4321	0.3425	0.531
0308	0.5898	0.4942	0.4064	0.533	1303	0.3009	0.2471	0.1960	0.580
0403	1.7198	1.4249	1.1511	0.494	1304	0.0210	0.0173	0.0140	0.500
0502	1.0892	0.8956	0.7146	0.470	1305	0.4638	0.3822	0.3055	0.530
0504	1.8749	1.5677	1.2897	0.403	1401	0.2387	0.2029	0.1714	0.474
0507	2.6935	2.2595	1.8671	0.435	1404	0.7197	0.5981	0.4858	0.527
0508	1.1168	0.9217	0.7418	0.391	1405	0.7027	0.5816	0.4681	0.539
0509	0.8123	0.6674	0.5322	0.408	1407	0.5577	0.4625	0.3734	0.576
0510	2.0734	1.7335	1.4245	0.442	1501	0.6650	0.5474	0.4370	0.514
0511	1.3647	1.1226	0.8950	0.494	1507	0.5346	0.4445	0.3606	0.518
0512	1.1192	0.9302	0.7558	0.457	1701	0.6897	0.5665	0.4511	0.519
0513	0.7975	0.6598	0.5319	0.477	1702	1.2692	1.0446	0.8369	0.364
0514	1.3274	1.0966	0.8804	0.509	1703	0.7850	0.6427	0.5095	0.421
0516	1.2558	1.0420	0.8442	0.465	1704	0.6897	0.5665	0.4511	0.519
0517	1.7192	1.4353	1.1776	0.414	1801	0.3817	0.3164	0.2558	0.459
0518	1.0329	0.8525	0.6840	0.451	1802	0.6540	0.5406	0.4340	0.508
0519	1.2468	1.0259	0.8186	0.498	2002	0.7873	0.6539	0.5304	0.492
0521	0.4314	0.3602	0.2945	0.505	2004	0.5318	0.4428	0.3594	0.545
0601	0.4477	0.3696	0.2964	0.500	2007	0.6667	0.5595	0.4620	0.482
0602	0.5867	0.4794	0.3787	0.422	2008	0.3317	0.2769	0.2261	0.505
0603	0.5731	0.4722	0.3780	0.448	2009	0.3405	0.2840	0.2311	0.572
0604	1.0116	0.8437	0.6895	0.473	2101	0.5332	0.4492	0.3727	0.506
0606	0.5203	0.4312	0.3476	0.554	2102	0.6762	0.5593	0.4498	0.549
0607	0.6587	0.5455	0.4407	0.483	2104	0.3183	0.2697	0.2246	0.599
0608	0.3116	0.2570	0.2056	0.492	2105	0.6077	0.5027	0.4040	0.552
0701	1.3700	1.1068	0.8551	0.421	2106	0.4010	0.3366	0.2775	0.493
0803	0.4942	0.4068	0.3243	0.563	2201	0.2565	0.2143	0.1755	0.533
0901	1.0329	0.8525	0.6840	0.451	2202	0.6203	0.5135	0.4141	0.494
1002	0.7930	0.6586	0.5346	0.468	2203	0.4831	0.4049	0.3327	0.536
1003	0.6438	0.5331	0.4300	0.504	2204	0.2565	0.2143	0.1755	0.533
1004	0.4043	0.3310	0.2614	0.501	2401	0.3719	0.3063	0.2449	0.484
1005	7.2783	5.9886	4.7908	0.448	2903	0.6654	0.5584	0.4602	0.517

((Class	2014	2015	2016	Primary Ratio	((Class	2014	2015	2016	Primary Ratio
2904	0.6257	0.5179	0.4174	0.504	3802	0.1969	0.1644	0.1342	0.552
2905	0.4831	0.4025	0.3276	0.527	3808	0.3765	0.3113	0.2503	0.497
2906	0.3859	0.3242	0.2669	0.528	3901	0.1312	0.1103	0.0906	0.611
2907	0.4347	0.3616	0.2934	0.547	3902	0.4535	0.3795	0.3107	0.561
2908	0.9359	0.7864	0.6483	0.508	3903	1.0413	0.8768	0.7269	0.519
2909	0.3736	0.3132	0.2574	0.529	3905	0.1314	0.1104	0.0908	0.597
3101	0.7331	0.6054	0.4852	0.547	3906	0.4442	0.3728	0.3072	0.533
3102	0.2846	0.2359	0.1905	0.488	3909	0.2557	0.2155	0.1784	0.546
3103	0.3965	0.3305	0.2699	0.471	4101	0.2619	0.2172	0.1754	0.520
3104	0.5758	0.4778	0.3865	0.508	4103	0.5154	0.4289	0.3485	0.545
3105	0.7003	0.5856	0.4784	0.555	4107	0.1780	0.1476	0.1191	0.551
3303	0.3722	0.3089	0.2499	0.536	4108	0.1590	0.1325	0.1078	0.554
3304	0.5677	0.4767	0.3928	0.562	4109	0.1867	0.1564	0.1282	0.526
3309	0.4043	0.3374	0.2754	0.533	4201	0.6618	0.5412	0.4272	0.505
3402	0.4432	0.3686	0.2990	0.521	4301	0.7635	0.6396	0.5251	0.567
3403	0.1576	0.1311	0.1063	0.506	4302	0.8723	0.7262	0.5903	0.570
3404	0.4468	0.3707	0.2994	0.557	4304	0.9188	0.7769	0.6485	0.506
3405	0.2875	0.2396	0.1948	0.521	4305	1.1387	0.9323	0.7375	0.523
3406	0.2752	0.2291	0.1860	0.591	4401	0.4044	0.3402	0.2815	0.505
3407	0.6755	0.5574	0.4471	0.490	4402	0.6982	0.5771	0.4629	0.583
3408	0.2106	0.1733	0.1379	0.604	4404	0.4405	0.3672	0.2990	0.522
3409	0.1538	0.1281	0.1040	0.607	4501	0.1717	0.1429	0.1158	0.598
3410	0.1754	0.1463	0.1192	0.593	4502	0.0539	0.0446	0.0361	0.544
3411	0.4610	0.3808	0.3059	0.499	4504	0.1138	0.0948	0.0769	0.611
3412	0.5712	0.4703	0.3759	0.489	4802	0.3493	0.2933	0.2417	0.558
3414	0.6611	0.5506	0.4489	0.467	4803	0.3361	0.2841	0.2362	0.600
3415	0.6906	0.5751	0.4692	0.444	4804	0.5567	0.4688	0.3879	0.569
3501	0.9819	0.8151	0.6604	0.513	4805	0.3986	0.3337	0.2738	0.552
3503	0.3010	0.2521	0.2068	0.550	4806	0.0991	0.0836	0.0694	0.614
3506	0.6907	0.5708	0.4587	0.491	4808	0.4178	0.3495	0.2865	0.520
3509	0.3743	0.3117	0.2532	0.583	4809	0.3411	0.2873	0.2382	0.534
3510	0.3156	0.2638	0.2156	0.556	4810	0.2040	0.1723	0.1430	0.588
3511	0.6886	0.5705	0.4602	0.541	4811	0.4147	0.3511	0.2928	0.564
3512	0.3777	0.3134	0.2527	0.587	4812	0.4159	0.3477	0.2842	0.558
3513	0.5119	0.4299	0.3544	0.521	4813	0.2034	0.1726	0.1445	0.574
3602	0.0839	0.0697	0.0565	0.563	4814	0.1308	0.1116	0.0942	0.581
3603	0.4724	0.3967	0.3273	0.501	4815	0.2685	0.2298	0.1949	0.594
3604	0.6350	0.5339	0.4409	0.495	4816	0.3679	0.3145	0.2669	0.535
3605	0.4939	0.4080	0.3275	0.531	4900	0.1322	0.1087	0.0868	0.446
3701	0.2846	0.2359	0.1905	0.488	4901	0.0395	0.0325	0.0260	0.516
3702	0.4079	0.3400	0.2767	0.529	4902	0.1036	0.0860	0.0693	0.567
3708	0.6184	0.5131	0.4148	0.530	4903	0.1583	0.1312	0.1055	0.591

((Class	2014	2015	2016	Primary Ratio	((Class	2014	2015	2016	Primary Ratio
4904	0.0184	0.0154	0.0125	0.563	6202	0.6496	0.5399	0.4374	0.528
4905	0.4127	0.3486	0.2898	0.589	6203	0.1224	0.1033	0.0854	0.639
4906	0.1081	0.0892	0.0712	0.581	6204	0.1318	0.1099	0.0895	0.581
4907	0.0665	0.0558	0.0455	0.599	6205	0.1898	0.1590	0.1306	0.547
4908	0.0912	0.0764	0.0623	0.588	6206	0.1870	0.1559	0.1267	0.583
4909	0.0342	0.0292	0.0243	0.514	6207	1.1425	0.9584	0.7911	0.508
4910	0.4480	0.3728	0.3032	0.508	6208	0.2468	0.2073	0.1708	0.591
4911	0.0575	0.0479	0.0390	0.505	6209	0.2800	0.2361	0.1957	0.540
5001	6.2248	5.1902	4.2557	0.381	6301	0.1142	0.0937	0.0745	0.517
5002	0.5712	0.4714	0.3775	0.551	6303	0.0553	0.0459	0.0371	0.520
5003	1.7576	1.4434	1.1509	0.445	6304	0.2574	0.2171	0.1796	0.591
5004	0.7534	0.6335	0.5250	0.470	6305	0.1024	0.0855	0.0695	0.607
5005	0.7080	0.5872	0.4762	0.445	6306	0.3203	0.2654	0.2140	0.557
5006	1.1173	0.9240	0.7469	0.381	6308	0.0578	0.0478	0.0384	0.539
5101	0.8296	0.6851	0.5509	0.452	6309	0.1894	0.1576	0.1278	0.568
5103	0.7071	0.5928	0.4870	0.522	6402	0.2612	0.2182	0.1779	0.599
5106	0.7071	0.5928	0.4870	0.522	6403	0.1635	0.1362	0.1104	0.606
5108	0.7369	0.6113	0.4941	0.538	6404	0.3025	0.2540	0.2092	0.579
5109	0.5432	0.4470	0.3564	0.491	6405	0.4848	0.4017	0.3239	0.535
5201	0.2996	0.2470	0.1969	0.559	6406	0.1307	0.1092	0.0890	0.601
5204	0.8579	0.7080	0.5688	0.475	6407	0.2493	0.2083	0.1700	0.567
5206	0.3844	0.3192	0.2588	0.471	6408	0.4698	0.3917	0.3193	0.510
5207	0.1559	0.1311	0.1081	0.567	6409	0.5835	0.4844	0.3923	0.492
5208	0.6464	0.5368	0.4344	0.523	6410	0.3165	0.2614	0.2096	0.565
5209	0.5991	0.4968	0.4013	0.494	6411	0.0755	0.0634	0.0521	0.565
5300	0.0983	0.0813	0.0653	0.605	6501	0.1109	0.0916	0.0734	0.601
5301	0.0300	0.0250	0.0203	0.534	6502	0.0283	0.0237	0.0192	0.556
5302	0.0093	0.0078	0.0062	0.556	6503	0.0711	0.0584	0.0463	0.566
5305	0.0518	0.0430	0.0348	0.592	6504	0.3356	0.2821	0.2320	0.608
5306	0.0449	0.0375	0.0305	0.581	6505	0.1496	0.1256	0.1030	0.655
5307	0.6135	0.5045	0.4023	0.529	6506	0.1224	0.1023	0.0834	0.575
5308	0.0847	0.0707	0.0575	0.585	6509	0.2785	0.2336	0.1915	0.589
6103	0.0930	0.0779	0.0637	0.606	6510	0.3829	0.3186	0.2600	0.420
6104	0.4452	0.3697	0.2990	0.558	6511	0.3287	0.2743	0.2238	0.581
6105	0.3695	0.3062	0.2469	0.513	6512	0.0893	0.0742	0.0602	0.505
6107	0.1285	0.1086	0.0897	0.618	6601	0.2009	0.1674	0.1363	0.550
6108	0.3257	0.2730	0.2235	0.587	6602	0.5582	0.4689	0.3872	0.545
6109	0.1040	0.0856	0.0684	0.541	6603	0.2639	0.2188	0.1767	0.524
6110	0.5041	0.4188	0.3393	0.531	6604	0.0856	0.0712	0.0576	0.590
6120	0.2828	0.2336	0.1871	0.548	6605	0.2480	0.2059	0.1664	0.551
6121	0.3043	0.2527	0.2049	0.481	6607	0.1267	0.1061	0.0868	0.541
6201	0.3151	0.2618	0.2122	0.495	6608	0.5135	0.4200	0.3321	0.425

((~~Class~~	~~2014~~	~~2015~~	~~2016~~	~~Primary Ratio~~
~~6620~~	~~3.0354~~	~~2.4869~~	~~1.9611~~	~~0.597~~
~~6704~~	~~0.1211~~	~~0.1006~~	~~0.0813~~	~~0.601~~
~~6705~~	~~0.7510~~	~~0.6307~~	~~0.5189~~	~~0.615~~
~~6706~~	~~0.2543~~	~~0.2145~~	~~0.1779~~	~~0.528~~
~~6707~~	~~10.1057~~	~~8.4099~~	~~6.8050~~	~~0.693~~
~~6708~~	~~8.0922~~	~~6.9748~~	~~5.9940~~	~~0.472~~
~~6709~~	~~0.2471~~	~~0.2066~~	~~0.1689~~	~~0.575~~
~~6801~~	~~0.6818~~	~~0.5513~~	~~0.4261~~	~~0.561~~
~~6802~~	~~0.7443~~	~~0.6157~~	~~0.4949~~	~~0.582~~
~~6803~~	~~0.5224~~	~~0.4287~~	~~0.3416~~	~~0.353~~
~~6804~~	~~0.2671~~	~~0.2229~~	~~0.1811~~	~~0.580~~
~~6809~~	~~4.9652~~	~~4.1772~~	~~3.4295~~	~~0.605~~
~~6901~~	~~0.0175~~	~~0.0163~~	~~0.0150~~	~~0.750~~
~~6902~~	~~0.7992~~	~~0.6616~~	~~0.5351~~	~~0.436~~
~~6903~~	~~5.5945~~	~~4.6657~~	~~3.8247~~	~~0.368~~
~~6904~~	~~0.8935~~	~~0.7319~~	~~0.5797~~	~~0.515~~
~~6905~~	~~0.6260~~	~~0.5124~~	~~0.4039~~	~~0.573~~
~~6906~~	~~0.2496~~	~~0.2241~~	~~0.2034~~	~~0.664~~
~~6907~~	~~0.9808~~	~~0.8133~~	~~0.6567~~	~~0.561~~
~~6908~~	~~0.3473~~	~~0.2892~~	~~0.2350~~	~~0.524~~
~~6909~~	~~0.1168~~	~~0.0972~~	~~0.0786~~	~~0.564~~
~~7100~~	~~0.0292~~	~~0.0245~~	~~0.0203~~	~~0.477~~
~~7101~~	~~0.0228~~	~~0.0189~~	~~0.0152~~	~~0.473~~
~~7103~~	~~0.8091~~	~~0.6628~~	~~0.5246~~	~~0.546~~
~~7104~~	~~0.0255~~	~~0.0213~~	~~0.0173~~	~~0.555~~
~~7105~~	~~0.0187~~	~~0.0154~~	~~0.0125~~	~~0.548~~
~~7106~~	~~0.2647~~	~~0.2211~~	~~0.1805~~	~~0.610~~
~~7107~~	~~0.2667~~	~~0.2260~~	~~0.1884~~	~~0.585~~
~~7108~~	~~0.1896~~	~~0.1586~~	~~0.1298~~	~~0.592~~
~~7109~~	~~0.1248~~	~~0.1041~~	~~0.0845~~	~~0.582~~
~~7110~~	~~0.3161~~	~~0.2651~~	~~0.2190~~	~~0.429~~
~~7111~~	~~0.3742~~	~~0.3067~~	~~0.2433~~	~~0.490~~
~~7112~~	~~0.9155~~	~~0.7606~~	~~0.6149~~	~~0.607~~
~~7113~~	~~0.4317~~	~~0.3611~~	~~0.2955~~	~~0.586~~
~~7114~~	~~0.7695~~	~~0.6418~~	~~0.5225~~	~~0.605~~
~~7115~~	~~0.5311~~	~~0.4435~~	~~0.3616~~	~~0.590~~
~~7116~~	~~0.4707~~	~~0.3930~~	~~0.3220~~	~~0.488~~
~~7117~~	~~1.2241~~	~~1.0191~~	~~0.8268~~	~~0.573~~
~~7118~~	~~1.5843~~	~~1.3188~~	~~1.0720~~	~~0.535~~
~~7119~~	~~1.6113~~	~~1.3252~~	~~1.0553~~	~~0.588~~
~~7120~~	~~5.6440~~	~~4.7012~~	~~3.8293~~	~~0.512~~
~~7121~~	~~5.1607~~	~~4.2962~~	~~3.4934~~	~~0.514~~

((~~Class~~	~~2014~~	~~2015~~	~~2016~~	~~Primary Ratio~~
~~7122~~	~~0.3622~~	~~0.3022~~	~~0.2467~~	~~0.538~~
~~7200~~	~~1.5696~~	~~1.2881~~	~~1.0243~~	~~0.505~~
~~7201~~	~~1.5175~~	~~1.2471~~	~~0.9935~~	~~0.529~~
~~7202~~	~~0.0258~~	~~0.0214~~	~~0.0173~~	~~0.524~~
~~7203~~	~~0.1107~~	~~0.0942~~	~~0.0784~~	~~0.617~~
~~7204~~	~~0.0000~~	~~0.0000~~	~~0.0000~~	~~0.500~~
~~7205~~	~~0.0000~~	~~0.0000~~	~~0.0000~~	~~0.500~~
~~7301~~	~~0.4816~~	~~0.4041~~	~~0.3326~~	~~0.541~~
~~7302~~	~~0.8362~~	~~0.7029~~	~~0.5817~~	~~0.488~~
~~7307~~	~~0.4617~~	~~0.3858~~	~~0.3157~~	~~0.553~~
~~7308~~	~~0.2704~~	~~0.2283~~	~~0.1895~~	~~0.557~~
~~7309~~	~~0.2816~~	~~0.2353~~	~~0.1920~~	~~0.608~~
~~7400~~	~~1.8051~~	~~1.4813~~	~~1.1780~~	~~0.505~~))

Class	2015	2016	2017	Primary Ratio
101	0.8104	0.7040	0.5600	0.445
103	1.2210	1.0713	0.8658	0.433
104	0.7676	0.6698	0.5362	0.436
105	0.9434	0.8247	0.6665	0.524
106	2.2532	1.9787	1.6055	0.466
107	0.7921	0.6894	0.5487	0.414
108	0.7676	0.6698	0.5362	0.436
112	0.5774	0.5082	0.4126	0.435
201	1.3159	1.1400	0.8998	0.409
202	1.7703	1.5405	1.2235	0.393
210	0.6383	0.5569	0.4451	0.431
212	0.8365	0.7275	0.5791	0.430
214	1.1572	1.0033	0.7946	0.430
217	1.0326	0.9026	0.7266	0.464
219	0.7424	0.6459	0.5136	0.416
301	0.7009	0.6181	0.5063	0.492
302	1.6445	1.4185	1.1133	0.430
303	1.6442	1.4349	1.1468	0.406
306	0.6470	0.5623	0.4484	0.474
307	0.7170	0.6246	0.4999	0.474
308	0.5102	0.4508	0.3710	0.516
403	1.5844	1.3839	1.1163	0.493
502	0.9842	0.8517	0.6749	0.476
504	1.6851	1.4854	1.2081	0.413
507	2.4824	2.2000	1.8071	0.435
508	0.9932	0.8653	0.6878	0.380
509	0.6970	0.6035	0.4753	0.390

Class	2015	2016	2017	Primary Ratio	Class	2015	2016	2017	Primary Ratio
510	1.8963	1.6721	1.3621	0.431	1501	0.6596	0.5717	0.4554	0.500
511	1.2101	1.0496	0.8348	0.478	1507	0.4704	0.4128	0.3358	0.521
512	1.0140	0.8895	0.7197	0.457	1701	0.6147	0.5340	0.4269	0.498
513	0.7169	0.6257	0.5024	0.469	1702	1.1671	1.0153	0.8034	0.347
514	1.1645	1.0166	0.8177	0.496	1703	0.7240	0.6271	0.4948	0.411
516	1.1434	1.0004	0.8062	0.462	1704	0.6147	0.5340	0.4269	0.498
517	1.5159	1.3361	1.0855	0.402	1801	0.3462	0.3025	0.2429	0.441
518	0.9090	0.7909	0.6306	0.454	1802	0.6009	0.5235	0.4191	0.500
519	1.0715	0.9296	0.7406	0.488	2002	0.7296	0.6404	0.5192	0.468
521	0.4009	0.3535	0.2892	0.487	2004	0.4678	0.4093	0.3316	0.543
601	0.3916	0.3411	0.2735	0.491	2007	0.6076	0.5374	0.4412	0.475
602	0.5529	0.4775	0.3744	0.396	2008	0.3046	0.2679	0.2184	0.496
603	0.5082	0.4411	0.3499	0.434	2009	0.3352	0.2939	0.2397	0.569
604	0.9062	0.7932	0.6413	0.487	2101	0.5078	0.4494	0.3708	0.523
606	0.4501	0.3930	0.3179	0.550	2102	0.6264	0.5456	0.4396	0.538
607	0.6215	0.5416	0.4350	0.487	2104	0.3148	0.2809	0.2355	0.593
608	0.3131	0.2714	0.2155	0.479	2105	0.5464	0.4758	0.3830	0.548
701	1.2732	1.0841	0.8298	0.418	2106	0.4066	0.3584	0.2930	0.504
803	0.4670	0.4046	0.3233	0.553	2201	0.2422	0.2138	0.1754	0.508
901	0.9090	0.7909	0.6306	0.454	2202	0.5477	0.4795	0.3875	0.488
1002	0.6875	0.6030	0.4872	0.439	2203	0.4236	0.3756	0.3104	0.509
1003	0.5834	0.5096	0.4108	0.494	2204	0.2422	0.2138	0.1754	0.508
1004	0.3608	0.3112	0.2449	0.491	2401	0.3603	0.3127	0.2494	0.485
1005	6.7358	5.8476	4.6419	0.438	2903	0.6155	0.5442	0.4481	0.523
1006	0.1723	0.1496	0.1201	0.565	2904	0.5877	0.5134	0.4128	0.471
1007	0.2401	0.2092	0.1674	0.463	2905	0.4093	0.3592	0.2919	0.517
1101	0.8904	0.7775	0.6265	0.489	2906	0.3859	0.3417	0.2811	0.522
1102	1.3090	1.1351	0.9000	0.437	2907	0.3989	0.3501	0.2853	0.535
1103	0.9243	0.8059	0.6490	0.502	2908	0.8644	0.7648	0.6288	0.516
1104	0.5553	0.4875	0.3967	0.514	2909	0.3419	0.3030	0.2498	0.509
1105	0.6515	0.5684	0.4571	0.493	3101	0.6610	0.5766	0.4648	0.521
1106	0.2904	0.2567	0.2113	0.531	3102	0.2805	0.2442	0.1953	0.480
1108	0.4187	0.3680	0.3000	0.514	3103	0.3514	0.3092	0.2512	0.458
1109	1.2502	1.0918	0.8802	0.495	3104	0.5496	0.4804	0.3885	0.524
1301	0.4967	0.4306	0.3429	0.502	3105	0.6369	0.5619	0.4610	0.541
1303	0.3152	0.2729	0.2187	0.582	3303	0.3390	0.2966	0.2406	0.540
1304	0.0180	0.0158	0.0127	0.492	3304	0.5481	0.4843	0.4000	0.551
1305	0.4138	0.3592	0.2870	0.506	3309	0.3780	0.3315	0.2701	0.531
1401	0.2238	0.2006	0.1683	0.473	3402	0.4132	0.3615	0.2926	0.520
1404	0.6336	0.5542	0.4492	0.515	3403	0.1402	0.1229	0.0995	0.500
1405	0.6163	0.5370	0.4325	0.535	3404	0.3907	0.3416	0.2769	0.551
1407	0.5000	0.4365	0.3542	0.572	3405	0.2628	0.2303	0.1868	0.508

Class	2015	2016	2017	Primary Ratio	Class	2015	2016	2017	Primary Ratio
3406	0.2537	0.2223	0.1814	0.580	4401	0.3766	0.3342	0.2761	0.495
3407	0.6217	0.5408	0.4328	0.485	4402	0.6397	0.5563	0.4485	0.573
3408	0.1896	0.1641	0.1311	0.584	4404	0.3854	0.3383	0.2751	0.524
3409	0.1378	0.1206	0.0986	0.598	4501	0.1575	0.1378	0.1122	0.594
3410	0.1544	0.1355	0.1109	0.585	4502	0.0533	0.0467	0.0376	0.530
3411	0.4428	0.3854	0.3085	0.484	4504	0.1059	0.0928	0.0756	0.612
3412	0.5314	0.4608	0.3662	0.471	4802	0.3472	0.3073	0.2541	0.544
3414	0.6083	0.5332	0.4315	0.469	4803	0.3187	0.2836	0.2372	0.590
3415	0.6481	0.5696	0.4624	0.447	4804	0.5208	0.4632	0.3859	0.538
3501	0.9194	0.8048	0.6519	0.504	4805	0.3564	0.3149	0.2596	0.549
3503	0.2680	0.2365	0.1941	0.532	4806	0.1020	0.0905	0.0755	0.619
3506	0.6416	0.5611	0.4516	0.467	4808	0.3981	0.3509	0.2870	0.497
3509	0.3450	0.3024	0.2470	0.569	4809	0.2991	0.2655	0.2198	0.507
3510	0.3156	0.2773	0.2266	0.551	4810	0.2041	0.1810	0.1507	0.572
3511	0.6344	0.5556	0.4504	0.514	4811	0.4007	0.3575	0.2993	0.557
3512	0.3380	0.2959	0.2407	0.592	4812	0.4009	0.3526	0.2886	0.544
3513	0.4291	0.3808	0.3146	0.504	4813	0.2034	0.1816	0.1526	0.580
3602	0.0805	0.0704	0.0571	0.563	4814	0.1206	0.1083	0.0918	0.574
3603	0.4634	0.4099	0.3365	0.480	4815	0.2477	0.2230	0.1903	0.588
3604	0.6002	0.5316	0.4373	0.486	4816	0.3409	0.3070	0.2605	0.527
3605	0.4539	0.3950	0.3170	0.523	4900	0.1059	0.0921	0.0733	0.438
3701	0.2805	0.2442	0.1953	0.480	4901	0.0352	0.0305	0.0243	0.510
3702	0.3625	0.3185	0.2592	0.514	4902	0.0887	0.0774	0.0627	0.569
3708	0.5852	0.5120	0.4151	0.530	4903	0.1440	0.1255	0.1013	0.580
3802	0.1748	0.1541	0.1264	0.533	4904	0.0158	0.0138	0.0113	0.565
3808	0.3406	0.2971	0.2385	0.482	4905	0.3758	0.3338	0.2788	0.576
3901	0.1295	0.1141	0.0941	0.607	4906	0.0979	0.0848	0.0680	0.578
3902	0.4326	0.3816	0.3136	0.541	4907	0.0607	0.0535	0.0441	0.603
3903	0.9627	0.8542	0.7075	0.511	4908	0.0825	0.0727	0.0594	0.581
3905	0.1170	0.1034	0.0856	0.602	4909	0.0317	0.0285	0.0237	0.506
3906	0.4287	0.3786	0.3114	0.524	4910	0.4188	0.3668	0.2977	0.513
3909	0.2484	0.2196	0.1812	0.563	4911	0.0485	0.0427	0.0347	0.483
4101	0.2286	0.2000	0.1620	0.520	5001	6.0798	5.3461	4.3191	0.380
4103	0.4810	0.4216	0.3430	0.531	5002	0.5247	0.4559	0.3658	0.544
4107	0.1674	0.1459	0.1175	0.535	5003	1.6454	1.4269	1.1317	0.437
4108	0.1431	0.1255	0.1025	0.552	5004	0.6923	0.6136	0.5056	0.460
4109	0.1748	0.1549	0.1276	0.516	5005	0.6759	0.5904	0.4736	0.426
4201	0.6503	0.5601	0.4411	0.495	5006	1.0012	0.8745	0.6980	0.369
4301	0.7522	0.6649	0.5495	0.552	5101	0.7912	0.6875	0.5468	0.446
4302	0.7462	0.6558	0.5370	0.550	5103	0.6784	0.5996	0.4923	0.516
4304	0.8970	0.8000	0.6679	0.514	5106	0.6784	0.5996	0.4923	0.516
4305	1.0475	0.9027	0.7136	0.527	5108	0.6934	0.6041	0.4866	0.539

Class	2015	2016	2017	Primary Ratio	Class	2015	2016	2017	Primary Ratio
5109	0.4913	0.4257	0.3380	0.485	6406	0.1318	0.1157	0.0947	0.591
5201	0.2610	0.2271	0.1820	0.548	6407	0.2444	0.2146	0.1755	0.556
5204	0.7936	0.6895	0.5500	0.463	6408	0.4387	0.3845	0.3114	0.494
5206	0.3627	0.3177	0.2564	0.462	6409	0.5610	0.4908	0.3962	0.487
5207	0.1443	0.1275	0.1054	0.561	6410	0.2804	0.2442	0.1966	0.552
5208	0.5811	0.5096	0.4132	0.507	6411	0.0578	0.0511	0.0421	0.549
5209	0.5282	0.4603	0.3700	0.514	6501	0.0943	0.0821	0.0663	0.591
5300	0.0875	0.0762	0.0617	0.589	6502	0.0254	0.0223	0.0181	0.543
5301	0.0284	0.0249	0.0201	0.509	6503	0.0654	0.0565	0.0448	0.560
5302	0.0084	0.0073	0.0059	0.551	6504	0.3159	0.2790	0.2309	0.612
5305	0.0458	0.0399	0.0323	0.584	6505	0.1507	0.1329	0.1101	0.660
5306	0.0399	0.0351	0.0288	0.576	6506	0.1213	0.1063	0.0867	0.574
5307	0.5652	0.4894	0.3898	0.514	6509	0.2511	0.2216	0.1825	0.587
5308	0.0806	0.0707	0.0576	0.585	6510	0.3702	0.3253	0.2625	0.387
6103	0.0857	0.0755	0.0623	0.603	6511	0.2726	0.2395	0.1964	0.577
6104	0.3898	0.3410	0.2770	0.561	6512	0.0806	0.0704	0.0568	0.511
6105	0.3567	0.3111	0.2498	0.497	6601	0.1739	0.1527	0.1247	0.555
6107	0.1243	0.1102	0.0917	0.634	6602	0.5135	0.4546	0.3764	0.539
6108	0.2934	0.2586	0.2126	0.577	6603	0.2512	0.2194	0.1768	0.528
6109	0.0958	0.0830	0.0663	0.532	6604	0.0787	0.0689	0.0562	0.585
6110	0.4553	0.3971	0.3200	0.523	6605	0.2224	0.1944	0.1572	0.542
6120	0.2748	0.2389	0.1919	0.547	6607	0.1111	0.0980	0.0803	0.545
6121	0.2805	0.2455	0.1980	0.467	6608	0.4642	0.4004	0.3139	0.423
6201	0.3383	0.2954	0.2377	0.494	6620	2.7812	2.3981	1.9034	0.594
6202	0.6592	0.5751	0.4637	0.536	6704	0.1167	0.1018	0.0827	0.602
6203	0.1052	0.0937	0.0784	0.636	6705	0.6408	0.5672	0.4712	0.603
6204	0.1286	0.1129	0.0924	0.589	6706	0.2247	0.1998	0.1660	0.511
6205	0.1737	0.1532	0.1255	0.535	6707	11.5610	10.0747	8.2497	0.693
6206	0.1760	0.1541	0.1257	0.583	6708	7.6176	6.9223	5.9075	0.466
6207	1.0281	0.9065	0.7430	0.502	6709	0.2335	0.2053	0.1683	0.576
6208	0.2290	0.2028	0.1683	0.585	6801	0.6627	0.5613	0.4316	0.571
6209	0.2562	0.2278	0.1891	0.530	6802	0.7495	0.6511	0.5240	0.573
6301	0.1036	0.0896	0.0711	0.515	6803	0.4689	0.4056	0.3179	0.346
6303	0.0494	0.0432	0.0349	0.519	6804	0.2610	0.2285	0.1860	0.589
6305	0.0884	0.0776	0.0637	0.594	6809	4.1622	3.6934	3.0558	0.595
6306	0.2884	0.2512	0.2028	0.560	6901	0.0167	0.0161	0.0149	0.756
6308	0.0522	0.0456	0.0368	0.532	6902	0.7663	0.6714	0.5411	0.422
6309	0.1793	0.1572	0.1285	0.579	6903	5.0143	4.4156	3.5720	0.358
6402	0.2352	0.2071	0.1703	0.586	6904	0.8478	0.7317	0.5780	0.493
6403	0.1454	0.1273	0.1037	0.604	6905	0.5895	0.5082	0.4028	0.563
6404	0.2899	0.2563	0.2123	0.564	6906	0.2393	0.2259	0.2076	0.655
6405	0.4826	0.4208	0.3390	0.530	6907	0.8426	0.7351	0.5946	0.558

Class	2015	2016	2017	Primary Ratio
6908	0.3233	0.2833	0.2298	0.517
6909	0.1045	0.0916	0.0743	0.555
7100	0.0270	0.0239	0.0197	0.468
7101	0.0207	0.0181	0.0145	0.466
7103	0.7639	0.6571	0.5185	0.537
7104	0.0230	0.0201	0.0164	0.540
7105	0.0169	0.0148	0.0119	0.546
7106	0.2664	0.2330	0.1903	0.612
7107	0.2655	0.2363	0.1974	0.584
7108	0.1854	0.1627	0.1335	0.602
7109	0.1051	0.0922	0.0752	0.564
7110	0.3121	0.2759	0.2257	0.427
7111	0.3253	0.2809	0.2217	0.481
7112	0.7790	0.6821	0.5562	0.592
7113	0.3817	0.3358	0.2761	0.573
7114	0.7173	0.6292	0.5154	0.605
7115	0.4947	0.4355	0.3581	0.588
7116	0.3903	0.3441	0.2809	0.463
7117	1.1384	0.9981	0.8122	0.545
7118	1.4517	1.2718	1.0327	0.526
7119	1.4180	1.2282	0.9823	0.558
7120	5.1925	4.5577	3.7068	0.503
7121	4.7278	4.1472	3.3671	0.506
7122	0.3415	0.3011	0.2469	0.522
7200	1.4181	1.2252	0.9701	0.485
7201	1.3151	1.1379	0.9061	0.522
7202	0.0244	0.0213	0.0174	0.516
7203	0.1001	0.0895	0.0750	0.612
7204	0.0000	0.0000	0.0000	0.500
7205	0.0000	0.0000	0.0000	0.500
7301	0.4807	0.4271	0.3539	0.516
7302	0.7749	0.6859	0.5653	0.496
7307	0.4452	0.3911	0.3200	0.553
7308	0.2394	0.2130	0.1775	0.559
7309	0.2520	0.2217	0.1823	0.601
7400	1.6308	1.4090	1.1156	0.485

Expected Loss Rates in Dollars Per Sq. Ft. of Wallboard Installed

((~~Class~~	~~2014~~	~~2015~~	~~2016~~	~~Primary Ratio~~
~~0540~~	~~0.0209~~	~~0.0173~~	~~0.0140~~	~~0.437~~
~~0541~~	~~0.0094~~	~~0.0078~~	~~0.0063~~	~~0.458~~
~~0550~~	~~0.0309~~	~~0.0255~~	~~0.0208~~	~~0.423~~
~~0551~~	~~0.0135~~	~~0.0112~~	~~0.0091~~	~~0.404~~))

Class	2015	2016	2017	Primary Ratio
0540	0.0191	0.0168	0.0135	0.439
0541	0.0077	0.0067	0.0055	0.460
0550	0.0291	0.0254	0.0205	0.412
0551	0.0127	0.0112	0.0090	0.400

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17-890 Table IV.

Maximum Experience Modifications
For Firms with No Compensable Accidents:
Effective January 1, ((~~2018~~)) 2019

Expected Loss Range			Maximum Experience Modification
((~~1~~	-	~~5,811~~	~~0.90~~
~~5,812~~	-	~~7,095~~	~~0.89~~
~~7,096~~	-	~~7,825~~	~~0.88~~
~~7,826~~	-	~~8,556~~	~~0.87~~
~~8,557~~	-	~~9,286~~	~~0.86~~
~~9,287~~	-	~~10,017~~	~~0.85~~
~~10,018~~	-	~~10,747~~	~~0.84~~
~~10,748~~	-	~~11,478~~	~~0.83~~
~~11,479~~	-	~~12,208~~	~~0.82~~
~~12,209~~	-	~~12,961~~	~~0.81~~
~~12,962~~	-	~~13,745~~	~~0.80~~
~~13,746~~	-	~~14,561~~	~~0.79~~
~~14,562~~	-	~~15,409~~	~~0.78~~
~~15,410~~	-	~~16,289~~	~~0.77~~
~~16,290~~	-	~~17,200~~	~~0.76~~
~~17,201~~	-	~~18,143~~	~~0.75~~
~~18,144~~	-	~~19,117~~	~~0.74~~
~~19,118~~	-	~~20,123~~	~~0.73~~
~~20,124~~	-	~~21,161~~	~~0.72~~
~~21,162~~	-	~~22,230~~	~~0.71~~
~~22,231~~	-	~~23,331~~	~~0.70~~
~~23,332~~	-	~~24,464~~	~~0.69~~
~~24,465~~	-	~~25,628~~	~~0.68~~
~~25,629~~	-	~~26,824~~	~~0.67~~
~~26,825~~	-	~~28,052~~	~~0.66~~
~~28,053~~	-	~~29,311~~	~~0.65~~

Expected Loss Range			Maximum Experience Modification
~~29,312~~	~~-~~	~~31,200~~	~~0.64~~
~~31,201~~	~~-~~	~~34,034~~	~~0.63~~
~~34,035~~	~~-~~	~~38,284~~	~~0.62~~
~~38,285~~	~~-~~	~~44,659~~	~~0.61~~
~~44,660~~		~~and higher~~	~~0.60~~))
1	-	5,520	0.90
5,521	-	6,740	0.89
6,741	-	7,434	0.88
7,435	-	8,128	0.87
8,129	-	8,822	0.86
8,823	-	9,516	0.85
9,517	-	10,210	0.84
10,211	-	10,904	0.83
10,905	-	11,598	0.82
11,599	-	12,314	0.81
12,315	-	13,061	0.80
13,062	-	13,838	0.79
13,839	-	14,644	0.78
14,645	-	15,481	0.77
15,482	-	16,347	0.76
16,348	-	17,243	0.75
17,244	-	18,170	0.74
18,171	-	19,126	0.73
19,127	-	20,112	0.72
20,113	-	21,128	0.71
21,129	-	22,174	0.70
22,175	-	23,249	0.69
23,250	-	24,355	0.68
24,356	-	25,491	0.67
25,492	-	26,657	0.66
26,658	-	27,852	0.65
27,853	-	29,645	0.64
29,646	-	32,335	0.63
32,336	-	36,370	0.62
36,371	-	42,423	0.61
42,424		and higher	0.60

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17-895 Industrial insurance accident fund base rates, stay at work and medical aid base rates by class of industry. Industrial insurance accident fund, stay at work and medical aid fund base rates by class of industry shall be as set forth below.

	Base Rates Effective January 1, ((~~2018~~)) 2019		
Class	Accident Fund	Stay at Work	Medical Aid Fund
((~~0101~~	~~1.7467~~	~~0.0227~~	~~0.6802~~
~~0103~~	~~2.4617~~	~~0.0317~~	~~1.2069~~
~~0104~~	~~1.5993~~	~~0.0207~~	~~0.6897~~
~~0105~~	~~1.6093~~	~~0.0205~~	~~0.9804~~
~~0106~~	~~3.2153~~	~~0.0412~~	~~1.7904~~
~~0107~~	~~1.7034~~	~~0.0222~~	~~0.6458~~
~~0108~~	~~1.5993~~	~~0.0207~~	~~0.6897~~
~~0112~~	~~1.1816~~	~~0.0152~~	~~0.5855~~
~~0201~~	~~2.6424~~	~~0.0344~~	~~0.9618~~
~~0202~~	~~3.8692~~	~~0.0503~~	~~1.4869~~
~~0210~~	~~1.3633~~	~~0.0177~~	~~0.5465~~
~~0212~~	~~1.9476~~	~~0.0253~~	~~0.7757~~
~~0214~~	~~2.2692~~	~~0.0295~~	~~0.8650~~
~~0217~~	~~2.0067~~	~~0.0259~~	~~0.9334~~
~~0219~~	~~1.5717~~	~~0.0205~~	~~0.5883~~
~~0301~~	~~1.1012~~	~~0.0140~~	~~0.7206~~
~~0302~~	~~3.8248~~	~~0.0500~~	~~1.2195~~
~~0303~~	~~3.3847~~	~~0.0440~~	~~1.3111~~
~~0306~~	~~1.3768~~	~~0.0179~~	~~0.5653~~
~~0307~~	~~1.3831~~	~~0.0179~~	~~0.6341~~
~~0308~~	~~0.8036~~	~~0.0101~~	~~0.5852~~
~~0403~~	~~2.8129~~	~~0.0362~~	~~1.4061~~
~~0502~~	~~1.9672~~	~~0.0255~~	~~0.7929~~
~~0504~~	~~3.2851~~	~~0.0423~~	~~1.6380~~
~~0507~~	~~4.3328~~	~~0.0554~~	~~2.5428~~
~~0508~~	~~2.2019~~	~~0.0287~~	~~0.8081~~
~~0509~~	~~1.6499~~	~~0.0215~~	~~0.5471~~
~~0510~~	~~3.3961~~	~~0.0435~~	~~1.8743~~
~~0511~~	~~2.4040~~	~~0.0311~~	~~1.0254~~
~~0512~~	~~1.9214~~	~~0.0247~~	~~0.9508~~
~~0513~~	~~1.3525~~	~~0.0174~~	~~0.6470~~
~~0514~~	~~2.1919~~	~~0.0282~~	~~1.0957~~
~~0516~~	~~2.1373~~	~~0.0275~~	~~1.0534~~
~~0517~~	~~2.9880~~	~~0.0385~~	~~1.4845~~
~~0518~~	~~1.9059~~	~~0.0247~~	~~0.8032~~
~~0519~~	~~2.1438~~	~~0.0277~~	~~0.9399~~
~~0521~~	~~0.6488~~	~~0.0083~~	~~0.4076~~
~~0601~~	~~0.7636~~	~~0.0099~~	~~0.3653~~
~~0602~~	~~1.2050~~	~~0.0158~~	~~0.3650~~
~~0603~~	~~1.0640~~	~~0.0138~~	~~0.4237~~

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
~~0604~~	~~1.6288~~	~~0.0209~~	~~0.9082~~
~~0606~~	~~0.7684~~	~~0.0098~~	~~0.4666~~
~~0607~~	~~1.0885~~	~~0.0140~~	~~0.5342~~
~~0608~~	~~0.5448~~	~~0.0070~~	~~0.2460~~
~~0701~~	~~3.0927~~	~~0.0407~~	~~0.6989~~
~~0803~~	~~0.7571~~	~~0.0097~~	~~0.4000~~
~~0901~~	~~1.9059~~	~~0.0247~~	~~0.8032~~
~~1002~~	~~1.3264~~	~~0.0171~~	~~0.6648~~
~~1003~~	~~1.0339~~	~~0.0133~~	~~0.5380~~
~~1004~~	~~0.7243~~	~~0.0094~~	~~0.3002~~
~~1005~~	~~13.1578~~	~~0.1707~~	~~5.3591~~
~~1006~~	~~0.2711~~	~~0.0035~~	~~0.1589~~
~~1007~~	~~0.4381~~	~~0.0057~~	~~0.2017~~
~~1101~~	~~1.4405~~	~~0.0185~~	~~0.7366~~
~~1102~~	~~2.4760~~	~~0.0322~~	~~0.9709~~
~~1103~~	~~1.6792~~	~~0.0216~~	~~0.8438~~
~~1104~~	~~0.8798~~	~~0.0112~~	~~0.5722~~
~~1105~~	~~1.1951~~	~~0.0154~~	~~0.6058~~
~~1106~~	~~0.4124~~	~~0.0052~~	~~0.3314~~
~~1108~~	~~0.6990~~	~~0.0089~~	~~0.4267~~
~~1109~~	~~1.8817~~	~~0.0241~~	~~1.0683~~
~~1301~~	~~0.8788~~	~~0.0114~~	~~0.3875~~
~~1303~~	~~0.4529~~	~~0.0058~~	~~0.2375~~
~~1304~~	~~0.0340~~	~~0.0004~~	~~0.0176~~
~~1305~~	~~0.7369~~	~~0.0095~~	~~0.3629~~
~~1401~~	~~0.3037~~	~~0.0038~~	~~0.2727~~
~~1404~~	~~1.0431~~	~~0.0133~~	~~0.6238~~
~~1405~~	~~1.0761~~	~~0.0138~~	~~0.6064~~
~~1407~~	~~0.7690~~	~~0.0098~~	~~0.4882~~
~~1501~~	~~1.1050~~	~~0.0143~~	~~0.5026~~
~~1507~~	~~0.8174~~	~~0.0104~~	~~0.4781~~
~~1701~~	~~1.1280~~	~~0.0146~~	~~0.5118~~
~~1702~~	~~2.6890~~	~~0.0352~~	~~0.8290~~
~~1703~~	~~1.5790~~	~~0.0206~~	~~0.5025~~
~~1704~~	~~1.1280~~	~~0.0146~~	~~0.5118~~
~~1801~~	~~0.6730~~	~~0.0087~~	~~0.3174~~
~~1802~~	~~1.0868~~	~~0.0140~~	~~0.5774~~
~~2002~~	~~1.2678~~	~~0.0163~~	~~0.6726~~
~~2004~~	~~0.7929~~	~~0.0101~~	~~0.5160~~
~~2007~~	~~0.9856~~	~~0.0125~~	~~0.6594~~

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
~~2008~~	~~0.5059~~	~~0.0065~~	~~0.3094~~
~~2009~~	~~0.4676~~	~~0.0059~~	~~0.3379~~
~~2101~~	~~0.7428~~	~~0.0094~~	~~0.5678~~
~~2102~~	~~1.0122~~	~~0.0130~~	~~0.5711~~
~~2104~~	~~0.3551~~	~~0.0043~~	~~0.3933~~
~~2105~~	~~0.9152~~	~~0.0117~~	~~0.5238~~
~~2106~~	~~0.6012~~	~~0.0076~~	~~0.4109~~
~~2201~~	~~0.3587~~	~~0.0045~~	~~0.2452~~
~~2202~~	~~1.0278~~	~~0.0132~~	~~0.5154~~
~~2203~~	~~0.6675~~	~~0.0084~~	~~0.4896~~
~~2204~~	~~0.3587~~	~~0.0045~~	~~0.2452~~
~~2401~~	~~0.6482~~	~~0.0084~~	~~0.2846~~
~~2903~~	~~0.9312~~	~~0.0118~~	~~0.6833~~
~~2904~~	~~1.0157~~	~~0.0131~~	~~0.5229~~
~~2905~~	~~0.7145~~	~~0.0091~~	~~0.4558~~
~~2906~~	~~0.5583~~	~~0.0070~~	~~0.4241~~
~~2907~~	~~0.6341~~	~~0.0081~~	~~0.4089~~
~~2908~~	~~1.3812~~	~~0.0174~~	~~1.0089~~
~~2909~~	~~0.5245~~	~~0.0066~~	~~0.3924~~
~~3101~~	~~1.1344~~	~~0.0146~~	~~0.6053~~
~~3102~~	~~0.4792~~	~~0.0062~~	~~0.2425~~
~~3103~~	~~0.6343~~	~~0.0081~~	~~0.3576~~
~~3104~~	~~0.9179~~	~~0.0118~~	~~0.5016~~
~~3105~~	~~0.9830~~	~~0.0124~~	~~0.7170~~
~~3303~~	~~0.5525~~	~~0.0071~~	~~0.3314~~
~~3304~~	~~0.7194~~	~~0.0090~~	~~0.5866~~
~~3309~~	~~0.5865~~	~~0.0075~~	~~0.3743~~
~~3402~~	~~0.6846~~	~~0.0087~~	~~0.4067~~
~~3403~~	~~0.2540~~	~~0.0033~~	~~0.1415~~
~~3404~~	~~0.6540~~	~~0.0083~~	~~0.4087~~
~~3405~~	~~0.4406~~	~~0.0056~~	~~0.2714~~
~~3406~~	~~0.3591~~	~~0.0045~~	~~0.2627~~
~~3407~~	~~1.1481~~	~~0.0148~~	~~0.5269~~
~~3408~~	~~0.2957~~	~~0.0038~~	~~0.1771~~
~~3409~~	~~0.1949~~	~~0.0025~~	~~0.1437~~
~~3410~~	~~0.2202~~	~~0.0028~~	~~0.1678~~
~~3411~~	~~0.7665~~	~~0.0099~~	~~0.3697~~
~~3412~~	~~0.9868~~	~~0.0128~~	~~0.4320~~
~~3414~~	~~1.0829~~	~~0.0139~~	~~0.5827~~
~~3415~~	~~1.1747~~	~~0.0151~~	~~0.5920~~

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
~~3501~~	~~1.5016~~	~~0.0192~~	~~0.8512~~
~~3503~~	~~0.4087~~	~~0.0051~~	~~0.3157~~
~~3506~~	~~1.1876~~	~~0.0153~~	~~0.5628~~
~~3509~~	~~0.4945~~	~~0.0063~~	~~0.3527~~
~~3510~~	~~0.4341~~	~~0.0055~~	~~0.3192~~
~~3511~~	~~1.0290~~	~~0.0132~~	~~0.5995~~
~~3512~~	~~0.5310~~	~~0.0067~~	~~0.3721~~
~~3513~~	~~0.7165~~	~~0.0090~~	~~0.5451~~
~~3602~~	~~0.1206~~	~~0.0015~~	~~0.0810~~
~~3603~~	~~0.6814~~	~~0.0086~~	~~0.4861~~
~~3604~~	~~0.9456~~	~~0.0120~~	~~0.6642~~
~~3605~~	~~0.7763~~	~~0.0100~~	~~0.4140~~
~~3701~~	~~0.4792~~	~~0.0062~~	~~0.2425~~
~~3702~~	~~0.6049~~	~~0.0077~~	~~0.3852~~
~~3708~~	~~0.9478~~	~~0.0121~~	~~0.5421~~
~~3802~~	~~0.2737~~	~~0.0035~~	~~0.1907~~
~~3808~~	~~0.6291~~	~~0.0081~~	~~0.3114~~
~~3901~~	~~0.1547~~	~~0.0019~~	~~0.1453~~
~~3902~~	~~0.6113~~	~~0.0077~~	~~0.4606~~
~~3903~~	~~1.3960~~	~~0.0176~~	~~1.0822~~
~~3905~~	~~0.1591~~	~~0.0020~~	~~0.1452~~
~~3906~~	~~0.5980~~	~~0.0075~~	~~0.4531~~
~~3909~~	~~0.3362~~	~~0.0042~~	~~0.2825~~
~~4101~~	~~0.4119~~	~~0.0053~~	~~0.2288~~
~~4103~~	~~0.7422~~	~~0.0094~~	~~0.4748~~
~~4107~~	~~0.2642~~	~~0.0034~~	~~0.1579~~
~~4108~~	~~0.2207~~	~~0.0028~~	~~0.1468~~
~~4109~~	~~0.2706~~	~~0.0034~~	~~0.1928~~
~~4201~~	~~1.1775~~	~~0.0153~~	~~0.4473~~
~~4301~~	~~0.9748~~	~~0.0122~~	~~0.7666~~
~~4302~~	~~1.1757~~	~~0.0149~~	~~0.8023~~
~~4304~~	~~1.2137~~	~~0.0152~~	~~1.0182~~
~~4305~~	~~1.9322~~	~~0.0251~~	~~0.7966~~
~~4401~~	~~0.5708~~	~~0.0072~~	~~0.4249~~
~~4402~~	~~0.9893~~	~~0.0126~~	~~0.5929~~
~~4404~~	~~0.6626~~	~~0.0084~~	~~0.4242~~
~~4501~~	~~0.2266~~	~~0.0029~~	~~0.1672~~
~~4502~~	~~0.0805~~	~~0.0010~~	~~0.0503~~
~~4504~~	~~0.1479~~	~~0.0019~~	~~0.1171~~
~~4802~~	~~0.4462~~	~~0.0056~~	~~0.3662~~

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
~~4803~~	~~0.3711~~	~~0.0046~~	~~0.3890~~
~~4804~~	~~0.6814~~	~~0.0085~~	~~0.5911~~
~~4805~~	~~0.5327~~	~~0.0067~~	~~0.3997~~
~~4806~~	~~0.1096~~	~~0.0013~~	~~0.1145~~
~~4808~~	~~0.5994~~	~~0.0076~~	~~0.4097~~
~~4809~~	~~0.4461~~	~~0.0056~~	~~0.3677~~
~~4810~~	~~0.2329~~	~~0.0029~~	~~0.2267~~
~~4811~~	~~0.4886~~	~~0.0060~~	~~0.4916~~
~~4812~~	~~0.5739~~	~~0.0072~~	~~0.4173~~
~~4813~~	~~0.2295~~	~~0.0028~~	~~0.2460~~
~~4814~~	~~0.1353~~	~~0.0016~~	~~0.1642~~
~~4815~~	~~0.2512~~	~~0.0030~~	~~0.3418~~
~~4816~~	~~0.4043~~	~~0.0049~~	~~0.4570~~
~~4900~~	~~0.2521~~	~~0.0033~~	~~0.0960~~
~~4901~~	~~0.0672~~	~~0.0009~~	~~0.0322~~
~~4902~~	~~0.1487~~	~~0.0019~~	~~0.0924~~
~~4903~~	~~0.2227~~	~~0.0028~~	~~0.1446~~
~~4904~~	~~0.0260~~	~~0.0003~~	~~0.0188~~
~~4905~~	~~0.4612~~	~~0.0057~~	~~0.4595~~
~~4906~~	~~0.1588~~	~~0.0020~~	~~0.0905~~
~~4907~~	~~0.0840~~	~~0.0011~~	~~0.0694~~
~~4908~~	~~0.1223~~	~~0.0015~~	~~0.1104~~
~~4909~~	~~0.0503~~	~~0.0006~~	~~0.0563~~
~~4910~~	~~0.6862~~	~~0.0088~~	~~0.4021~~
~~4911~~	~~0.0906~~	~~0.0012~~	~~0.0532~~
~~5001~~	~~11.3189~~	~~0.1242~~	~~5.1745~~
~~5002~~	~~0.8755~~	~~0.0112~~	~~0.4793~~
~~5003~~	~~3.2727~~	~~0.0426~~	~~1.2129~~
~~5004~~	~~1.1271~~	~~0.0143~~	~~0.7275~~
~~5005~~	~~1.2131~~	~~0.0157~~	~~0.5685~~
~~5006~~	~~2.1904~~	~~0.0285~~	~~0.8105~~
~~5101~~	~~1.4926~~	~~0.0193~~	~~0.6461~~
~~5103~~	~~1.0221~~	~~0.0129~~	~~0.7455~~
~~5106~~	~~1.0221~~	~~0.0129~~	~~0.7455~~
~~5108~~	~~1.0999~~	~~0.0141~~	~~0.6487~~
~~5109~~	~~0.9601~~	~~0.0124~~	~~0.4186~~
~~5201~~	~~0.4741~~	~~0.0061~~	~~0.2619~~
~~5204~~	~~1.4709~~	~~0.0190~~	~~0.6460~~
~~5206~~	~~0.6557~~	~~0.0084~~	~~0.3269~~
~~5207~~	~~0.1969~~	~~0.0025~~	~~0.1666~~

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
~~5208~~	~~0.9988~~	~~0.0128~~	~~0.5911~~
~~5209~~	~~0.9962~~	~~0.0128~~	~~0.5103~~
~~5300~~	~~0.1339~~	~~0.0017~~	~~0.0879~~
~~5301~~	~~0.0454~~	~~0.0006~~	~~0.0282~~
~~5302~~	~~0.0146~~	~~0.0002~~	~~0.0083~~
~~5305~~	~~0.0700~~	~~0.0009~~	~~0.0486~~
~~5306~~	~~0.0600~~	~~0.0008~~	~~0.0448~~
~~5307~~	~~0.9915~~	~~0.0128~~	~~0.4604~~
~~5308~~	~~0.1145~~	~~0.0014~~	~~0.0868~~
~~6103~~	~~0.1145~~	~~0.0014~~	~~0.1000~~
~~6104~~	~~0.6408~~	~~0.0082~~	~~0.4026~~
~~6105~~	~~0.5983~~	~~0.0077~~	~~0.3184~~
~~6107~~	~~0.1544~~	~~0.0019~~	~~0.1704~~
~~6108~~	~~0.4278~~	~~0.0054~~	~~0.3546~~
~~6109~~	~~0.1661~~	~~0.0021~~	~~0.0863~~
~~6110~~	~~0.7593~~	~~0.0097~~	~~0.4520~~
~~6120~~	~~0.4394~~	~~0.0056~~	~~0.2354~~
~~6121~~	~~0.5039~~	~~0.0065~~	~~0.2541~~
~~6201~~	~~0.5123~~	~~0.0066~~	~~0.2785~~
~~6202~~	~~0.9911~~	~~0.0126~~	~~0.5992~~
~~6203~~	~~0.1344~~	~~0.0016~~	~~0.1500~~
~~6204~~	~~0.1744~~	~~0.0022~~	~~0.1307~~
~~6205~~	~~0.2578~~	~~0.0032~~	~~0.1985~~
~~6206~~	~~0.2508~~	~~0.0032~~	~~0.1849~~
~~6207~~	~~1.5705~~	~~0.0199~~	~~1.1285~~
~~6208~~	~~0.2937~~	~~0.0037~~	~~0.2667~~
~~6209~~	~~0.3623~~	~~0.0045~~	~~0.3197~~
~~6301~~	~~0.1951~~	~~0.0025~~	~~0.0841~~
~~6303~~	~~0.0876~~	~~0.0011~~	~~0.0494~~
~~6304~~	~~0.3059~~	~~0.0038~~	~~0.2940~~
~~6305~~	~~0.1290~~	~~0.0016~~	~~0.1032~~
~~6306~~	~~0.4724~~	~~0.0060~~	~~0.2810~~
~~6308~~	~~0.0890~~	~~0.0011~~	~~0.0506~~
~~6309~~	~~0.2639~~	~~0.0033~~	~~0.1806~~
~~6402~~	~~0.3327~~	~~0.0042~~	~~0.2698~~
~~6403~~	~~0.2081~~	~~0.0026~~	~~0.1630~~
~~6404~~	~~0.3650~~	~~0.0046~~	~~0.3106~~
~~6405~~	~~0.7441~~	~~0.0095~~	~~0.4223~~
~~6406~~	~~0.1651~~	~~0.0021~~	~~0.1316~~
~~6407~~	~~0.3392~~	~~0.0043~~	~~0.2464~~
~~6408~~	~~0.7245~~	~~0.0092~~	~~0.4422~~
~~6409~~	~~0.9524~~	~~0.0122~~	~~0.5063~~
~~6410~~	~~0.4693~~	~~0.0060~~	~~0.2658~~
~~6411~~	~~0.0977~~	~~0.0012~~	~~0.0791~~
~~6501~~	~~0.1511~~	~~0.0019~~	~~0.0943~~
~~6502~~	~~0.0393~~	~~0.0005~~	~~0.0277~~
~~6503~~	~~0.1159~~	~~0.0015~~	~~0.0605~~
~~6504~~	~~0.3971~~	~~0.0049~~	~~0.3729~~
~~6505~~	~~0.1623~~	~~0.0020~~	~~0.1703~~
~~6506~~	~~0.1638~~	~~0.0021~~	~~0.1241~~
~~6509~~	~~0.3592~~	~~0.0045~~	~~0.3075~~
~~6510~~	~~0.6686~~	~~0.0086~~	~~0.3188~~
~~6511~~	~~0.4214~~	~~0.0053~~	~~0.3183~~
~~6512~~	~~0.1385~~	~~0.0018~~	~~0.0766~~
~~6601~~	~~0.2779~~	~~0.0035~~	~~0.1886~~
~~6602~~	~~0.7157~~	~~0.0090~~	~~0.5668~~
~~6603~~	~~0.4108~~	~~0.0053~~	~~0.2382~~
~~6604~~	~~0.1149~~	~~0.0015~~	~~0.0822~~
~~6605~~	~~0.3719~~	~~0.0047~~	~~0.2384~~
~~6607~~	~~0.1735~~	~~0.0022~~	~~0.1271~~
~~6608~~	~~1.0503~~	~~0.0137~~	~~0.3290~~
~~6620~~	~~4.6749~~	~~0.0601~~	~~2.4618~~
~~6704~~	~~0.1608~~	~~0.0020~~	~~0.1137~~
~~6705~~	~~0.8586~~	~~0.0107~~	~~0.7963~~
~~6706~~	~~0.3448~~	~~0.0043~~	~~0.2768~~
~~6707~~	~~10.3724~~	~~0.1287~~	~~9.6607~~
~~6708~~	~~9.7527~~	~~0.1187~~	~~11.2448~~
~~6709~~	~~0.3245~~	~~0.0041~~	~~0.2533~~
~~6801~~	~~1.1877~~	~~0.0155~~	~~0.4156~~
~~6802~~	~~1.0446~~	~~0.0133~~	~~0.6430~~
~~6803~~	~~1.1518~~	~~0.0151~~	~~0.3142~~
~~6804~~	~~0.3688~~	~~0.0046~~	~~0.2790~~
~~6809~~	~~6.3082~~	~~0.0778~~	~~6.2741~~
~~6901~~	~~0.0000~~	~~0.0000~~	~~0.0631~~
~~6902~~	~~1.4030~~	~~0.0182~~	~~0.6212~~
~~6903~~	~~10.6938~~	~~0.1386~~	~~4.4650~~
~~6904~~	~~1.5152~~	~~0.0196~~	~~0.6356~~
~~6905~~	~~1.0063~~	~~0.0130~~	~~0.4681~~
~~6906~~	~~0.0000~~	~~0.0000~~	~~0.4681~~
~~6907~~	~~1.4021~~	~~0.0179~~	~~0.8712~~

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
~~6908~~	~~0.5299~~	~~0.0068~~	~~0.3202~~
~~6909~~	~~0.1689~~	~~0.0021~~	~~0.1148~~
~~7100~~	~~0.0444~~	~~0.0006~~	~~0.0291~~
~~7101~~	~~0.0393~~	~~0.0005~~	~~0.0201~~
~~7103~~	~~1.3026~~	~~0.0169~~	~~0.5793~~
~~7104~~	~~0.0359~~	~~0.0005~~	~~0.0245~~
~~7105~~	~~0.0272~~	~~0.0003~~	~~0.0173~~
~~7106~~	~~0.3164~~	~~0.0040~~	~~0.2565~~
~~7107~~	~~0.3084~~	~~0.0038~~	~~0.3257~~
~~7108~~	~~0.2347~~	~~0.0029~~	~~0.1898~~
~~7109~~	~~0.1672~~	~~0.0021~~	~~0.1224~~
~~7110~~	~~0.5104~~	~~0.0065~~	~~0.2967~~
~~7111~~	~~0.6668~~	~~0.0087~~	~~0.2621~~
~~7112~~	~~1.1913~~	~~0.0150~~	~~0.8718~~
~~7113~~	~~0.5408~~	~~0.0068~~	~~0.4255~~
~~7114~~	~~0.9453~~	~~0.0119~~	~~0.7571~~
~~7115~~	~~0.6748~~	~~0.0085~~	~~0.5277~~
~~7116~~	~~0.7090~~	~~0.0090~~	~~0.4338~~
~~7117~~	~~1.6927~~	~~0.0214~~	~~1.1904~~
~~7118~~	~~2.3210~~	~~0.0296~~	~~1.4619~~
~~7119~~	~~2.2885~~	~~0.0293~~	~~1.2757~~
~~7120~~	~~8.5336~~	~~0.1089~~	~~5.1263~~
~~7121~~	~~7.9002~~	~~0.1008~~	~~4.7706~~
~~7122~~	~~0.5081~~	~~0.0064~~	~~0.3469~~
~~7200~~	~~2.6630~~	~~0.0345~~	~~1.1002~~
~~7201~~	~~2.4379~~	~~0.0315~~	~~1.1072~~
~~7202~~	~~0.0398~~	~~0.0005~~	~~0.0231~~
~~7203~~	~~0.1320~~	~~0.0016~~	~~0.1640~~
~~7204~~	~~0.0000~~	~~0.0000~~	~~0.0000~~
~~7205~~	~~0.0000~~	~~0.0000~~	~~0.0000~~
~~7301~~	~~0.6586~~	~~0.0083~~	~~0.5160~~
~~7302~~	~~1.2161~~	~~0.0154~~	~~0.8259~~
~~7307~~	~~0.6155~~	~~0.0078~~	~~0.4460~~
~~7308~~	~~0.3416~~	~~0.0042~~	~~0.3160~~
~~7309~~	~~0.3432~~	~~0.0043~~	~~0.2875~~
~~7400~~	~~3.0624~~	~~0.0397~~	~~1.2652~~))
101	1.5016	0.0218	0.6002
103	2.0919	0.0302	1.0231
104	1.3892	0.0201	0.6059
105	1.4318	0.0205	0.8635
106	3.5957	0.0516	1.9986
107	1.5485	0.0226	0.5819
108	1.3892	0.0201	0.6059
112	0.9820	0.0141	0.5165
201	2.6488	0.0387	0.8894
202	3.5049	0.0511	1.2625
210	1.1804	0.0171	0.5099
212	1.5704	0.0228	0.6147
214	2.2702	0.0331	0.8068
217	1.7453	0.0252	0.8573
219	1.4411	0.0210	0.5401
301	1.0307	0.0147	0.6741
302	3.2940	0.0482	1.0582
303	3.0785	0.0447	1.2339
306	1.1483	0.0166	0.5096
307	1.2493	0.0181	0.5851
308	0.7056	0.0100	0.5133
403	2.5748	0.0371	1.3175
502	1.7616	0.0256	0.7104
504	2.8685	0.0413	1.4637
507	3.8754	0.0554	2.3974
508	1.9789	0.0289	0.7110
509	1.4534	0.0213	0.4576
510	3.1185	0.0448	1.7019
511	2.1777	0.0316	0.9172
512	1.7039	0.0245	0.8826
513	1.2157	0.0176	0.5875
514	1.9156	0.0276	1.0069
516	1.9240	0.0277	0.9643
517	2.6371	0.0380	1.3025
518	1.6675	0.0242	0.7124
519	1.8589	0.0269	0.8183
521	0.6041	0.0086	0.3859
601	0.6700	0.0097	0.3297
602	1.1660	0.0171	0.3454
603	0.9703	0.0141	0.3670
604	1.4577	0.0210	0.7867
606	0.6662	0.0095	0.4110
607	1.0228	0.0148	0.4967
608	0.5650	0.0082	0.2361

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund	Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
701	2.8875	0.0426	0.6492	2104	0.3494	0.0048	0.3910
803	0.7334	0.0106	0.3773	2105	0.8327	0.0119	0.4784
901	1.6675	0.0242	0.7124	2106	0.6047	0.0086	0.4029
1002	1.1885	0.0172	0.5788	2201	0.3438	0.0049	0.2378
1003	0.9388	0.0135	0.4912	2202	0.8926	0.0128	0.4805
1004	0.6537	0.0095	0.2662	2203	0.5926	0.0084	0.4470
1005	12.2018	0.1773	4.9640	2204	0.3438	0.0049	0.2378
1006	0.2563	0.0037	0.1495	2401	0.6175	0.0089	0.2788
1007	0.4156	0.0060	0.1906	2903	0.8368	0.0118	0.6387
1101	1.4340	0.0207	0.7365	2904	0.9992	0.0144	0.4956
1102	2.4357	0.0355	0.9163	2905	0.6137	0.0088	0.3877
1103	1.4763	0.0213	0.7416	2906	0.5574	0.0079	0.4337
1104	0.8289	0.0118	0.5224	2907	0.5779	0.0082	0.3853
1105	1.0840	0.0156	0.5432	2908	1.2457	0.0176	0.9396
1106	0.3998	0.0056	0.3062	2909	0.4744	0.0067	0.3693
1108	0.6309	0.0090	0.4058	3101	1.0485	0.0151	0.5610
1109	1.9664	0.0283	1.0473	3102	0.4866	0.0070	0.2276
1301	0.8432	0.0122	0.3795	3103	0.5644	0.0081	0.3191
1303	0.4626	0.0066	0.2568	3104	0.8420	0.0121	0.4873
1304	0.0298	0.0004	0.0151	3105	0.8962	0.0127	0.6745
1305	0.6793	0.0098	0.3216	3303	0.4915	0.0070	0.3077
1401	0.2773	0.0039	0.2530	3304	0.7069	0.0100	0.5610
1404	0.9411	0.0135	0.5418	3309	0.5560	0.0079	0.3445
1405	0.9450	0.0136	0.5283	3402	0.6384	0.0091	0.3757
1407	0.6921	0.0099	0.4435	3403	0.2273	0.0033	0.1265
1501	1.1171	0.0162	0.4929	3404	0.5733	0.0082	0.3642
1507	0.7015	0.0100	0.4375	3405	0.4123	0.0059	0.2446
1701	1.0130	0.0146	0.4769	3406	0.3374	0.0048	0.2421
1702	2.4927	0.0365	0.7647	3407	1.0535	0.0152	0.4932
1703	1.4341	0.0209	0.4865	3408	0.2774	0.0040	0.1582
1704	1.0130	0.0146	0.4769	3409	0.1785	0.0025	0.1317
1801	0.6222	0.0090	0.2815	3410	0.1966	0.0028	0.1495
1802	1.0043	0.0144	0.5320	3411	0.7514	0.0109	0.3522
2002	1.1916	0.0171	0.6379	3412	0.9471	0.0137	0.3938
2004	0.7065	0.0101	0.4451	3414	0.9870	0.0142	0.5250
2007	0.9000	0.0128	0.6007	3415	1.0736	0.0155	0.5630
2008	0.4662	0.0067	0.2857	3501	1.4025	0.0201	0.8058
2009	0.4623	0.0066	0.3319	3503	0.3743	0.0053	0.2812
2101	0.6972	0.0098	0.5303	3506	1.1159	0.0161	0.5543
2102	0.9424	0.0135	0.5299	3509	0.4641	0.0066	0.3275

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
3510	0.4401	0.0062	0.3132
3511	0.9651	0.0138	0.5737
3512	0.4604	0.0065	0.3496
3513	0.6043	0.0085	0.4788
3602	0.1174	0.0017	0.0768
3603	0.6897	0.0098	0.4665
3604	0.8958	0.0127	0.6206
3605	0.7184	0.0103	0.3830
3701	0.4866	0.0070	0.2276
3702	0.5466	0.0078	0.3451
3708	0.8811	0.0126	0.5193
3802	0.2453	0.0035	0.1761
3808	0.5754	0.0083	0.2877
3901	0.1560	0.0022	0.1391
3902	0.5917	0.0084	0.4391
3903	1.2908	0.0182	1.0023
3905	0.1394	0.0019	0.1315
3906	0.5856	0.0083	0.4307
3909	0.3224	0.0045	0.2707
4101	0.3534	0.0051	0.2080
4103	0.7004	0.0100	0.4460
4107	0.2593	0.0037	0.1450
4108	0.1984	0.0028	0.1341
4109	0.2472	0.0035	0.1934
4201	1.1717	0.0171	0.4353
4301	0.9561	0.0134	0.7800
4302	1.0243	0.0145	0.7122
4304	1.1381	0.0159	1.0057
4305	1.7625	0.0256	0.7440
4401	0.5296	0.0075	0.3963
4402	0.9235	0.0132	0.5448
4404	0.5740	0.0082	0.3718
4501	0.2101	0.0030	0.1535
4502	0.0807	0.0012	0.0497
4504	0.1383	0.0019	0.1094
4802	0.4429	0.0062	0.3640
4803	0.3564	0.0049	0.3733
4804	0.6531	0.0091	0.5686
4805	0.4648	0.0065	0.3711
4806	0.1114	0.0015	0.1173

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
4808	0.5929	0.0084	0.3870
4809	0.4093	0.0058	0.3190
4810	0.2418	0.0034	0.2224
4811	0.4701	0.0065	0.4785
4812	0.5644	0.0080	0.3923
4813	0.2234	0.0031	0.2459
4814	0.1247	0.0017	0.1519
4815	0.2313	0.0031	0.3166
4816	0.3728	0.0051	0.4234
4900	0.2023	0.0029	0.0801
4901	0.0599	0.0009	0.0290
4902	0.1258	0.0018	0.0802
4903	0.2079	0.0030	0.1309
4904	0.0221	0.0003	0.0160
4905	0.4308	0.0060	0.4191
4906	0.1459	0.0021	0.0816
4907	0.0764	0.0011	0.0685
4908	0.1122	0.0016	0.0989
4909	0.0463	0.0006	0.0517
4910	0.6344	0.0091	0.3739
4911	0.0789	0.0011	0.0468
5001	10.9970	0.1592	4.9292
5002	0.8109	0.0117	0.4437
5003	3.0397	0.0443	1.1514
5004	1.0444	0.0149	0.6621
5005	1.2032	0.0174	0.5237
5006	1.9702	0.0287	0.7225
5101	1.4437	0.0210	0.5953
5103	0.9793	0.0139	0.7232
5106	0.9793	0.0139	0.7232
5108	1.0468	0.0150	0.5948
5109	0.8801	0.0128	0.3804
5201	0.4182	0.0060	0.2433
5204	1.3891	0.0202	0.5821
5206	0.6182	0.0089	0.3117
5207	0.1829	0.0026	0.1518
5208	0.9010	0.0129	0.5457
5209	0.8604	0.0124	0.4503
5300	0.1219	0.0017	0.0792
5301	0.0448	0.0006	0.0262

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund	Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
5302	0.0132	0.0002	0.0073	6502	0.0373	0.0005	0.0238
5305	0.0645	0.0009	0.0425	6503	0.1081	0.0016	0.0564
5306	0.0532	0.0008	0.0409	6504	0.3735	0.0052	0.3576
5307	0.9377	0.0136	0.4219	6505	0.1629	0.0022	0.1715
5308	0.1095	0.0015	0.0832	6506	0.1660	0.0024	0.1192
6103	0.1052	0.0015	0.0933	6509	0.3234	0.0045	0.2779
6104	0.5486	0.0078	0.3633	6510	0.6680	0.0097	0.3007
6105	0.5992	0.0086	0.3046	6511	0.3490	0.0049	0.2692
6107	0.1466	0.0020	0.1660	6512	0.1239	0.0018	0.0684
6108	0.3923	0.0055	0.3226	6601	0.2341	0.0033	0.1673
6109	0.1569	0.0023	0.0786	6602	0.6506	0.0092	0.5265
6110	0.7116	0.0102	0.3952	6603	0.3912	0.0056	0.2324
6120	0.4286	0.0062	0.2339	6604	0.1062	0.0015	0.0767
6121	0.4734	0.0068	0.2320	6605	0.3405	0.0049	0.2171
6201	0.5513	0.0079	0.2934	6607	0.1511	0.0021	0.1136
6202	1.0078	0.0144	0.5965	6608	0.9453	0.0138	0.2969
6203	0.1147	0.0016	0.1364	6620	4.3208	0.0621	2.3222
6204	0.1656	0.0023	0.1271	6704	0.1559	0.0022	0.1093
6205	0.2428	0.0034	0.1789	6705	0.7418	0.0103	0.7073
6206	0.2368	0.0034	0.1731	6706	0.3074	0.0043	0.2464
6207	1.4349	0.0204	0.9866	6707	12.2291	0.1710	10.7834
6208	0.2717	0.0038	0.2535	6708	9.0596	0.1238	10.5073
6209	0.3281	0.0046	0.2948	6709	0.3070	0.0043	0.2398
6301	0.1767	0.0026	0.0772	6801	1.1649	0.0170	0.3806
6303	0.0766	0.0011	0.0452	6802	1.0784	0.0154	0.6287
6305	0.1135	0.0016	0.0908	6803	1.0463	0.0154	0.2713
6306	0.4254	0.0061	0.2543	6804	0.3576	0.0051	0.2651
6308	0.0801	0.0011	0.0464	6809	5.3182	0.0735	5.4676
6309	0.2398	0.0034	0.1768	6901	0.0000	0.0000	0.0590
6402	0.3019	0.0042	0.2486	6902	1.3180	0.0191	0.6181
6403	0.1866	0.0026	0.1445	6903	9.5845	0.1392	3.9507
6404	0.3561	0.0050	0.2965	6904	1.6496	0.0240	0.6278
6405	0.7502	0.0108	0.4168	6905	1.1174	0.0162	0.4781
6406	0.1704	0.0024	0.1307	6906	0.0000	0.0000	0.4521
6407	0.3416	0.0048	0.2393	6907	1.2181	0.0174	0.7544
6408	0.7010	0.0101	0.4003	6908	0.5008	0.0072	0.2956
6409	0.9059	0.0130	0.4860	6909	0.1529	0.0022	0.1033
6410	0.4217	0.0060	0.2438	7100	0.0411	0.0006	0.0267
6411	0.0761	0.0011	0.0611	7101	0.0357	0.0005	0.0182
6501	0.1298	0.0019	0.0818	7103	1.2786	0.0186	0.5242

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
7104	0.0337	0.0005	0.0217
7105	0.0248	0.0004	0.0159
7106	0.3300	0.0047	0.2474
7107	0.3097	0.0043	0.3166
7108	0.2293	0.0032	0.1820
7109	0.1455	0.0021	0.1044
7110	0.4996	0.0072	0.2881
7111	0.5866	0.0085	0.2276
7112	1.0276	0.0145	0.7606
7113	0.4894	0.0069	0.3769
7114	0.8853	0.0125	0.7165
7115	0.6155	0.0086	0.5105
7116	0.6020	0.0086	0.3613
7117	1.6310	0.0232	1.0962
7118	2.1539	0.0308	1.3329
7119	2.1123	0.0304	1.1251
7120	7.8824	0.1128	4.7317
7121	7.2755	0.1041	4.3794
7122	0.4736	0.0067	0.3395
7200	2.4920	0.0363	0.9706
7201	2.1380	0.0310	0.9560
7202	0.0376	0.0005	0.0219
7203	0.1198	0.0016	0.1485
7204	0.0000	0.0000	0.0000

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund
7205	0.0000	0.0000	0.0000
7301	0.6481	0.0091	0.5379
7302	1.1060	0.0157	0.7676
7307	0.5980	0.0085	0.4263
7308	0.2933	0.0041	0.2857
7309	0.3095	0.0043	0.2614
7400	2.8658	0.0417	1.1163

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17-89502 Industrial insurance accident fund, stay at work, medical aid and supplemental pension rates by class of industry for nonhourly rated classifications. The base rates as set forth below are for classifications whose premium rates are based on units other than hours worked.

Class	Base Rates Effective January 1, ((~~2018~~)) 2019 Accident Fund	Stay at Work	Medical Aid Fund	Supplemental Pension Fund
((~~0540~~	~~0.0378~~	~~0.0005~~	~~0.0165~~	~~0.0008~~
~~0541~~	~~0.0156~~	~~0.0002~~	~~0.0081~~	~~0.0008~~
~~0550~~	~~0.0559~~	~~0.0007~~	~~0.0237~~	~~0.0008~~
~~0551~~	~~0.0249~~	~~0.0003~~	~~0.0106~~	~~0.0008~~))
0540	0.0345	0.0005	0.0154	0.0009
0541	0.0125	0.0002	0.0068	0.0009
0550	0.0523	0.0008	0.0229	0.0009
0551	0.0227	0.0003	0.0102	0.0009

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17-89507 Horse racing rates. Horse racing industry industrial insurance accident fund, stay at work fund, medical aid fund, supplemental pension fund and composite rate by class.

Base Rates Effective January 1, ((~~2018~~)) 2019

Class	Accident Fund	Stay at Work Fund	Medical Aid Fund	Supplemental Pension Fund	Composite Rate
((~~6618~~	~~80.00*~~	~~2.00*~~	~~67.00*~~	~~1.00*~~	~~150.00*~~
~~6625~~	~~70.60**~~	~~1.02**~~	~~72.43**~~	~~10.30**~~	~~154.35*~~
~~6626~~	~~0.5994***~~	~~0.0091***~~	~~0.6885***~~	~~0.1030***~~	~~1.40*~~
~~6627~~	~~9.4016****~~	~~0.1359****~~	~~8.4400****~~	~~0.7725****~~	~~18.75*~~))
6618	80.00*	2.00*	67.00*	1.00*	150.00*
6625	68.10**	1.10**	70.99**	11.20**	151.39**
6626	0.6009***	0.0090***	0.6481***	0.1120***	1.37***
6627	9.0993****	0.1467****	8.0340****	0.8400****	18.12****

*This rate is calculated on a percentage of ownership in a horse or horses.

**This rate is calculated per month.
***This rate is calculated per horse per day.
****This rate is calculated per day.

Note: These rates are not subject to experience rating or retrospective rating.

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17-901 Risk classification hazard group table. Effective June 30, 2017.

Risk Classification	Hazard Group
101	9
103	9
104	8
105	4
106	7
107	9
108	9
112	7
201	9
202	9
210	9
212	9
214	8
217	8
219	8
301	5
302	9
303	9
306	8
307	7
308	3
403	7
502	8
504	9
507	8
508	9
509	9
510	7
511	7
512	9
513	7
514	6
516	8
517	9
518	9
519	8
521	8
540	9
541	9
550	9
551	9
601	7
602	8
603	9
604	7
606	4
607	6
608	7
701	8
803	4
901	9
1002	7
1003	6
1004	5
1005	8
1006	4
1007	7
1101	5
1102	8
1103	8
1104	3
1105	7
1106	6
1108	6
1109	7
1301	3
1303	3
1304	5
1305	6
1401	8
1404	3
1405	3
1407	4
1501	5
1507	6
1701	6
1702	9
1703	9

Risk Classification	Hazard Group
1704	6
1801	7
1802	6
2002	6
2004	4
2007	7
2008	6
2009	3
2101	6
2102	5
2104	2
2105	3
2106	5
2201	4
2202	5
2203	3
2204	4
2401	4
2903	4
2904	4
2905	5
2906	5
2907	2
2908	7
2909	4
3101	5
3102	6
3103	7
3104	6
3105	5
3303	3
3304	3
3309	6
3402	6
3403	6
3404	4
3405	3
3406	1
3407	7
3408	1
3409	1
3410	2
3411	6
3412	8
3414	7
3415	9
3501	6
3503	3
3506	5
3509	1
3510	3
3511	6
3512	3
3513	5
3602	3
3603	4
3604	7
3605	5
3701	6
3702	4
3708	5
3802	4
3808	7
3901	1
3902	3
3903	6
3905	1
3906	4
3909	5
4101	5
4103	5
4107	6
4108	3
4109	4
4201	6
4301	4
4302	4
4304	5
4305	5
4401	6
4402	1
4404	6
4501	1
4502	5
4504	1
4601	6

Risk Classification	Hazard Group
4802	6
4803	2
4804	2
4805	2
4806	3
4808	6
4809	3
4810	2
4811	3
4812	3
4813	3
4814	2
4815	1
4816	5
4900	9
4901	5
4902	3
4903	2
4904	2
4905	1
4906	2
4907	3
4908	1
4909	5
4910	6
4911	6
5001	9
5002	4
5003	9
5004	7
5005	9
5006	9
5101	8
5103	4
5106	3
5108	5
5109	6
5201	4
5204	8
5206	7
5207	3
5208	5
5209	6

Risk Classification	Hazard Group
5300	1
5301	3
5302	3
5305	2
5306	1
5307	4
5308	1
6103	1
6104	3
6105	5
6107	1
6108	1
6109	4
6110	4
6120	3
6121	7
6201	7
6202	6
6203	1
6204	2
6205	3
6206	2
6207	6
6208	1
6209	4
6301	7
6303	5
((~~6304~~	~~1~~))
6305	1
6306	4
6308	5
6309	3
6402	1
6403	2
6404	3
6405	5
6406	3
6407	2
6408	7
6409	6
6410	3
6411	1
6501	1

Risk Classification	Hazard Group
6502	3
6503	4
6504	1
6505	1
6506	2
6509	2
6510	8
6511	3
6512	7
6601	4
6602	4
6603	4
6604	1
6605	2
6607	4
6608	9
6620	1
6704	1
6705	1
6706	4
6707	1
6708	7
6709	3
6801	5
6802	3
6803	9
6804	4
6809	1
6901	1
6902	9
6903	9
6904	4
6905	3
6906	1
6907	5
6908	4
6909	3
7100	7
7101	7
7102	3
7103	5
7104	3
7105	3
7106	3
7107	2
7108	5
7109	4
7110	5
7111	3
7112	3
7113	3
7114	5
7115	3
7116	8
7117	5
7118	8
7119	6
7120	9
7121	9
7122	5
7200	6
7201	6
7202	5
7203	1
7301	6
7302	7
7307	4
7308	3
7309	1
7400	5

The following classes have no hazard group assigned to them

6618
6625
6626
6627
7204
7205

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17-920 Assessment for supplemental pension fund. The amount of ((~~51.5~~)) 56.0 mils ($((~~0.0515~~)) 0.056) shall be retained by each employer from the earnings of each worker for each hour or fraction thereof the worker is employed. The amount of money so retained from the employee shall be matched in an equal amount by each employer, except as otherwise provided in these rules, all such moneys shall be remitted to the department on or before

the last day of January, April, July, and October of each year for the preceding calendar quarter, provided self-insured employers shall remit to the department as provided under WAC 296-15-229. All such moneys shall be deposited in the supplemental pension fund.

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17B-540 Determining loss incurred for each claim. (1) Calculating the initial loss incurred:

For each of your claims, we will multiply the case incurred loss by the appropriate discounted loss development factors to determine the initial loss incurred.

If you have a fatality, we will use ((~~three hundred thirty-five thousand~~)) three hundred fifty-seven thousand two hundred dollars as the claim's initial incurred loss for the claim, with ((~~two hundred ninety-eight thousand eight hundred~~)) three hundred twenty-three thousand dollars for accident fund incurred loss and ((~~thirty-six thousand two hundred~~)) thirty-four thousand two hundred dollars for the medical aid incurred loss, regardless of the case incurred loss, and before recovery factors if applicable.

(2) Applying the single loss occurrence limit:

The initial loss incurred for a claim will be the amount we use as the loss incurred unless the single loss occurrence limit applies.

The single loss occurrence limit applies when the sum of all initial losses incurred for your claims arising out of a single event is greater than your selected single loss occurrence limit. In that case, each claim's initial loss incurred will be its proportionate share of your single loss occurrence limit.

(3) Applying the expected loss ratio factors:

The preliminary loss incurred for a claim will be the amount of the initial loss incurred, after application of the single loss limit, multiplied by the appropriate expected loss ratio factor. The accident fund and medical aid fund portions of each claim will have separate expected loss ratio factors applied.

AMENDATORY SECTION (Amending WSR 17-24-041, filed 11/30/17, effective 1/1/18)

WAC 296-17B-900 Retrospective rating plans standard premium size ranges.

RETROSPECTIVE RATING STANDARD PREMIUM SIZE RANGES

Effective January 1, ((~~2018~~)) 2019

Size Group Number	Standard Premium Range From:		To:
((~~1~~	~~5,870~~	-	~~6,859~~
~~2~~	~~6,860~~	-	~~7,759~~
~~3~~	~~7,760~~	-	~~8,729~~
~~4~~	~~8,730~~	-	~~9,779~~
~~5~~	~~9,780~~	-	~~10,899~~
~~6~~	~~10,900~~	-	~~12,099~~
~~7~~	~~12,100~~	-	~~13,379~~
~~8~~	~~13,380~~	-	~~14,739~~
~~9~~	~~14,740~~	-	~~16,179~~
~~10~~	~~16,180~~	-	~~17,699~~
~~11~~	~~17,700~~	-	~~19,309~~
~~12~~	~~19,310~~	-	~~21,039~~
~~13~~	~~21,040~~	-	~~22,869~~
~~14~~	~~22,870~~	-	~~24,809~~
~~15~~	~~24,810~~	-	~~26,839~~
~~16~~	~~26,840~~	-	~~29,019~~
~~17~~	~~29,020~~	-	~~31,309~~
~~18~~	~~31,310~~	-	~~33,749~~
~~19~~	~~33,750~~	-	~~36,309~~
~~20~~	~~36,310~~	-	~~39,029~~
~~21~~	~~39,030~~	-	~~41,939~~
~~22~~	~~41,940~~	-	~~45,009~~
~~23~~	~~45,010~~	-	~~48,269~~
~~24~~	~~48,270~~	-	~~51,739~~
~~25~~	~~51,740~~	-	~~55,419~~
~~26~~	~~55,420~~	-	~~59,339~~
~~27~~	~~59,340~~	-	~~63,509~~
~~28~~	~~63,510~~	-	~~67,949~~
~~29~~	~~67,950~~	-	~~72,679~~
~~30~~	~~72,680~~	-	~~77,739~~
~~31~~	~~77,740~~	-	~~83,149~~
~~32~~	~~83,150~~	-	~~88,939~~
~~33~~	~~88,940~~	-	~~95,149~~
~~34~~	~~95,150~~	-	~~101,699~~
~~35~~	~~101,700~~	-	~~108,899~~
~~36~~	~~108,900~~	-	~~116,699~~
~~37~~	~~116,700~~	-	~~125,099~~
~~38~~	~~125,100~~	-	~~133,999~~
~~39~~	~~134,000~~	-	~~143,799~~
~~40~~	~~143,800~~	-	~~154,199~~
~~41~~	~~154,200~~	-	~~165,399~~
~~42~~	~~165,400~~	-	~~177,499~~
~~43~~	~~177,500~~	-	~~190,499~~
~~44~~	~~190,500~~	-	~~204,699~~
~~45~~	~~204,700~~	-	~~219,999~~
~~46~~	~~220,000~~	-	~~236,699~~
~~47~~	~~236,700~~	-	~~254,599~~
~~48~~	~~254,600~~	-	~~274,599~~
~~49~~	~~274,600~~	-	~~296,199~~

Size Group Number	Standard Premium Range From:		To:
~~50~~	~~296,200~~	~~-~~	~~319,899~~
~~51~~	~~319,900~~	~~-~~	~~346,199~~
~~52~~	~~346,200~~	~~-~~	~~375,399~~
~~53~~	~~375,400~~	~~-~~	~~408,099~~
~~54~~	~~408,100~~	~~-~~	~~444,399~~
~~55~~	~~444,400~~	~~-~~	~~485,299~~
~~56~~	~~485,300~~	~~-~~	~~531,799~~
~~57~~	~~531,800~~	~~-~~	~~584,299~~
~~58~~	~~584,300~~	~~-~~	~~644,899~~
~~59~~	~~644,900~~	~~-~~	~~714,699~~
~~60~~	~~714,700~~	~~-~~	~~796,399~~
~~61~~	~~796,400~~	~~-~~	~~892,299~~
~~62~~	~~892,300~~	~~-~~	~~1,005,999~~
~~63~~	~~1,006,000~~	~~-~~	~~1,144,999~~
~~64~~	~~1,145,000~~	~~-~~	~~1,314,999~~
~~65~~	~~1,315,000~~	~~-~~	~~1,527,999~~
~~66~~	~~1,528,000~~	~~-~~	~~1,802,999~~
~~67~~	~~1,803,000~~	~~-~~	~~2,164,999~~
~~68~~	~~2,165,000~~	~~-~~	~~2,671,999~~
~~69~~	~~2,672,000~~	~~-~~	~~3,417,999~~
~~70~~	~~3,418,000~~	~~-~~	~~4,648,999~~
~~71~~	~~4,649,000~~	~~-~~	~~6,967,999~~
~~72~~	~~6,968,000~~	~~-~~	~~12,749,999~~
~~73~~	~~12,750,000~~	~~-~~	~~32,629,999~~
~~74~~	~~32,630,000~~	~~-~~	~~and over~~))
1	5,430	-	6,349
2	6,350	-	7,179
3	7,180	-	8,079
4	8,080	-	9,049
5	9,050	-	10,079
6	10,080	-	11,189
7	11,190	-	12,379
8	12,380	-	13,629
9	13,630	-	14,969
10	14,970	-	16,369
11	16,370	-	17,859
12	17,860	-	19,459
13	19,460	-	21,149
14	21,150	-	22,949
15	22,950	-	24,829
16	24,830	-	26,839
17	26,840	-	28,959

Size Group Number	Standard Premium Range From:		To:
18	28,960	-	31,219
19	31,220	-	33,589
20	33,590	-	36,099
21	36,100	-	38,789
22	38,790	-	41,629
23	41,630	-	44,649
24	44,650	-	47,859
25	47,860	-	51,259
26	51,260	-	54,889
27	54,890	-	58,749
28	58,750	-	62,849
29	62,850	-	67,229
30	67,230	-	71,909
31	71,910	-	76,909
32	76,910	-	82,269
33	82,270	-	88,009
34	88,010	-	94,069
35	94,070	-	100,699
36	100,700	-	107,899
37	107,900	-	115,699
38	115,700	-	123,999
39	124,000	-	132,999
40	133,000	-	142,599
41	142,600	-	152,999
42	153,000	-	164,199
43	164,200	-	176,199
44	176,200	-	189,299
45	189,300	-	203,499
46	203,500	-	218,899
47	218,900	-	235,499
48	235,500	-	253,999
49	254,000	-	273,999
50	274,000	-	295,899
51	295,900	-	320,199
52	320,200	-	347,199
53	347,200	-	377,499
54	377,500	-	411,099
55	411,100	-	448,899
56	448,900	-	491,899
57	491,900	-	540,499
58	540,500	-	596,499
59	596,500	-	661,099

Size Group Number	Standard Premium Range From:		To:
60	661,100	-	736,699
61	736,700	-	825,399
62	825,400	-	930,599
63	930,600	-	1,058,999
64	1,059,000	-	1,215,999
65	1,216,000	-	1,412,999
66	1,413,000	-	1,667,999
67	1,668,000	-	2,002,999
68	2,003,000	-	2,471,999
69	2,472,000	-	3,161,999
70	3,162,000	-	4,299,999
71	4,300,000	-	6,444,999
72	6,445,000	-	11,789,999
73	11,790,000	-	30,179,999
74	30,180,000	-	and over

WSR 18-19-082
PROPOSED RULES
DEPARTMENT OF LABOR AND INDUSTRIES
(Board of Boiler Rules)

[Filed September 18, 2018, 10:27 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-14-113.

Title of Rule and Other Identifying Information: Proposed amendments and fee increase to the boiler rules in chapter 296-104 WAC, Board of boiler rules—Substantive.

Hearing Location(s): On November 14, 2018, at 10:00 a.m., at the Department of Labor and Industries (L&I), 950 Broadway, Suite 200, Tacoma, WA 98402-4453.

Date of Intended Adoption: November 20, 2018.

Submit Written Comments to: Alicia Curry, L&I, P.O. Box 44400, Olympia, WA 98504-4400, email Alicia.Curry@Lni.wa.gov, fax 360-902-5292, by 11 a.m., on November 13, 2018.

Assistance for Persons with Disabilities: Contact Alicia Curry, phone 360-902-6244, fax 360-902-5292, email Alicia.Curry@Lni.wa.gov, by October 31, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The board of boiler rules and L&I's boiler program is proposing amendments to adopt new safety codes, update and clarify existing rules, and increase fees by the fiscal growth factor of four percent. The fee increase is the office of financial management's maximum allowable fiscal growth factor for fiscal year 2019. The boiler program's budget and projected revenue indicate a fee increase is necessary to cover the program's operating expenses.

Proposed amendments to this chapter will:

- Amend the definition of "hot water heater" to clarify existing requirements.
- Replace the "A" endorsement with authorized inspector commission to align with National Board Inspection Code (NBIC), NB-263 RCI-1 for inspector commissions and endorsements.
- Amend language to align with NBIC, current edition, Part 4 for installation, inservice inspection, and repair of pressure relief devices.
- Adopt NBIC, current edition, Part 1, as the standard for installation of nonnuclear boilers, unfired pressure vessels and safety devices.
- Clarify the duties of in-service inspectors in relation to other standards and requirements for which other regulatory agencies have authority or responsibility.
- Adopt the Uniform Plumbing Code (UPC), Section 608.5 with Washington state amendments as discharge piping requirements for water heaters.
- Replace Supplement 10 with Supplement 7 for nonnuclear repairs and alterations to align the rule with NBIC, current edition, Part 3.
- Increase fees by the fiscal-growth factor of four percent to cover operating expenses.

Reasons Supporting Proposal: This rule making is needed to ensure the rules are consistent with national safety standards and industry practice for the proper construction, installation, inspection, operation, maintenance, alterations, and repairs of boilers and unfired pressure vessels to protect public safety.

The fee increase ensures the boiler program's revenues match expenditures; otherwise, service levels may need to be reduced. The last fiscal-growth increase took effect on January 31, 2018. According to RCW 70.79.330 and 70.79.350, a fee schedule for inspections is to be set by the board of boiler rules and the fees are to be used to administer the boiler program.

Statutory Authority for Adoption: Chapter 70.79 RCW, Boilers and unfired pressure vessels.

Statute Being Implemented: Chapter 70.79 RCW, Boilers and unfired pressure vessels.

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

Name of Proponent: Board of boiler rules, L&I, governmental.

Name of Agency Personnel Responsible for Drafting: Tony Oda, Program Manager, Tumwater, Washington, 360-902-5270; Implementation and Enforcement: David Puente, Jr., Assistant Director, Tumwater, Washington, 360-902-6348.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. This rule is exempt from the cost-benefit analysis requirement under the Administrative Procedure Act: RCW 34.05.328 (5)(b)(iii), rules adopting or incorporating by reference, without material change, national consensus codes; RCW 34.05.328 (5)(b)(vi) rules that set or adjust fees; RCW 34.05.328 (5)(b)(iv), rules that clarify language without

changing its effect; and RCW 34.05.328 (5)(b)(v), rules the content of which is explicitly and specifically dictated by statute.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules are adopting or incorporating by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule; rules only correct typographical errors, make address or name changes, or clarify language of a rule without changing its effect; rule content is explicitly and specifically dictated by statute; and rules set or adjust fees under the authority of RCW 19.02.075 or that set or adjust fees or rates pursuant to legislative standards, including fees set or adjusted under the authority of RCW 19.80.045.

September 18, 2018
Terry Chapin, Chair
Board of Boiler Rules

AMENDATORY SECTION (Amending WSR 18-01-113, filed 12/19/17, effective 1/31/18)

WAC 296-104-010 Administration—What are the definitions of terms used in this chapter? "Accident" shall mean a failure of the boiler or unfired pressure vessel resulting in personal injury or property loss or an event which renders a boiler or unfired pressure vessel unsafe to return to operation.

"Agriculture purposes" shall mean any act performed on a farm in production of crops or livestock, and shall include the storage of such crops and livestock in their natural state, but shall not be construed to include the processing or sale of crops or livestock.

"Attendant" shall mean the person in charge of the operation of a boiler or unfired pressure vessel.

"Automatic operation of a boiler" shall mean automatic unattended control of feed water and fuel in order to maintain the pressure and temperature within the limits set. Controls must be such that the operation follows the demand without interruption. Manual restart may be required when the burner is off because of low water, flame failure, power failure, high temperatures or pressures.

"Board of boiler rules" or **"board"** shall mean the board created by law and empowered under RCW 70.79.010.

"Boiler and unfired pressure vessel installation/reinstallation permit," shall mean a permit approved by the chief inspector before starting installation or reinstallation of any boiler and unfired pressure vessel within the jurisdiction of Washington.

"Boilers and/or unfired pressure vessels" - Below are definitions for types of boilers and unfired pressure vessels used in these regulations:

- **"Boiler/unfired pressure vessel status"** shall mean:

* Active - Boilers or pressure vessels that are currently in service.
* Inactive - Boilers or pressure vessels still located at the facility but are physically disconnected from the energy input and system.
* Out-of-service - Boilers or pressure vessels that are no longer at the facility.
* Scrapped - Boilers or pressure vessels that have been condemned as defined below.

- **"Condemned boiler or unfired pressure vessel"** shall mean a boiler or unfired pressure vessel that has been inspected and declared unsafe or disqualified for further use by legal requirements. The following procedure shall be utilized:

(a) The inspector will issue and follow the department's "red tag" procedure.
(b) The object will be immediately removed from service.
(c) The existing national board and state number shall be obliterated by the inspector.
(d) The ASME nameplate and/or stamping shall be physically removed by the owner/user and verified by the inspector.
(e) If required by the inspector, a portion of the pressure vessel shall be physically removed by the owner/user. This action will render the object incapable of holding pressure.
(f) The inspector shall document this procedure on the boiler/pressure vessel inspection report and change the object status to "scrapped."

- **"Corrosion"** shall mean the destruction or deterioration of a material, that results from a reaction with its environment.
- **"Expansion tank"** shall mean a tank used to absorb excess water pressure. Expansion tanks installed in closed water heating systems and hot water supply systems shall meet the requirements of ASME Section IV, HG-709.
- **"Historical boilers and unfired pressure vessel"** shall mean nonstandard boilers and pressure vessels including steam tractors, traction engines, hobby steam boilers, portable steam boilers, and other such boilers or pressure vessels that are preserved, restored, and maintained only for demonstration, viewing, or educational purposes. They do not include miniature hobby boilers as described in RCW 70.79.070.
- **"Hot water heater"** shall mean a closed vessel designed to supply hot water for external use to the system.

* All vessels must be listed by a nationally recognized testing agency ((~~and~~)).
* Shall be protected with an approved temperature and pressure safety relief valve ((~~and~~)) with the appropriate pressure and relieving capacity ratings.
* The hot water heater shall not exceed any of the following limits:
* Pressure of 160 psi (1100 kpa);
* Temperature of 210 degrees F (99°C).
* 120 gallons in capacity.
* 200,000 Btu/hr (58.6 kW).

Additional requirements:

* Hot water heaters exceeding 120 gallons (454 liters) must be ASME code stamped;
* Hot water heaters exceeding 200,000 Btu/hr (((~~58.58~~)) 58.6 kW) input must be ASME code stamped.

- **"Indirect water heater"** shall mean a closed vessel appliance used to heat water for use external to itself, which includes a heat exchanger used to transfer heat to water from an external source. The requirements and limits described above shall apply.
- **"Installer"** shall mean any entity or individual who physically or mechanically installs a boiler, pressure vessel or water heater that meets the in-service inspection requirements of this chapter. The installer is defined as a registered contractor, owner, user or designee.
- **"Low pressure boiler"** shall mean a steam boiler operating at a pressure not exceeding 15 psig or a boiler in which water is heated and intended for operation at pressures not exceeding 160 psig or temperatures not exceeding 250 degrees F by the direct application of energy from the combustion of fuels or from electricity, solar or nuclear energy. Low pressure boilers open to atmosphere and vacuum boilers are excluded.
- **"Nonstandard boiler or unfired pressure vessel"** shall mean a boiler or unfired pressure vessel that does not bear marking of the codes adopted in WAC 296-104-200.
- **"Pool heaters"** shall mean a gas, oil, or electric appliance that is used to heat water contained in swimming pools, spas, and hot tubs.

(a) Pool heaters with energy input equivalent to 399,999 Btu/hr (117.2 kW) or less shall be manufactured and certified to ANSI Z21.56, UL1261, CSA 4.7 or equivalent manufacturing standards, as approved by the chief inspector, and are excluded from the limit and control devices requirements of WAC 296-104-300 through 296-104-303.

(b) Pool heaters with energy input of 400,000 Btu/hr and above shall be stamped with an ASME Section IV Code symbol, and the requirements of WAC 296-104-300 through 296-104-303 shall apply.

(c) Pool heaters open to the atmosphere are excluded.

- **"Power boiler"** shall mean a boiler in which steam or other vapor is generated at a pressure of more than 15 psig for use external to itself or a boiler in which water is heated and intended for operation at pressures in excess of 160 psig and/or temperatures in excess of 250 degrees F by the direct application of energy from the combustion of fuels or from electricity, solar or nuclear energy.
- **"Reinstalled boiler or unfired pressure vessel"** shall mean a boiler or unfired pressure vessel removed from its original setting and reset at the same location or at a new location without change of ownership.
- **"Rental boiler"** shall mean any power or low pressure heating boiler that is under a rental contract between owner and user.
- **"Second hand boiler or unfired pressure vessel"** shall mean a boiler or unfired pressure vessel of which both the location and ownership have changed after primary use.
- **"Standard boiler or unfired pressure vessel"** shall mean a boiler or unfired pressure vessel which bears the marking of the codes adopted in WAC 296-104-200.
- **"Unfired pressure vessel"** shall mean a closed vessel under pressure excluding:

* Fired process tubular heaters;
* Pressure containers which are integral parts of components of rotating or reciprocating mechanical devices where the primary design considerations and/or stresses are derived from the functional requirements of the device;
* Piping whose primary function is to transport fluids from one location to another;
* Those vessels defined as low pressure heating boilers or power boilers.

- **"Unfired steam boiler"** shall mean a pressure vessel in which steam is generated by an indirect application of heat. It shall not include pressure vessels known as evaporators, heat exchangers, or vessels in which steam is generated by the use of heat resulting from the operation of a processing system containing a number of pressure vessels, such as used in the manufacture of chemical and petroleum products, which will be classed as unfired pressure vessels.

"Certificate of competency" shall mean a certificate issued by the Washington state board of boiler rules to a person who has passed the tests as set forth in WAC 296-104-050.

"Certificate of inspection" shall mean a certificate issued by the chief boiler inspector to the owner/user of a boiler or unfired pressure vessel upon inspection by an inspector. The boiler or unfired pressure vessel must comply with rules, regulations, and appropriate fee payment shall be made directly to the chief boiler inspector.

"Code, API-510" shall mean the Pressure Vessel Inspection Code of the American Petroleum Institute with addenda and revisions, thereto made and approved by the institute which have been adopted by the board of boiler rules in accordance with the provisions of RCW 70.79.030.

"Code, ASME" shall mean the boiler and pressure vessel code of the American Society of Mechanical Engineers with addenda thereto made and approved by the council of the society which have been adopted by the board of boiler rules in accordance with the provisions of RCW 70.79.030.

"Code, NBIC" shall mean the National Board Inspection Code of the National Board of Boiler and Pressure Vessel Inspectors with addenda and revisions, thereto made and approved by the National Board of Boiler and Pressure Vessel Inspectors and adopted by the board of boiler rules in accordance with the provisions of RCW 70.79.030.

"Commission" shall mean an annual commission card issued to a person in the employ of Washington state, an insurance company or a company owner/user inspection agency holding a Washington state certificate of competency which authorizes them to perform inspections of boilers and/or unfired pressure vessels.

"Department" as used herein shall mean the department of labor and industries of the state of Washington.

"Director" shall mean the director of the department of labor and industries.

"Domestic and/or residential purposes" shall mean serving a private residence or an apartment house of less than six families.

"Existing installations" shall mean any boiler or unfired pressure vessel constructed, installed, placed in operation, or contracted for before January 1, 1952.

"Inspection certificate" see "certificate of inspection."

"Inspection, external" shall mean an inspection made while a boiler or unfired pressure vessel is in operation and includes the inspection and demonstration of controls and safety devices required by these rules.

"Inspection, internal" shall mean an inspection made when a boiler or unfired pressure vessel is shut down and handholes, manholes, or other inspection openings are open or removed for examination of the interior. An external ultrasonic examination of unfired pressure vessels less than 36" inside diameter shall constitute an internal inspection.

"Inspector" shall mean the chief boiler inspector, a deputy inspector, or a special inspector.

- **"Chief inspector"** shall mean the inspector appointed under RCW 70.79.100 who serves as the secretary to the board without a vote.
- **"Deputy inspector"** shall mean an inspector appointed under RCW 70.79.120.
- **"Special inspector"** shall mean an inspector holding a Washington commission identified under RCW 70.79.130.

"Jacketed steam kettle" shall mean a pressure vessel with inner and outer walls that is subject to steam pressure and is used to boil or heat liquids or to cook food. Jacketed steam kettles with a total volume greater than or equal to one and one-half cubic feet (11.25 gallons) shall be ASME code stamped.

(a) **"Unfired jacketed steam kettle"** is one where the steam within the jacket's walls is generated external to itself, such as from a boiler or other steam source.

(b) **"Direct fired jacketed steam kettle"** is a jacketed steam kettle having its own source of energy, such as gas or electricity for generating steam within the jacket's walls.

"Nationwide engineering standard" shall mean a nationally accepted design method, formulae and practice acceptable to the board.

"Operating permit" see "certificate of inspection."

"Owner" or **"user"** shall mean a person, firm, or corporation owning or operating any boiler or unfired pressure vessel within the state.

"Owner/user inspection agency" shall mean an owner or user of boilers and/or pressure vessels that maintains an established inspection department, whose organization and inspection procedures meet the requirements of a nationally recognized standard acceptable to the department.

"Place of public assembly" or **"assembly hall"** shall mean a building or portion of a building used for the gathering together of 50 or more persons for such purposes as deliberation, education, instruction, worship, entertainment, amusement, drinking, or dining or waiting transportation. This shall also include child care centers (those agencies which operate for the care of thirteen or more children), public and private hospitals, nursing homes and assisted living facilities.

"Special design" shall mean a design using nationally or internationally recognized engineering standards other than the codes adopted in WAC 296-104-200.

AMENDATORY SECTION (Amending WSR 04-01-194, filed 12/24/03, effective 1/24/04)

WAC 296-104-065 Administration—How should an inspector obtain a Washington state commission? A commission as a deputy inspector of boilers and/or unfired pressure vessels may be issued by the chief inspector to an inspector complying with WAC 296-104-065 (1) or (4). Upon the request of a boiler insurance company authorized to insure and insuring against loss from explosion of boilers and/or unfired pressure vessels in this state, or a company with an owner/user inspection agency, a commission as a special inspector of boilers and/or unfired pressure vessels shall be issued by the chief inspector to an inspector in the employ and supervision of such company provided the inspector has had the experience prescribed in chapter 70-79 RCW and complies with one of the following:

(1) Passed an examination covering the Washington state boilers and unfired pressure vessels law, chapters 70.79 RCW and 296-104 WAC; and holds a national board commission.

(2) Is certified by the American Petroleum Institute in accordance with API-510 for pressure vessel inspection, hav-

ing passed an examination covering the Washington state boilers and unfired pressure vessels law, chapters 70.79 RCW and 296-104 WAC.

(3) Is certified by the American Petroleum Institute in accordance with API-510 for pressure vessel inspection, and specifically and temporarily in the direct employ of an owner/user inspection agency as set forth in RCW 70.79.130. This inspector shall be exempted from the state examination requirement in WAC 296-104-065(2).

(4) Is an inspector holding the national board ((~~"A" endorsement~~)) authorized inspector commission and performs shop inspections only. This inspector shall be exempt from the exam requirement set forth in WAC 296-104-065(1).

AMENDATORY SECTION (Amending WSR 18-01-113, filed 12/19/17, effective 1/31/18)

WAC 296-104-102 Inspection—What are the standards for in-service inspection? Where a conflict exists between the requirements of the standards listed below and this chapter, this chapter shall prevail. The duties of the in-service inspector do not include the installation's compliance with other standards and requirements (environmental, construction, electrical, undefined industrial standards, etc.), for which other regulatory agencies have authority and responsibility to oversee.

(1) The standard for inspection of nonnuclear boilers((~~,~~)) and unfired pressure vessels((~~, and safety devices in~~)) is the National Board Inspection Code (NBIC), current edition Part 2, excluding Section 6, Supplements 1, 5, 6, and 7 which may be used as nonmandatory guidelines.

(2) The standard for installation, in-service inspection, and repair of pressure relief devices is the National Board Inspection Code (NBIC), current edition Part 4, excluding Section 6, Supplements 1 and 3 which may be used as nonmandatory guidelines.

(3) The standard for inspection of historical steam boilers of riveted construction preserved, restored, or maintained for hobby or demonstration use, shall be Part 2, Section 6, Supplement 2 of the National Board Inspection Code (NBIC) current edition.

(((~~(3)~~))) (4) The standard for inspection of nuclear items is ASME section XI. The applicable ASME Code edition and addenda shall be as specified in the owner in-service inspection program plan.

(((~~(4)~~))) (5) Where a petroleum or chemical process industry owner/user inspection agency so chooses, the standard for inspection of unfired pressure vessels used by the owner shall be the API-510 Pressure Vessel Inspection Code, current edition. This code may be used on or after the date of issue.

(((~~(5)~~))) (6) TAPPI TIP 0402-16, revised 2011 may be used for both pulp dryers and paper machine dryers when requested by the owner. When requested by the owner, this document becomes a requirement and not a guideline.

NEW SECTION

WAC 296-104-251 Installation—What are the standards for installation for nonnuclear boiler and pressure vessels? Where a conflict exists between the requirements of the standards listed below and this chapter, this chapter shall prevail. The duties of the in-service inspector do not include the installation's compliance with other standards and requirements (environmental, construction, electrical, undefined industrial standards, etc.), for which other regulatory agencies have authority and responsibility to oversee.

The standard for installation of nonnuclear boilers, unfired pressure vessels, and safety devices is the National Board Inspection Code (NBIC), current edition Part 1, excluding Section 5 and Section 6, Supplements 1, 2, and 5 which may be used as nonmandatory guidelines.

AMENDATORY SECTION (Amending WSR 04-01-194, filed 12/24/03, effective 1/24/04)

WAC 296-104-320 Installation—Where should the discharge from safety pressure relief devices, blow offs and drains be directed? Discharge from safety pressure relief devices, blow offs and drains shall be directed to a safe point of discharge to prevent injury to personnel and property. Discharge lines from boilers, accumulators, or headers, with a capacity of 1,000 pounds of steam per hour or more, shall be directed outside of the building.

For hot water heater discharge lines as defined in WAC 296-104-010 that do not exceed 120 gallons or 200,000 Btu/hr input the following requirements shall be followed:

The discharge piping serving a temperature relief valve, pressure relief valve, or combination of both shall have no valves, or obstructions, or means of isolation and be provided with the following:

(1) Equal to the size of the valve outlet and shall discharge full size to the flood level of the area receiving the discharge and pointing down.

(2) Materials shall be rated at not less than the operating temperature of the system and approved for such use.

(3) Discharge pipe shall discharge independently by gravity through an air gap into the drainage system or outside of the building with the end of the pipe not exceeding 2 feet (610 mm) and not less than 6 inches (152 mm) above the ground and pointing downwards.

(4) Discharge in such a manner that does not cause personal injury or structural damage.

(5) No part of such discharge pipe shall be trapped or subject to freezing.

(6) The terminal end of the pipe shall not be threaded.

(7) Discharge from a relief valve into a water heater pan shall be prohibited.

Exception: Where no drainage was provided, replacement water heating equipment shall only be required to provide a drain pointing downward from the relief valve to extend between 2 feet (610 mm) and 6 inches (152 mm) from the floor. No additional floor drain need be provided.

AMENDATORY SECTION (Amending WSR 18-01-113, filed 12/19/17, effective 1/31/18)

WAC 296-104-502 Repairs—What is the standard for nonnuclear repairs and alterations? The standard for repairs/alterations is:

(1) National Board Inspection Code (NBIC), current edition Part 3, excluding Section 6, Supplements 1, 5, 6, and ((~~10~~)) 7 which may be used as nonmandatory guidelines.

(2) The standard for repair of historical boilers or riveted construction preserved, restored, or maintained for hobby or demonstration use, shall be Part 3, Section 6, Supplement 2 of the National Board Inspection Code (NBIC) current edition.

AMENDATORY SECTION (Amending WSR 18-01-113, filed 12/19/17, effective 1/31/18)

WAC 296-104-700 What are the inspection fees—Examination fees—Certificate fees—Expenses? The following fees shall be paid by, or on behalf of, the owner or user upon the completion of the inspection. The inspection fees apply to inspections made by inspectors employed by the state.

The boiler and pressure vessel installation/reinstallation permit fee of $((~~54.00~~)) 56.16 shall be paid by the installer, as defined in WAC 296-104-010.

Certificate of inspection fees: For objects inspected, the certificate of inspection fee per object is $((~~23.30~~)) 24.23.

Hot water heaters per RCW 70.79.090, inspection fee: $((~~7.10~~)) 7.38.

Heating boilers:	Internal	External
Cast iron—All sizes	$((~~39.30~~)) 40.87	$((~~31.40~~)) 32.65
All other boilers less than 500 sq. ft.	$((~~39.30~~)) 40.87	$((~~31.40~~)) 32.65
500 sq. ft. to 2500 sq. ft.	$((~~78.60~~)) 81.74	$((~~39.30~~)) 40.87
Each additional 2500 sq. ft. of total heating surface, or any portion thereof	$((~~31.40~~)) 32.65	$((~~15.40~~)) 16.01

Power boilers:	Internal	External
Less than 100 sq. ft.	$((~~39.30~~)) 40.87	$((~~31.40~~)) 32.65
100 sq. ft. to less than 500 sq. ft.	$((~~47.60~~)) 49.50	$((~~31.40~~)) 32.65
500 sq. ft. to 2500 sq. ft.	$((~~78.60~~)) 81.74	$((~~39.30~~)) 40.87
Each additional 2500 sq. ft. of total heating surface, or any portion thereof	$((~~31.40~~)) 32.65	$((~~15.40~~)) 16.01

Pressure vessels:

Square feet shall be determined by multiplying the length of the shell by its diameter.

	Internal	External
Less than 15 sq. ft.	$((~~31.40~~)) 32.65	$((~~23.30~~)) 24.23
15 sq. ft. to less than 50 sq. ft.	$((~~46.60~~)) 48.46	$((~~23.30~~)) 24.23
50 sq. ft. to 100 sq. ft.	$((~~54.40~~)) 56.57	$((~~31.40~~)) 32.65
For each additional 100 sq. ft. or any portion thereof	$((~~54.30~~)) 56.47	$((~~15.40~~)) 16.01

Nonnuclear shop inspections, field construction inspections, and special inspection services:

For each hour or part of an hour up to 8 hours	$((~~47.60~~)) 49.50
For each hour or part of an hour in excess of 8 hours	$((~~71.10~~)) 73.94

Nuclear shop inspections, nuclear field construction inspections, and nuclear triennial shop survey and audit:

For each hour or part of an hour up to 8 hours	$((~~71.10~~)) 73.94
For each hour or part of an hour in excess of 8 hours	$((~~111.20~~)) 115.64

Nonnuclear triennial shop survey and audit:

When state is authorized inspection agency:

For each hour or part of an hour up to 8 hours	$((~~47.60~~)) 49.50
For each hour or part of an hour in excess of 8 hours	$((~~71.10~~)) 73.94

When insurance company is authorized inspection agency:

For each hour or part of an hour up to 8 hours	$((~~71.10~~)) 73.94
For each hour or part of an hour in excess of 8 hours	$((~~111.20~~)) 115.64

Examination fee: A fee of $((~~88.00~~)) 91.52 will be charged for each applicant sitting for an inspection examination(s).

Special inspector commission: A fee of $((~~47.50~~)) 49.40 for initial work card. A fee of $((~~29.50~~)) 30.68 for annual renewal.

If a special inspector changes companies: A work card fee of $((~~47.50~~)) 49.40.

Expenses shall include:

Travel time and mileage: The department shall charge for its inspectors' travel time from their offices to the inspection sites and return. The travel time shall be charged for at the same rate as that for the inspection, audit, or survey. The department shall also charge the current Washington office of financial management accepted mileage cost fees or the actual cost of purchased transportation. Hotel and meals: Actual cost not to exceed the office of financial management approved rate.

Requests for Washington state specials and extensions of inspection frequency: For each vessel to be considered by the board, a fee of $((~~442.60~~)) 460.30 must be paid to

the department before the board meets to consider the vessel. The board may, at its discretion, prorate the fee when a number of vessels that are essentially the same are to be considered.

WSR 18-19-088
PROPOSED RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin. #2018-03—Filed September 18, 2018, 4:03 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-11-025.

Title of Rule and Other Identifying Information: Chapter 182-16 WAC, Practice and procedure.

Hearing Location(s): On October 23, 2018, at 10:00 a.m., at the Health Care Authority (HCA), Cherry Street Plaza Building, Pear Conference Room, 626 8th Avenue, Olympia, WA 98504. Metered public parking is available street side around building. A map is available at https://www.hca.wa.gov/assets/program/Drivingparking-checkin-instructions.pdf or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: No sooner than October 24, 2018.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 45504, Olympia, WA 98504-5504, email arc@hca.wa.gov, fax 360-586-9727, by October 23, 2018.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication relay services 711, email amber.lougheed@hca.wa.gov, by October 19, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA is amending, recodifying, and repealing existing sections within chapter 182-16 WAC, and adding new sections. The agency is proposing to divide the chapter into three parts: Part I: General Provisions, Part II: Brief Adjudicative Proceedings, and Part III: Formal Administrative Hearings. The intent of these changes is to make the public employees benefits board (PEBB) appeals process easier for appellants to understand, to align with the Washington Administrative Procedures [Procedure] Act, and to improve resolution timelines.

Part II sets forth the rules that will govern the PEBB brief adjudicative proceeding process. The new process generally requires a presiding officer designated by the HCA director to issue an initial order within ten days of the appeal being received by the PEBB appeals unit. The rule also creates a second level of review in a brief adjudicative proceeding that will be completed by an internal review officer or officers designated by the HCA director and will result in a final order. Requests for review can be made orally to the PEBB appeals unit or by a written request within twenty-one days of the initial order. If no request for review is made within the twenty days, the initial order will become the final order without further action by HCA.

Where the issues and interests involved in an appeal warrant, a brief adjudicative proceeding can be converted from a brief adjudicative proceeding to a formal administrative hearing at any time by a presiding officer or a review officer or officers.

An appeal can also be converted to a formal administrative hearing when it is found that the use of the brief adjudicative proceeding violates any provision of law, when the protection of the public interest requires the authority to give notice and an opportunity to participate to persons other than the parties, or when the issues and interests involved in the controversy warrant the use of the procedures or RCW 34.05.413 through 34.05.479 that govern formal administrative hearings.

Part III governs the formal administrative hearings in conjunction with chapter 34.05 RCW. A hearing officer will preside over the formal administrative hearings. The hearing officer will issue a final order that can be appealed to superior court.

Reasons Supporting Proposal: See purpose.

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: Stella Ng, 626 8th Avenue S.E., Olympia, WA, 360-725-0852; Implementation: Barbara Scott, 626 8th Avenue S.E., Olympia, WA 360-725-0830; and Enforcement Scott Palafox, 626 8th Avenue S.E., Olympia, WA, 360-725-1858.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The proposed rules do not impose any cost on small businesses.

September 18, 2018
Wendy Barcus
Rules Coordinator

PART I

GENERAL PROVISIONS

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-16-010 ((~~Appeals—Purpose and scope.~~)) Purpose. (((~~(1) For WAC 182-16-025 through 182-16-040, the model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended, are hereby adopted for use by the authority in public employees benefits board (PEBB) benefits related proceedings. The model rules of procedure may be found in chapter 10-08 WAC. Other procedural rules adopted in chap-~~

~~ters 182-08, 182-12, and 182-16 WAC are supplementary to the model rules of procedure. In the case of a conflict between the model rules of procedure and the procedural rules adopted in WAC 182-16-025 through 182-16-040, the procedural rules adopted by the health care authority (HCA) shall govern.~~

~~(2) WAC 182-16-050 through 182-16-110 describes the general rules and procedures that apply to an administrative hearing, requested under WAC 182-16-050, of a PEBB appeals committee decision.~~

~~(a) WAC 182-16-050 through 182-16-110 supplements the Administrative Procedure Act (APA), chapter 34.05 RCW, and the model rules of procedure in chapter 10-08 WAC. The model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended are adopted for use in a hearing. In the case of a conflict between the model rules of procedure and the rules adopted in WAC 182-16-050 through 182-16-110, the rules adopted in WAC 182-16-050 through 182-16-110 shall prevail.~~

~~(b) If there is a conflict between WAC 182-16-050 through 182-16-110 and specific PEBB program rules, the specific PEBB program rules prevail. PEBB program rules are found in chapters 182-08 and 182-12 WAC.~~

~~(c) Nothing in WAC 182-16-050 through 182-16-110 is intended to affect the constitutional rights of any person or to limit or change additional requirements imposed by statute or other rule. Other laws or rules determine if a hearing right exists, including the APA and program rules or laws.~~

~~(d) The hearing rules for the PEBB program in WAC 182-16-050 through 182-16-110 do not apply to any other HCA program.~~

~~(3) The definitions in WAC 182-16-020 apply throughout this chapter.~~)) This chapter describes the general rules and procedures that apply to the authority's brief adjudicative proceedings and formal administrative hearings.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-16-020 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Appellant" means a person or entity who requests a review by the PEBB appeals ((~~committee or an~~)) unit or a formal administrative hearing about the action of the HCA or its contracted vendor.

"Authority" or "HCA" means the Washington state health care authority.

"Brief adjudicative proceeding" means the process described in RCW 34.05.482 through 34.05.494.

"Business days" means all days except Saturdays, Sundays, and all legal holidays as set forth in RCW 1.16.050.

"Calendar days" or "days" means all days including Saturdays and Sundays.

"Continuance" means a change in the date or time of when a brief adjudicative proceeding or formal administrative hearing will occur.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of PEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of PEBB benefits.

"Denial" or "denial notice" means an action by, or communication from, either an employing agency, or the PEBB program that aggrieves a subscriber, a dependent, or an applicant, with regard to PEBB benefits including, but not limited to, actions or communications expressly designated as a "denial," "denial notice," or "cancellation notice."

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan ((~~authorized in chapter 41.05 RCW~~)) under this chapter pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance pro-

grams by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, educational service districts, and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority as described in WAC 182-08-245.

"Employing agency" for the public employees benefits board program means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; ((~~charter school; or~~)) and a tribal government covered by chapter 41.05 RCW.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in PEBB benefits, and for whom applicable premium payments have been made.

"File" or "filing" means the act of delivering documents to the office of the presiding ((~~officer's office~~)) officer, review officer, or hearing officer. A document is considered filed when it is received by the authority or its designee.

"Final order" means an order that is the final PEBB program decision.

"Formal administrative hearing" means a proceeding before a hearing officer that gives an appellant an opportunity for an evidentiary hearing.

"HCA hearing representative" means a person who is authorized to represent the PEBB program in a formal administrative hearing. The person may be an assistant attorney general or authorized HCA employee.

"Health plan" means a plan offering medical or dental, or both, developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

((~~"Hearing" means a proceeding before a presiding officer that gives an appellant an opportunity to be heard in a dispute about a decision made by the PEBB appeals committee, including prehearing conferences, dispositive motion hearings, status conferences, and evidentiary hearings.~~

~~"Hearing representative" means a person who is authorized to represent the PEBB program in an administrative hearing. The person may be an assistant attorney general, a licensed attorney, or authorized HCA employee.~~))

"Hearing officer" means an impartial decision maker who presides at a formal administrative hearing, and is:

• A director-designated HCA employee; or

• When the director has designated the office of administrative hearings (OAH) as a hearing body, an administrative law judge employed by the OAH.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen State College, the community and technical colleges, and the state board for community and technical colleges.

"Life insurance" for eligible employees includes basic life insurance and accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as optional life insurance and optional AD&D insurance offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"LTD insurance" or "long-term disability insurance" includes any basic long-term disability insurance paid for by the employing agency and any supplemental long-term disability insurance offered to and paid by employees ((~~on an optional basis~~)).

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan ((~~authorized in chapter 41.05 RCW~~)) under this chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"PEBB" means the public employees benefits board.

((~~"PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB program. The director has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.~~))

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB insurance coverage" means any health plan, life insurance, long-term disability (LTD) insurance, long-term care insurance, or property and casualty insurance administered as a PEBB benefit.

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171 and 182-12-180), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260), and others as defined in RCW 41.05.011.

"Prehearing conference" means a proceeding scheduled and conducted by a ((~~presiding~~)) hearing officer to address issues in preparation for a formal administrative hearing.

"Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium

contribution, due to an enrollee's tobacco use or ((a)) an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in ((his or her)) their employer-based group medical when:

• The spouse's or state registered domestic partner's share of the medical premiums ((are)) is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the Uniform Medical Plan (UMP) Classic ((premiums)); and

• The benefits have an actuarial value of ((benefits is)) at least ninety-five percent of the actuarial value of UMP Classic benefits.

"Presiding officer" means an impartial decision maker who conducts a brief adjudicative proceeding and is ((an attorney, presides at an administrative hearing, and is either:

•)) a director-designated HCA employee((; or

• When the director has designated the office of administrative hearings (OAH) as a hearing body, an administrative law judge employed by the OAH.

"Record" means the official documentation of the hearing process. The record includes recordings or transcripts, admitted exhibits, decisions, briefs, notices, orders, and other filed documents)).

"Review officer or officers" means one or more delegates from the director that consider appeals relating to the administration of PEBB benefits by the PEBB program.

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program (DCAP), medical flexible spending arrangement (FSA), or premium payment plan ((as authorized in chapter 41.05 RCW)) offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Service" or "serve" means the ((delivery of documents as described in WAC 182-16-067)) process described in WAC 182-16-058.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government, and all personnel thereof. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education, and any unit of state government established by law.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, state agency, or charter school and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of enrollees.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-16-055 Mailing address changes. (1) During the appeal process if the appellant's mailing address changes, the appellant must notify the ((hearing representative and the presiding officer)) public employees benefits board (PEBB) appeals unit as soon as possible((, when the appellant's mailing address changes)).

(2) If the appellant does not notify the ((hearing representative and the presiding officer)) PEBB appeals unit of a change in the appellant's mailing address and the ((presiding officer and hearing representative)) PEBB appeals unit continues to serve notices and other important documents to the appellant's last known mailing address, the documents will be deemed served on the appellant.

(3) This requirement to provide notice of an address change is in addition to WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262 that require a subscriber to update their address.

NEW SECTION

WAC 182-16-058 Service or serve. (1) When the rules in this chapter or in other public employees benefits board (PEBB) program rules or statutes require a party to serve copies of documents on other parties, a party must send copies of the documents to all other parties or their representatives as described in this chapter. In this section, requirements for service or delivery by a party apply also when service is required by the presiding officer, review officer or officers, or hearing officer.

(2) Unless otherwise stated in applicable law, documents may be sent only as identified in this chapter to accomplish service. A party may serve someone by:

(a) Personal service (hand delivery);

(b) First class, registered, or certified mail sent via the United States Postal Service or Washington state consolidated mail services;

(c) Fax;

(d) Commercial delivery service; or

(e) Legal messenger service.

(3) A party must serve all other parties or their representatives whenever the party files a motion, pleading, brief, or other document with the presiding officer, review officer or officers, or hearing officer's office, or when required by law.

(4) Service is complete when:

(a) Personal service is made;

(b) Mail is properly stamped, addressed, and deposited in the United States Postal Service;

(c) Mail is properly addressed, and deposited in the Washington state consolidated mail services;

(d) Fax produces proof of transmission;

(e) A parcel is delivered to a commercial delivery service with charges prepaid; or

(f) A parcel is delivered to a legal messenger service with charges prepaid.

(5) A party may prove service by providing any of the following:

(a) A signed affidavit or certificate of mailing;

(b) The certified mail receipt signed by the person who received the parcel;

(c) A signed receipt from the person who accepted the commercial delivery service or legal messenger service parcel;

(d) Proof of fax transmission.

(6) Service cannot be made by electronic mail unless mutually agreed to in advance and in writing by the parties.

(7) If the document is a subpoena, follow the compliance procedure as described in WAC 182-16-3130.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-064 Applicable rules and laws. ((~~During a hearing,~~)) A presiding officer, review officer or officers, or hearing officer must first apply the applicable public employees benefits board (PEBB) program rules adopted in the Washington Administrative Code (WAC). If no PEBB program rule applies, the presiding officer, review officer or officers, or hearing officer must decide the issue according to the best legal authority and reasoning available, including federal and Washington state constitutions, statutes, regulations, significant decisions indexed as described in WAC 182-16-130, and court decisions.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-066 Burden of proof, standard of proof, and presumptions. (1) The burden of proof is a party's responsibility to provide evidence regarding disputed facts and persuade the presiding officer, review officer or officers, or hearing officer that a position is correct based on the standard of proof.

(2) Standard of proof refers to the amount of evidence needed to prove a party's position. Unless stated otherwise in rules or law, the standard of proof brief adjudicative proceeding or formal administrative in a hearing is a preponderance of the evidence, meaning that something is more likely to be true than not.

(3) Public officers and agencies are presumed to have properly performed their duties and acted as described in ((~~accordance with~~)) the law, unless substantial evidence to the contrary is presented. A party challenging this presumption bears the burden of proof.

NEW SECTION

WAC 182-16-120 Computation of time. (1) In computing any period of time prescribed by this chapter, the day of the event from which the time begins to run is not included. For example, if an initial order is served on Tuesday and the party has twenty-one days to request a review, start counting the days with Wednesday.

(2) Except as provided in subsection (3) of this section, the last day of the period so computed is included unless it is a Saturday, Sunday, or legal holiday as defined in RCW 1.16.050, in which case the period extends to the end of the next business day.

(3) When the period of time prescribed or allowed is less than ten days, intermediate Saturdays, Sundays and legal holidays shall be excluded in the computation.

(4) The deadline is 5:00 p.m. on the last day of the computed period.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-16-130 Index of significant decisions. (1) A final decision may be relied upon, used, or cited as precedent by a party if the final order has been indexed in the authority's index of significant decisions in accordance with RCW 34.05.473 (1)(b).

(2) ((~~The~~)) An index of significant decisions is available to the public ((~~at~~)) on the health care ((~~authority (HCA) internet page~~)) authority's (HCA) web site. As decisions are indexed they will be ((~~linked on this page. For additional information on how to obtain a copy of the index, contact the HCA hearing representative~~)) available on the web site.

(3) A final decision published in the index of significant decisions may be removed from the index when:

(a) A ((~~precedential~~)) published decision entered by the court of appeals or the supreme court reverses an indexed final decision; or

(b) HCA determines that the indexed final decision is no longer precedential due to changes in statute, rule, or policy.

PART II

BRIEF ADJUDICATIVE PROCEEDINGS

NEW SECTION

WAC 182-16-2000 Brief adjudicative proceedings. Pursuant to RCW 34.05.482, the authority will use brief adjudicative proceedings for issues identified in this chapter when doing so would not violate law, or when protection of the public interest does not require the authority to give notice and an opportunity to participate to persons other than the parties, or the issue and interests involved in the controversy do not warrant use of the procedures of RCW 34.05.413 through 34.05.479 which govern formal administrative hearings.

NEW SECTION

WAC 182-16-2005 Record—Brief adjudicative proceeding. The record in a brief adjudicative proceeding consists of any documents regarding the matter, considered or prepared by the presiding officer for the brief adjudicative proceeding or by the review officer or officers for any review. The authority's record does not have to constitute the exclusive basis for agency action, unless otherwise required by law.

NEW SECTION

WAC 182-16-2010 Where to appeal a decision regarding eligibility, enrollment, premium payments, premium surcharges, a public employees benefits board (PEBB) wellness incentive, or the administration of benefits? (1) Any current or former employee of a state agency or their dependent aggrieved by a decision made by the state agency with regard to public employees benefits board (PEBB) eligibility, enrollment, or premium surcharges may appeal that decision to the state agency by the process outlined in WAC 182-16-2020.

Note: Eligibility decisions address whether a subscriber or a subscriber's dependent is entitled to PEBB insurance coverage, as described in PEBB rules and policies. Enrollment decisions address the application for PEBB benefits as described in PEBB rules and policies including, but not limited to, the submission of proper documentation and meeting enrollment deadlines.

(2) Any current or former employee of an employer group or their dependent who is aggrieved by a decision made by an employer group with regard to PEBB eligibility, enrollment, or premium surcharges may appeal that decision to the employer group through the process established by the employer group.

Exception: Any current or former employee of an employer group aggrieved by a decision regarding life insurance, long-term disability (LTD) insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive may appeal that decision to the PEBB appeals committee by the process described in WAC 182-16-2030.

(3) Any subscriber or dependent aggrieved by a decision made by the PEBB program with regard to PEBB eligibility, enrollment, premium payments, premium surcharges, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive, may appeal that decision to the PEBB appeals unit by the process described in WAC 182-16-2030.

(4) Any PEBB enrollee aggrieved by a decision regarding the administration of a health plan, life insurance, or long-term disability insurance may appeal that decision by following the appeal provisions of those plans, with the exception of:

(a) Enrollment decisions;

(b) Premium payment decisions other than life insurance premium payment decisions; and

(c) Eligibility decisions.

(5) Any PEBB enrollee aggrieved by a decision regarding the administration of PEBB long-term care insurance or property and casualty insurance may appeal that decision by following the appeal provisions of those plans.

(6) Any PEBB employee aggrieved by a decision regarding the administration of a benefit offered under the state's salary reduction plan may appeal that decision by the process described in WAC 182-16-2050.

(7) Any subscriber aggrieved by a decision made by the PEBB wellness incentive program contracted vendor regarding the completion of the PEBB wellness incentive program requirements, or a request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision by the process described in WAC 182-16-2040.

NEW SECTION

WAC 182-16-2020 How can a current or former employee or an employee's dependent appeal a decision made by a state agency about eligibility, premium surcharge, or enrollment in benefits? (1) An eligibility, premium surcharge, or enrollment decision made by a state agency may be appealed by submitting a written request for administrative review to the state agency. The state agency must receive the request for administrative review no later than thirty days after the date of the denial notice. The contents of the request for administrative review are to be provided as described in WAC 182-16-2070.

(a) Upon receiving the request for administrative review, the state agency shall perform a complete review of the denial by one or more staff who did not take part in the decision resulting in the denial. As part of the administrative review, the state agency may hold a formal meeting or formal administrative hearing, but is not required to do so.

(b) The state agency shall render a written decision within thirty days of receiving the request for administrative review. The written decision shall be sent to the employee or employee's dependent who submitted the request for administrative review and must include a description of appeal rights. The state agency shall also send a copy of the state agency's written decision to the state agency's administrator (or designee) and to the public employees benefits board (PEBB) appeals unit. If a state agency fails to render a written decision within thirty days of receiving the written request for administrative review, the request for administrative review may be considered denied and the original underlying state agency decision may be appealed to the PEBB appeals unit by following the process in this section.

(c) The state agency may reverse eligibility, premium surcharge, or enrollment decisions based only on circumstances that arose due to delays caused by the state agency or errors made by the state agency.

(2) Any current or former employee or employee's dependent who disagrees with the state agency's decision in response to a written request for administrative review, as described in subsection (1) of this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the state agency's written decision on the request for administrative review. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit shall notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the PEBB appeals unit receives a request for a brief adjudicative proceeding, the PEBB appeals unit will send a request for documentation and information to the applicable state agency. The state agency will then have two business days to respond to the request and provide the

requested documentation and information. The state agency will also send a copy of the documentation and information to the employee, former employee, or the employee's dependent.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal the state agency's written decision within thirty days by following the process in (a) of this subsection, the state agency's prior written decision becomes the health care authority's final decision.

NEW SECTION

WAC 182-16-2030 Appealing a public employees benefits board (PEBB) program decision regarding eligibility, enrollment, premium payments, premium surcharges, a PEBB wellness incentive, or certain decisions made by an employer group? (1) A decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, premium payments, premium surcharges, a PEBB wellness incentive, may be appealed by submitting a request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(2) A decision made by an employer group regarding life insurance, LTD insurance, eligibility to participate in the PEBB wellness incentive program, or eligibility to receive a PEBB wellness incentive may be appealed by submitting a request to the PEBB appeals unit for a brief adjudicative proceeding to be conducted by the authority.

(3) The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(4) The request for a brief adjudicative proceeding from a current or former employee or employee's dependent must be received by the PEBB appeals unit no later than thirty days after the date of the denial notice.

(5) The request for a brief adjudicative proceeding from a retiree, self-pay enrollee, or dependent of a retiree or self-pay enrollee must be received by the PEBB appeals unit no later than sixty days after the date of the denial notice.

(6) The PEBB appeals unit shall notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(7) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(8) Failing to timely request a brief adjudicative proceeding to appeal a decision made under this section within the applicable time frame described in subsections (4) and (5) of this section, will result in the prior PEBB program decision becoming the authority's final decision without further employing agency action.

NEW SECTION

WAC 182-16-2040 How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements? (1) Any subscriber aggrieved by a decision regarding the completion of the wellness incentive program requirements, or request for a reasonable alternative to a wellness incentive program requirement, may appeal that decision to the public employees benefits board (PEBB) wellness incentive program contracted vendor.

(2) Any subscriber who disagrees with a decision in response to an appeal filed with the PEBB wellness incentive program contracted vendor may appeal the decision by submitting a request for a brief adjudicative proceeding to the PEBB appeals unit.

(a) The request for a brief adjudicative proceeding from a current or former employee must be received by the PEBB appeals unit no later than thirty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(b) The request for a brief adjudicative proceeding from a retiree or self-pay subscriber must be received by the PEBB appeals unit no later than sixty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(3) The PEBB appeals unit shall notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(4) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(5) If a subscriber fails to timely request a brief adjudicative proceeding of a decision made under subsection (1) of this section within thirty days by following the process in WAC 182-16-2020(2), the decision of the PEBB wellness incentive program contracted vendor becomes the authority's final decision.

NEW SECTION

WAC 182-16-2050 How can an employee who is eligible to participate in the state's salary reduction plan appeal a decision regarding the administration of benefits offered under the state's salary reduction plan? (1) Any employee who disagrees with a decision that denies eligibility for, or enrollment in, a benefit offered under the state's salary reduction plan may appeal that decision by submitting a written request for administrative review to their state agency. The state agency must receive the written request for administrative review no later than thirty days after the date of the denial. The contents of the written request for administrative review are to be provided as described in WAC 182-16-2070.

(a) Upon receiving the written request for administrative review, the state agency shall perform a complete review of the denial by one or more staff who did not take part in the decision resulting in the denial.

(b) The state agency shall render a written decision within thirty days of receiving the request for administrative review. The written decision shall be sent to the employee who submitted the written request for review and must include a description of appeal rights. The state agency shall also send a copy of the state agency's administrator (or designee) and to the PEBB appeals unit. If a state agency fails to render a written decision within thirty days of receiving the written request for administrative review, the request for administrative review may be considered denied and the orig-

inal underlying state agency decision may be appealed to the PEBB appeals unit by following the process in this section.

(2) Any employee who disagrees with the state agency's decision in response to a written request for administrative review, as described in this section, may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the state agency's written decision on the request for administrative review. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit shall notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) Once the PEBB appeals unit receives a request for a brief adjudicative proceeding, the PEBB appeals unit will send a request for documentation and information to the applicable state agency. The state agency will then have two business days to respond to the request. The state agency will also send a copy of the documentation and information to the employee.

(iii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in this subsection, the state agency's prior written decision becomes the authority's final decision without further state agency action.

(3) Any employee aggrieved by a decision regarding a claim for benefits under the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) offered under the state's salary reduction plan may appeal that decision to the authority's contracted vendor by following the appeal process of that contracted vendor.

(a) Any employee who disagrees with a decision in response to an appeal filed with the contracted vendor that administers the medical FSA and DCAP under the state's salary reduction plan may request a brief adjudicative proceeding by submitting a written request to the PEBB appeals unit. The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the contracted vendor's appeal decision. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit shall notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in this subsection, the contracted vendor's prior written decision becomes the authority's final decision.

(4) Any employee aggrieved by a decision regarding the administration of the premium payment plan offered under the state's salary reduction plan may request a brief adjudicative proceeding to be conducted by the authority by submitting a written request to the PEBB appeals unit for a brief adjudicative proceeding.

(a) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the denial notice by the PEBB program. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(i) The PEBB appeals unit shall notify the appellant in writing when the notice of appeal has been received.

(ii) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(b) If an employee fails to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in this subsection, the PEBB program's prior written decision becomes the authority's final decision.

NEW SECTION

WAC 182-16-2060 How can an entity or organization appeal a decision of the health care authority to deny an employer group application? (1) An entity or organization whose employer group application is denied by the authority may appeal the decision by submitting a request for a brief adjudicative proceeding to the public employees benefits board (PEBB) appeals unit. For rules regarding eligible entities, see WAC 182-12-111.

(2) The PEBB appeals unit must receive the request for a brief adjudicative proceeding no later than thirty days after the date of the denial notice. The contents of the request for a brief adjudicative proceeding are to be provided as described in WAC 182-16-2070.

(3) The PEBB appeals unit shall notify the appellant in writing when the request for a brief adjudicative proceeding has been received.

(4) The brief adjudicative proceeding will be conducted by a presiding officer designated by the director.

(5) Failing to timely request a brief adjudicative proceeding to appeal a decision made under this section within thirty days by following the process described in subsection (2) of this section, will result in the prior PEBB program decision becoming the authority's final decision.

NEW SECTION

WAC 182-16-2070 What should a written request for administrative review and a request for brief adjudicative proceeding contain? A written request for administrative review and a request for brief adjudicative proceeding should contain:

(1) The name and mailing address of the party requesting an administrative review or the brief adjudicative proceeding;

(2) The name and mailing address of the appealing party's representative, if any;

(3) Documentation, or reference to documentation, of decisions previously rendered through the appeal process, if any;

(4) A statement identifying the specific portion of the decision being appealed and clarifying what is believed to be unlawful or in error;

(5) A statement of facts in support of the appealing party's position;

(6) Any information or documentation that the appealing party would like considered;

(7) The type of relief sought; and

(8) The signature of the appealing party or the appealing party's representative.

NEW SECTION

WAC 182-16-2080 Who can appeal or represent a party in a brief adjudicative proceeding? (1) The appellant may act as their own representative or may choose to be represented by another person, except employees of the health care authority (HCA) or HCA's authorized agents.

(2) If the appellant is represented by a person who is not an attorney admitted to practice in Washington state, the representative must provide the presiding officer and other parties with the representative's name, address, and telephone number. In cases involving confidential information, the nonattorney representative must provide the PEBB appeals unit and other parties with a signed, written consent permitting release to the nonattorney representative of the appellant's personal health information protected by state or federal law.

(3) An attorney admitted to practice law in Washington state representing the appellant must file a written notice of appearance containing the attorney's name, address, and telephone number with the presiding officer's office and serve all parties with the notice. In cases involving confidential information, the attorney must provide the PEBB appeals unit and other parties with a signed, written consent permitting release to the attorney of the appellant's personal health information protected by state or federal law. If the appellant's attorney representative no longer represents the appellant, then the attorney must file a written notice of withdrawal of representation with the presiding officer or review officer or officers' office and serve all parties with the notice.

NEW SECTION

WAC 182-16-2085 Continuances. The presiding officer or review officer or officers may grant, in their sole discretion, a request for a continuance on motion of the appellant, the authority, or on its own motion. The continuance may be up to thirty calendar days.

NEW SECTION

WAC 182-16-2090 Initial order. Unless a continuance has been granted, within ten days after the PEBB appeals unit receives a request for a brief adjudicative proceeding, the presiding officer shall render a written initial order that addresses the issue or issues raised by the appellant in their appeal. The presiding officer shall serve a copy of the initial order on all parties and the initial order shall contain information on how the appellant may request review of the initial order.

NEW SECTION

WAC 182-16-2100 How to request a review of an initial order resulting from a brief administrative proceeding. (1) An appellant who has received an initial order upholding an employing agency decision, PEBB program decision, or a decision made by PEBB program contracted vendor, may request review of the initial order by the authority. The appellant must file a written request for review of the initial order or by making an oral request for review of the initial order with the public employees benefits board (PEBB) appeals unit within twenty-one days after service of the initial order. The written request for review of the initial order must be provided using the contact information included in the initial order. If the appellant fails to request review of the initial order within twenty-one days, the order becomes the final order without any further action by the authority.

(2) Upon timely request by the appellant, a review of an initial order will be performed by one or more review officers designated by the director of the authority.

(3) If the parties have not requested review, the authority may review an order resulting from a brief adjudicative proceeding on its own motion, and without notice to the parties, but it may not take action on review less favorable to any party than the initial order without giving that party notice and an opportunity to explain that party's view of the matter.

NEW SECTION

WAC 182-16-2105 Withdrawing the request for a brief adjudicative proceeding or review of an initial order. (1) The appellant may withdraw the request for a brief adjudicative proceeding or review of an initial order for any reason, and at any time, by contacting the public employees benefits board (PEBB) appeals unit. The PEBB appeals unit will present the withdrawal request to the presiding officer or review officer or officers.

(2) The request for withdrawal must be made in writing.

(3) After a withdrawal request is received, the presiding officer or review officer or officers must enter and serve a written order dismissing the appeal.

(4) If an appellant withdraws a request for a brief adjudicative proceeding or review of an initial order, the appellant may not reinstate the request for a brief adjudicative proceeding or review of an initial order unless time remains on their original appeal period.

NEW SECTION

WAC 182-16-2110 Final order. (1) A final order issued by the review officer or officers will be issued in writing and include a brief statement of the reasons for the decision.

(2) The final order must be rendered and served within twenty days of the date of the initial order or of the date the request for review of the initial order was received by the PEBB appeals unit, whichever is later.

(3) The final order will include a notice that reconsideration and judicial review may be available.

(4) A request for review of the initial order is deemed denied if the authority does not issue a final order within twenty days after the request for review of the initial order is filed.

NEW SECTION

WAC 182-16-2120 Request for reconsideration. (1) A request for reconsideration asks the review officer or officers to reconsider the final order because the party believes the review officer or officers made a mistake of law, mistake of fact, or clerical error.

(2) A request for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) Requests for reconsideration must be filed with the review officer or officers who entered the final order.

(4) If a party files a request for reconsideration:

(a) The review officer or officers must receive the request for reconsideration on or before the tenth business day after the service date of the final order.

(b) The party filing the request must send copies of the request to all other parties.

(c) Within five business days of receiving a request for reconsideration, the review officer or officers must serve all parties a notice that provides the date the request for reconsideration was received.

(5) The other parties may respond to the request for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(a) Responses to a request for reconsideration must be received by the review officer or officers no later than seven business days after the service date of the review officer's or officers' notice as described in subsection (4)(c) of this section, or the response will not be considered.

(b) Service of responses to a request for reconsideration must be made to all parties.

(6) If a party needs more time to file a request for reconsideration or respond to a request for reconsideration, the review officer or officers may extend the required time frame if the party makes a written request providing a good reason for the request within the required time frame.

(7) Unless the request for reconsideration is denied as untimely filed under WAC 182-16-2120 (4)(a), the same review officer or officers who entered the final order, if reasonably available, will also consider the request as well as any responses received.

(8) The decision on the request for reconsideration must be in the form of a written order denying the request, granting the request in whole or in part and issuing a new written final order, or granting the petition and setting the matter for further hearing.

(9) If the review officer or officers do not send an order on the request for reconsideration within twenty calendar days of the date of the notice described in subsection (4)(c) of this section, the request is deemed denied.

(10) If any party files a request for reconsideration of the final order, the reconsideration process must be completed before any judicial review may be requested. However, the filing of a petition for reconsideration is not required before requesting judicial review.

(11) An order denying a request for reconsideration is not subject to judicial review.

(12) No evidence may be offered in support of a motion for reconsideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not with reasonable diligence have discovered and produced at the hearing or before the ruling on a dispositive motion.

NEW SECTION

WAC 182-16-2130 Judicial review of final order. (1) Judicial review is the process of appealing a final order to a court.

(2) The appellant may appeal a final order by filing a written petition for judicial review that meets the requirements of RCW 34.05.546. The public employees benefits board (PEBB) program may not request judicial review.

(3) The appellant should consult RCW 34.05.510 through 34.05.598 for further details and requirements of the judicial review process.

NEW SECTION

WAC 182-16-2140 Presiding officer—Designation and authority. The designation of a presiding officer shall be consistent with the requirements of RCW 34.05.485 and the presiding officer shall not have personally participated in the decision made by the employing agency or PEBB program.

(1) The presiding officer will decide the issue based on the information provided by the parties during the presiding officer's review of the appeal.

(2) A presiding officer is limited to those powers granted by the state constitution, statutes, rules, or applicable case law.

(3) A presiding officer may not decide that a rule is invalid or unenforceable.

(4) In addition to the record, the presiding officer may employ authority expertise as a basis for the decision.

NEW SECTION

WAC 182-16-2150 Review officer or officers—Designation and authority. (1) The designation of a review officer or officers shall be consistent with the requirements of RCW 34.05.491 and the review officer or officers shall not have personally participated in the decision made by the employing agency or PEBB program.

(2) The review officer or officers shall review the initial order and the record to determine if the initial order was correctly decided.

(3) The review officer or officers will issue a final order that will either:

(a) Affirm the initial order in whole or in part;

(b) Reverse the initial order in whole or in part; or

(c) Refer the matter for a formal administrative hearing; or

(d) Remand to the presiding officer in whole or in part.

(4) A review officer or officers are limited to those powers granted by the state constitution, statutes, rules, or applicable case law.

(5) A review officer or officers may not decide that a rule is invalid or unenforceable.

(6) In addition to the record, the review officer or officers may employ authority expertise as a basis for the decision.

NEW SECTION

WAC 182-16-2160 Conversion of a brief adjudicative proceeding to a formal administrative hearing. (1) The presiding officer or the review officer or officers, in their sole discretion may convert a brief adjudicative proceeding to a formal administrative hearing at any time on motion by the subscriber or enrollee or their representative, the authority, or on the presiding officer or review officer or officers' own motion.

(2) The presiding officer or review officer or officers must convert the brief adjudicative proceeding to a formal administrative hearing when it is found that the use of the brief adjudicative proceeding violates any provision of law, when the protection of the public interest requires the authority to give notice and an opportunity to participate to persons other than the parties, or when the issues and interests involved in the controversy warrant the use of the procedures or RCW 34.05.413 through 34.05.479 that govern formal administrative hearings.

(3) When a brief adjudicative proceeding is converted to a formal administrative hearing, the director may become the hearing officer or may designate a replacement hearing officer to conduct the formal administrative hearing upon notice to the subscriber or enrollee and the authority.

(4) When a brief adjudicative proceeding is converted to a formal administrative hearing, WAC 182-16-010 through 182-16-130 and 182-16-3000 through 182-16-3200 apply to the formal administrative hearing.

PART III

FORMAL ADMINISTRATIVE HEARINGS

NEW SECTION

WAC 182-16-3000 Formal administrative hearings. (1) When a brief adjudicative proceeding is converted to a formal administrative hearing consistent with WAC 182-16-2160, the director designates a hearing officer to conduct the formal administrative hearing.

(2) Formal administrative hearings are conducted consistent with the Administrative Procedure Act, RCW 34.05.413 through 34.05.479.

(3) This part describes the general rules and procedures that apply to public employees benefits board (PEBB) benefits formal administrative hearings.

(a) This part supplements the Administrative Procedure Act (APA), chapter 34.05 RCW, and the model rules of procedure in chapter 10-08 WAC. The model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended, are hereby adopted for use by the authority in public employees benefits board (PEBB) benefits formal administrative hearings. Other procedural rules adopted in chapters 182-08, 182-12, and 182-16 WAC are supplementary to the model rules of procedure.

(b) In the case of a conflict between the model rules of procedure and this part, the procedural rules adopted in this part shall govern.

(c) If there is a conflict between this part and specific PEBB program rules, the specific PEBB program rules prevail. PEBB program rules are found in chapters 182-08 and 182-12 WAC.

(d) Nothing in this part is intended to affect the constitutional rights of any person or to limit or change additional requirements imposed by statute or other rule. Other laws or rules determine if a hearing right exists, including the APA and program rules or laws.

NEW SECTION

WAC 182-16-3005 Record—Formal administrative hearings. The record in a formal administrative hearing consists of the official documentation of the hearing process. The record includes, but is not limited to, recordings or transcripts, admitted exhibits, decisions, briefs, notices, orders, and other filed documents.

NEW SECTION

WAC 182-16-3010 Requirements to appear and represent a party in the formal administrative hearing process. (1) All parties must provide the hearing officer and all other parties with their name, address, and telephone number.

(2) The appellant may act as their own representative or have another person represent them, except employees of the health care authority (HCA) or HCA's authorized agents.

(3) If the appellant is represented by a person who is not an attorney admitted to practice in Washington state, the representative must provide the hearing officer and all other parties with the representative's name, address, and telephone number. In cases involving confidential information, the nonattorney representative must provide the HCA hearing representative with a signed, written consent permitting release to the nonattorney representative of personal health information protected by state or federal law.

(4) An attorney admitted to practice law in Washington state, who wishes to represent the appellant, must file a written notice of appearance containing the attorney's name, address, and telephone number with the hearing officer's office and serve all parties with the notice. In cases involving confidential information, the attorney representative must provide the HCA hearing representative with a signed, written consent permitting release to the attorney representative of the appellant's personal health information protected by state or federal law. If the appellant's attorney representative no longer represents the appellant, then the attorney must file a written notice of withdrawal of representation with the hearing officer's office and serve all parties with the notice.

NEW SECTION

WAC 182-16-3015 Hearing officers—Assignment, motions of prejudice, and disqualification. (1) **Assignment.** A hearing officer will be assigned at least five business days before a hearing. A party may ask which hearing officer is assigned to a hearing by contacting the hearing officer's office listed on the notice of hearing. If requested by a party, the hearing officer's office must send the name of the assigned hearing officer to all parties, by electronic mail or in writing, at least five business days before the scheduled hearing date.

(2) **Motion of prejudice.** Any party requesting a different hearing officer may file a written motion of prejudice against the hearing officer assigned to the matter before the hearing officer rules on a discretionary issue in the case, admits evidence, or takes testimony.

(a) A motion of prejudice must include a declaration stating that a party does not believe the hearing officer can hear the case fairly. Service of copies of the motion must also be made to all parties listed on the notice of hearing.

(b) Any party's first motion of prejudice will be automatically granted. Any subsequent motion of prejudice made by a party may be granted or denied at the discretion of the hearing officer no later than seven days after receiving the motion.

(c) A party may make an oral motion of prejudice at the beginning of a hearing before the hearing officer rules on a discretionary issue in the matter, admits evidence, or takes testimony if:

(i) The hearing officer was not assigned at least five business days before the date of the hearing; or

(ii) The hearing officer was changed within five business days of the date of the hearing.

(3) **Disqualification.** A hearing officer may be disqualified from presiding over a hearing for bias, prejudice, conflict of interest, or ex parte contact with a party to the hearing.

(a) Any party may file a petition to disqualify a hearing officer as described in RCW 34.05.425. A petition to disqualify must be in writing and service promptly made to all parties and the hearing officer upon discovering facts of possible grounds for disqualification.

(b) The hearing officer whose disqualification is requested will determine whether to grant or deny the petition in a written order, stating facts and reasons for the determination. The hearing officer must serve the order no later than seven days after receiving the petition for disqualification.

NEW SECTION

WAC 182-16-3030 Authority of the hearing officer. (1) A hearing officer must hear and decide the issues de novo (anew) based on the evidence and oral or written arguments presented during a formal administrative hearing and admitted into the record.

(2) A hearing officer has no inherent or common law powers, and is limited to those powers granted by the state constitution, statutes, or rules.

(3) A hearing officer may not decide that a rule is invalid or unenforceable. If the validity of a rule is raised during a formal administrative hearing, the hearing officer may allow only argument to preserve the record for judicial review.

NEW SECTION

WAC 182-16-3080 Time requirements for service of notices made by the hearing officer. (1) The hearing officer or their designee must serve a notice of a formal administrative hearing to all parties and their representatives at least twenty-one calendar days before the hearing date. The parties may agree to, but the hearing officer cannot impose, a shorter notice period.

(2) If a prehearing conference or dispositive motion hearing is scheduled, the hearing officer must serve a notice of the prehearing conference or dispositive motion hearing to the parties and their representatives at least seven business days before the date of the prehearing conference or dispositive motion hearing except:

(a) The hearing officer may change any scheduled formal administrative hearing into a prehearing conference or dispositive motion hearing and provide less than seven business days' notice of the prehearing conference or dispositive motion hearing; and

(b) The hearing officer may give less than seven business days' notice if the only purpose of the prehearing conference is to consider whether to grant a continuance.

(3) The hearing officer must reschedule a formal administrative hearing if necessary to comply with the notice requirements in this section.

NEW SECTION

WAC 182-16-3090 Formal administrative hearing location. (1) A hearing officer must be present at all hearings. Hearings may be held either in person or telephonically.

(a) A telephonic hearing is where all parties and the hearing officer are present by telephone.

(b) An in-person hearing is where the appellant appears face-to-face with the hearing officer. The other parties can choose to appear either in person or by telephone, but cannot be ordered to appear in person.

(2) Whether a hearing is held in person or telephonically, the parties have the right to see all documents, hear all testimony, and question all witnesses.

(3) If a hearing is originally scheduled to be held in person, the appellant may ask the hearing officer to change the in-person hearing to a telephonic hearing. Once a telephonic hearing begins, the hearing officer may stop, reschedule, and change the telephonic hearing to an in-person hearing if any party makes such a request.

NEW SECTION

WAC 182-16-3100 Rescheduling and continuances for formal administrative hearings. (1) Any party may request the hearing officer to reschedule a formal administrative hearing if a rule requires notice of a hearing and the amount of notice required was not provided.

(a) The hearing officer must reschedule the hearing under circumstances identified in subsection (1) of this section if requested by any party.

(b) The parties may agree to shorten the amount of notice required by any rule.

(2) Any party may request a continuance of a formal administrative hearing either orally or in writing.

(a) In each formal administrative hearing, the hearing officer must grant each party's first request for a continuance. The continuance may be up to thirty calendar days.

(b) The hearing officer may grant each party up to one additional continuance of up to thirty calendar days because of extraordinary circumstances established at a proceeding.

(c) After granting a continuance, the hearing officer or their designee must:

(i) Immediately telephone all other parties to inform them the hearing was continued; and

(ii) Serve an order of continuance on the parties no later than fourteen days before the new formal administrative hearing date. All orders of continuance must provide a new deadline for filing documents with the hearing officer. The new filing deadline can be no less than ten calendar days prior to the new formal administrative hearing date. If the continuance is granted pursuant to (b) of this subsection, then the order of continuance must also include findings of fact that state with specificity the extraordinary circumstances for which the hearing officer granted the continuance.

(3) Regardless of whether a party has been granted a continuance as described in subsection (1) of this section, the hearing officer must grant a continuance if a new material issue is raised during the formal administrative hearing and a party requests a continuance.

NEW SECTION

WAC 182-16-3110 Prehearing conferences. (1) A prehearing conference is a formal proceeding conducted on the record by a hearing officer to prepare for a formal administrative hearing.

(a) The hearing officer must record a prehearing conference using audio recording equipment.

(b) The hearing officer may conduct a prehearing conference in person, by telephone conference call, or in any other manner acceptable to the parties.

(2) Any party can request a prehearing conference. The hearing officer must grant each party's first request for a prehearing conference if it is filed with the hearing officer at least seven business days before the next scheduled hearing date. The hearing officer may grant requests for additional prehearing conferences.

(3) The appellant must attend or participate in any scheduled prehearing conference. If the appellant does not attend or participate in a scheduled prehearing conference, the hearing officer will enter an order of default dismissing the matter.

(4) During a prehearing conference the parties and the hearing officer may:

(a) Identify the issue or issues to be decided;

(b) Agree to the date, time, and place of any requested or necessary hearing or hearings;

(c) Identify accommodation and safety issues; or

(d) Establish a schedule for:

(i) The exchange and filing of briefs;

(ii) Providing a list of proposed witnesses;

(iii) Providing exhibit lists; and

(iv) Providing proposed exhibits before the hearing.

(5) After the prehearing conference ends, the hearing officer must enter a written order that recites the action taken at the prehearing conference, a case schedule outlining hearing dates and deadlines for exchanging witness lists and exhibits, and any other agreements reached by the parties.

(6) The hearing officer must serve the prehearing order to the parties at least fourteen calendar days before the next scheduled hearing.

(7) A party may object to the prehearing order by filing an objection with the hearing officer in writing no later than ten days after the service date of the order. The hearing officer must serve a written ruling on the objection.

(8) If no objection is made to the prehearing order, the order determines how the case will be conducted by the hearing officer, including whether a hearing will be in person or held by telephone conference, unless the hearing officer enters an amended prehearing conference order.

NEW SECTION

WAC 182-16-3120 Dispositive motions. (1) A dispositive motion could dispose of one or all the issues in a formal administrative hearing, such as a motion to dismiss or motion for summary judgment.

(2) To request a dispositive motion hearing a party must file a written dispositive motion with the hearing officer and serve a copy of the motion to all other parties. The hearing officer may also set a dispositive motion hearing, and request briefing from the parties, to address any possible dispositive issues the hearing officer believes must be addressed before the hearing.

(3) The deadline to file a timely dispositive motion shall be ten calendar days before the scheduled hearing.

(4) Upon receiving a dispositive motion, a hearing officer:

(a) Must convert the scheduled hearing to a dispositive motion hearing when:

(i) The dispositive motion is timely filed with the hearing officer at least ten calendar days before the date of the hearing; and

(ii) The party filing the dispositive motion has not previously filed a dispositive motion.

(b) May schedule a dispositive motion hearing in all instances other than described in (a) of this subsection.

(5) The hearing officer may conduct the dispositive motion hearing in person or by telephone conference. For dispositive motion hearings scheduled to be held in person, the HCA hearing representative may choose to attend and participate in person or by telephone conference call.

(6) The party requesting the dispositive motion hearing must attend and participate in the dispositive motion hearing in person or by telephone. If the party requesting the motion hearing does not attend and participate in the dispositive motion hearing, the hearing officer will enter an order of default.

(7) During a dispositive motion hearing, the hearing officer can only consider the filed dispositive motions, any

response to the motions, evidence submitted to support or oppose the motions, and argument on the motions. Prior to rescheduling any necessary hearings, the hearing officer must serve a written order on the dispositive motions.

(8) The hearing officer must serve the written order on the dispositive motions to all parties no later than eighteen calendar days after the dispositive motion hearing is held. Orders on dispositive motions are subject to motions for reconsideration or petitions for judicial review as described in WAC 182-16-2120 and 182-16-2130.

NEW SECTION

WAC 182-16-3130 Subpoenas. (1) Hearing officers, the HCA hearing representative, and attorneys for the parties may prepare subpoenas as described in Washington state civil rule 45, unless otherwise prohibited by law. Any party may request the hearing officer prepare a subpoena on their behalf.

(2) The hearing officer may schedule a prehearing conference to decide whether to issue a subpoena.

(3) If a party requests the hearing officer prepare a subpoena on its behalf, the party is responsible for:

(a) Service of the subpoena; and

(b) Any costs associated with:

(i) Compliance with the subpoena; and

(ii) Witness fees as described in RCW 34.05.446(7).

(4) Service of a subpoena must be made by a person who is at least eighteen years old and not a party to the hearing. Service of the subpoena is complete when the person serving the subpoena:

(a) Gives the person or entity named in the subpoena a copy of the subpoena; or

(b) Leaves a copy of the subpoena with a person over the age of eighteen at the residence or place of business of the person or entity named in the subpoena.

(5) To prove service of a subpoena on a witness, the person serving the subpoena must file with the hearing officer's office a signed, written, and dated statement that includes:

(a) The name of the person to whom service of the subpoena occurred;

(b) The date the service of the subpoena occurred;

(c) The address where the service of the subpoena occurred; and

(d) The name, age, and address of the person who provided service of the subpoena.

(6) A party may request the hearing officer quash (set aside) or change a subpoena request at any time before the deadline given in the subpoena.

(7) A hearing officer may quash (set aside) or change a subpoena if it is unreasonable.

NEW SECTION

WAC 182-16-3140 Orders of dismissal—Reinstating a formal administrative hearing after an order of dismissal. (1) An order of dismissal is an order from the hearing officer ending the matter. The order is entered because the party who made the appeal withdrew from the proceeding, the appellant is no longer aggrieved, the hearing officer granted a dispositive motion dismissing the matter, or the hearing officer entered an order of default because the party who made the appeal failed to attend or refused to participate in a prehearing conference or the formal administrative hearing.

(2) The order of dismissal becomes a final order if no party files a request to vacate the order as described in subsections (3) through (7) of this section.

(3) If the hearing officer enters and serves an order dismissing the formal administrative hearing, the appellant may file a written request to vacate (set aside) the order of dismissal. Upon receipt of a request to vacate an order of dismissal, the hearing officer must schedule and serve notice of a prehearing conference as described in WAC 182-16-3080. At the prehearing conference, the party asking that the order of dismissal be vacated has the burden to show good cause according to subsection (8) of this section for an order of dismissal to be vacated and the matter to be reinstated.

(4) The request to vacate an order of dismissal must be filed with the hearing officer and the other parties. The party requesting that an order of dismissal be vacated should specify in the request why the order of dismissal should be vacated.

(5) The request to vacate an order of dismissal must be filed with the hearing officer no later than twenty-one calendar days after the date the order of dismissal was entered. If no request is received within that deadline, the dismissal order becomes a final order and the final order will stand.

(6) If the hearing officer finds good cause, as described in subsection (8) of this section, for the order of dismissal to be vacated, the hearing officer must enter and serve a written order to the parties setting forth the findings of fact, conclusions of law, and reinstatement of the matter.

(7) If the order of dismissal is vacated, the hearing officer will conduct a formal administrative hearing at which the parties may present argument and evidence about issues raised in the original appeal. The formal administrative hearing may occur immediately following the prehearing conference on the request to vacate only if agreed to by the parties and the hearing officer, otherwise a formal administrative hearing date must be scheduled by the hearing officer.

(8) Good cause is a substantial reason or legal justification for failing to appear, act, or respond to an action using the provisions of Superior Court civil rule 60 as a guideline. This good cause exception applies only to this chapter. This good cause exception does not apply to any other chapter or chapters in Title 182 WAC.

NEW SECTION

WAC 182-16-3150 Settlement agreements. (1) If the parties reach a mutually agreeable resolution the agreement must be in writing.

(2) Any written agreements will be entered into the record by either party for consideration by the hearing officer.

(3) If all of the issues are resolved by the written agreement, the hearing officer must enter and serve an order of dismissal.

(4) If all of the issues are not resolved by a written agreement, either party, or the hearing officer, may request a pre-

hearing conference before a formal administrative hearing on any remaining issues can occur.

NEW SECTION

WAC 182-16-3160 Withdrawing a formal administrative hearing. (1) The appellant may withdraw a formal administrative hearing for any reason, and at any time, by contacting the HCA hearing representative who will coordinate the withdrawal with the hearing officer.

(2) The request for withdrawal must generally be made in writing. An oral withdrawal by the appellant is permitted during a formal administrative hearing when both the hearing officer and HCA hearing representative are present.

(3) After a withdrawal request is received, the hearing officer must cancel any scheduled hearings and enter and serve a written order dismissing the case.

NEW SECTION

WAC 182-16-3170 Final order deadline—Required information. (1) Within ninety days after the formal administrative hearing record is closed, the hearing officer shall serve a final order that shall be the final decision of the authority. The hearing officer shall serve a copy of the final order to all parties.

(2) The hearing officer must include the following information in the written final order:

(a) Identify the order as a final order of the public employees benefits board (PEBB) program;

(b) List the name and docket number of the case and the names of all parties and representatives;

(c) Enter findings of fact used to resolve the dispute based on the evidence admitted in the record;

(d) Explain why evidence is, or is not, credible when describing the weight given to evidence related to disputed facts;

(e) State the law that applies to the dispute;

(f) Apply the law to the facts of the case in the conclusions of law;

(g) Discuss the reasons for the decision based on the facts and the law;

(h) State the result and remedy ordered; and

(i) Include any other information required by law or program rules.

NEW SECTION

WAC 182-16-3180 Request for reconsideration and response—Process. (1) A request for reconsideration asks the hearing officer to reconsider the final order because the party believes the hearing officer made a mistake of law, mistake of fact, or clerical error.

(2) A request for reconsideration must state in writing why the party wants the final order to be reconsidered.

(3) Requests for reconsideration must be filed with the hearing officer who entered the final order.

(4) If a party files a request for reconsideration:

(a) The hearing officer must receive the request for reconsideration on or before the tenth business day after the service date of the final order.

(b) The party filing the request must serve copies of the request to all other parties.

(c) Within five business days of receiving a request for reconsideration, the hearing officer must serve to all parties a notice that provides the date the request for reconsideration was received.

(5) The other parties may respond to the request for reconsideration. The response must state in writing why the final order should stand. Responses are optional. If a party chooses not to respond, that party will not be prejudiced because of that choice.

(a) Responses to a request for reconsideration must be received by the hearing officer no later than seven business days after the service date of the hearing officer's notice as described in subsection (4)(c) of this section, or the response will not be considered.

(b) Service of responses to a request for reconsideration must be made to all parties.

(6) If a party needs more time to file a request for reconsideration or respond to a request for reconsideration, the hearing officer may extend the required time frame if the party makes a written request providing a good reason for the request within the required time frame.

(7) No evidence may be offered in support of a motion for re-consideration, except newly discovered evidence that is material for the party moving for reconsideration and that the party could not with reasonable diligence have discovered and produced at the hearing or before the ruling on a dispositive motion.

NEW SECTION

WAC 182-16-3190 Decisions on requests for reconsideration. (1) Unless the request for reconsideration is denied as untimely filed under WAC 182-16-3180, the same hearing officer who entered the final order, if reasonably available, will also dispose of the request as well as any responses received.

(2) The decision on the request for reconsideration must be in the form of a written order denying or granting the request in whole or in part and issuing a new written final order.

(3) If the hearing officer does not send an order on the request for reconsideration within twenty calendar days of the date of the notice described in WAC 182-16-2120, the request is deemed denied.

(4) If any party files a request for reconsideration of the final order, the reconsideration process must be completed before any judicial review may be requested. However, the filing of a request for reconsideration is not required before requesting judicial review.

(5) An order denying a request for reconsideration is not subject to judicial review.

NEW SECTION

WAC 182-16-3200 Judicial review of final order. (1) Judicial review is the process of appealing a final order to a court.

(2) The appellant may appeal a final order by filing a written petition for judicial review that meets the require-

ments of RCW 34.05.546. The public employees benefits board (PEBB) program may not request judicial review.

(3) The appellant should consult RCW 34.05.510 through 34.05.598 for further details and requirements of the judicial review process.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-16-025	Where do members appeal decisions regarding eligibility, enrollment, premium payments, premium surcharges, a public employees benefits board (PEBB) wellness incentive, or the administration of benefits?
WAC 182-16-030	How can a current or former employee or an employee's dependent appeal a decision made by a state agency about eligibility, premium surcharge, or enrollment in benefits?
WAC 182-16-032	How can a decision made by the public employees benefits board (PEBB) program regarding eligibility, enrollment, premium payments, premium surcharge, eligibility to participate in the PEBB wellness incentive program or receive a PEBB wellness incentive; or a decision made by an employer group regarding life insurance or LTD insurance be appealed?
WAC 182-16-035	How can a subscriber appeal a decision regarding the administration of wellness incentive program requirements?
WAC 182-16-036	How can an employee who is eligible to participate in the state's salary reduction plan appeal a decision regarding the administration of benefits offered under the state's salary reduction plan?
WAC 182-16-038	How can an entity or organization appeal a decision of the health care authority to deny an employer group application?
WAC 182-16-040	What should the request for review or notice of appeal contain?
WAC 182-16-050	How can an appellant aggrieved by a written decision made by the public employees benefits board (PEBB) appeals committee request an administrative hearing?
WAC 182-16-052	Requirements to appear and represent a party in the administrative hearing process.
WAC 182-16-061	Presiding officers—Assignment, motions of prejudice, and disqualification.
WAC 182-16-062	Authority of the presiding officer.
WAC 182-16-067	Service of documents on another party.
WAC 182-16-070	Calculating when a hearing deadline ends.
WAC 182-16-071	Time requirements for service of notices made by the presiding officer.
WAC 182-16-072	Hearing location.
WAC 182-16-073	Rescheduling and continuances.
WAC 182-16-080	Determining if an administrative hearing right exists.
WAC 182-16-081	Prehearing conferences.
WAC 182-16-082	Dispositive motions.
WAC 182-16-085	Subpoenas.
WAC 182-16-090	Orders of dismissal—Reinstating a hearing after an order of dismissal.
WAC 182-16-091	Settlement agreements.
WAC 182-16-092	Withdrawing the request for an administrative hearing.
WAC 182-16-100	Final order deadline—Required information.
WAC 182-16-105	Motion for reconsideration and response—Process.
WAC 182-16-106	Decisions on motions for reconsideration.
WAC 182-16-110	Judicial review of final order.

WSR 18-19-093
PROPOSED RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2018-07—Filed September 18, 2018, 4:58 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-14-106.

Title of Rule and Other Identifying Information: Valuation of the stick [stock] of a subsidiary of a domestic insurance company.

Hearing Location(s): On October 23, 2018, at 10:00 a.m., at the Office of the Insurance Commissioner, 302 Sid Snyder Avenue S.W., Suite 200, Olympia, WA 98501.

Date of Intended Adoption: October 24, 2018.

Submit Written Comments to: Jim Tompkins, P.O. Box 40620 [40260], Olympia, WA 98504-0260, email rulescoordinator@oic.wa.gov, fax 360-586-3109, by October 22, 2018.

Assistance for Persons with Disabilities: Contact Lorie Villaflores, phone 360-725-7087, TTY 360-586-0241, email LorieV@oic.wa.gov, by October 22, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: WAC 284-16-150 through 284-16-220 regarding the valuation of the stock of the subsidiary of a domestic insurance company were adopted under previous versions of the Insurer Holding Company Act (chapter 48.31B RCW). The commissioner will consider adopting amendments to these rules to update the rules to be compatible with the current version of the Insurance Holding Company Act.

Reasons Supporting Proposal: WAC 284-16-150 through 284-16-220 regarding the valuation of the stock of the subsidiary of a domestic insurance company were adopted under previous versions of the Insurer Holding Company Act (chapter 48.31B RCW). The commissioner will consider adopting amendments to these rules to update the rules to be compatible with the current version of the Insurance Holding Company Act.

Statutory Authority for Adoption: RCW 48.02.060, 48.12.180, and 48.31B.040.

Statute Being Implemented: RCW 48.12.180.

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

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Jim Tompkins, P.O. Box 40260, Olympia, WA 98504-0260, 360-725-7036; Implementation: Steve Drutz, P.O. Box 40255, Olympia, WA 98504-0255, 360-725-7209; and Enforcement: Doug Hartz, P.O. Box 40255, Olympia, WA 98504-0255, 360-725-7214.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed rule only corrects or clarifies language as a result of statutory changes.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules only correct typographical errors, make address or name changes, or clarify language of a rule without changing its effect.

September 18, 2018
Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Order R 76-7, filed 11/30/76)

WAC 284-16-160 Definitions. For purpose of this regulation:

(1) ((~~The term~~)) "Subsidiary" ((~~shall have~~)) has the same meaning ((~~given it by RCW 48.31A.010~~)) as in RCW 48.31B.005;

(2) ((~~The term~~)) "Book value" ((~~shall~~)) means that value determined by dividing the amount of its capital and surplus as shown in its last annual statement or subsequent report of examination (excluding from its surplus, any reserves required by statute and any portion of surplus properly allocable to policyholders, ((~~rather~~)) other than stockholders) less the ((~~value (~~))par ((~~of~~)) or redemption value, whichever is the greater((~~)~~)) of all of its preferred stock((~~, if any,~~)) outstanding, by the total number of shares of its common stock issued and outstanding.

AMENDATORY SECTION (Amending Order R 76-7, filed 11/30/76)

WAC 284-16-170 Usual valuation of stock of a subsidiary. The common stock of any subsidiary of an insurer may always be valued on the basis of the value of only such of the assets of such subsidiary as would constitute lawful investments for the insurer if acquired or held directly by the insurer under either the requirements of chapter 48.13 or 48.31B RCW, or both.

AMENDATORY SECTION (Amending Order R 76-7, filed 11/30/76)

WAC 284-16-180 Other methods of valuing stock of a subsidiary. If sound business judgment of an insurer's management causes it to believe that a valuation of common stock of a subsidiary pursuant to WAC 284-16-170 is inappropriate, it may value such stock on one of the following bases:

(1) "Book value," provided, however, that the common stock of a noninsurance company may not be valued on the basis of this subsection, and further provided that an insurer may value its holdings of stock in a subsidiary insurer at acquisition cost if acquisition cost is less than market or book value.

(2) One of the following bases appropriate to each type of subsidiary owned by it, provided, however, that an insurer shall not be required to value the stock of all its subsidiaries on the same basis:

(a) Subject to the limitations imposed under WAC 284-16-190, the net worth of a noninsurance company determined in accordance with generally accepted accounting principles, as of the end of its most recent fiscal year, provided, subject to WAC 284-16-200, that the financial statements of the company for its most recent fiscal year have been audited by an independent certified public accountant in accordance with generally accepted auditing standards. The common stock of an insurance company may not be valued under this subsection.

(b) Subject to the limitations imposed under WAC 284-16-190, a value equal to the cost of the common stock of the subsidiary, provided such value is determined and adjusted to reflect subsequent operating results, in the case of insurance companies in accordance with statutory accounting requirements, and for other than insurance companies in accordance with generally accepted accounting principles.

(c) The market value of the common stock of the subsidiary, if the stock is listed on a national securities exchange.

(d) The value, if any, placed on the common stock of such subsidiary by the National Association of Insurance Commissioners.

(e) Any other value which the insurer can substantiate to the satisfaction of the commissioner as being a reasonable value.

AMENDATORY SECTION (Amending Order R 76-7, filed 11/30/76)

WAC 284-16-190 Limitation on values. (1) With respect to values determined under WAC 284-16-180 (2)(a) or (b), amounts attributable to "good will," and other intangibles shall not in the aggregate (of all direct and indirect subsidiaries) exceed (either initially on acquisition of a subsidiary, or thereafter), 10% of the capital and surplus of an insurer, as reported in its next preceding annual statement. Such amounts shall be written off over a period not in excess of ten years, written down for any other than temporary decline of the fair value of an investment as a subsidiary, or other adjustments in accordance with the NAIC statements of statutory accounting principles.

(2) For purposes of this section, "good will" shall be defined as the amount arising at a given point in time, resulting from an arm's-length transaction involving the transfer of a business, representing the difference between the value of the consideration given and the net asset value of the properties acquired on the books of the predecessor company.

(3) Where warranted in exceptional cases, the commissioner may require a more rapid write-off of good will than is otherwise provided in this section.

WSR 18-19-094
PROPOSED RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2018-08—Filed September 18, 2018, 5:01 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-13-103.

Title of Rule and Other Identifying Information: Variable life and annuity definition product alignment.

Hearing Location(s): On October 24, 2018, at 1:00 p.m., at the Office of the Insurance Commissioner, 302 Sid Snyder Avenue S.W., Suite 200, Olympia, WA 98504. All attendees should check in at reception.

Date of Intended Adoption: November 7, 2018.

Submit Written Comments to: Zachary Mason, P.O. Box 40260, Olympia, WA 98504-0260, email rulescoordinator@oic.wa.gov, fax 360-586-3109, by October 19, 2018.

Assistance for Persons with Disabilities: Contact Lorie Villaflores, phone 360-725-7087, TTY 360-586-0241, email LorieV@oic.wa.gov, by October 19, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This proposed rule clarifies language which exists in statute. It corrects a reference from FINRA to the Washington department of financial institutions and clarifies wording for variable life and variable annuity producer authority.

Reasons Supporting Proposal: This proposed rule aligns rule language with that of the department of financial institutions and more clearly communicates the requirements and responsibilities of producers seeking the variable life and variable annuity life of authority.

Statutory Authority for Adoption: RCW 48.18A.070, 48.02.060 (3)(a).

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

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Zachary Mason, P.O. Box 40260, Olympia, WA 98504-0260, 360-725-7043; Implementation and Enforcement: Jeff Baughman, P.O. Box 40260, Olympia, WA 98504-0260, 360-725-7156.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Pursuant to RCW 34.05.328 (5)(b)(iv) it has been determined that it is not necessary to prepare a cost-benefit analysis.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules only correct typographical errors, make address or name changes, or clarify language of a rule without changing its effect.

September 18, 2018
Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 09-02-073, filed 1/6/09, effective 7/1/09)

WAC 284-17-015 Variable life and variable annuity products—Standards for resident licenses. (1) ((~~Resident insurance~~)) Any producer((~~s~~)) who desires to sell, solicit or negotiate variable life and variable annuity products in this state must:

(a) Obtain a securities salesperson license from the department of financial institutions for a FINRA member broker-dealer; and

(b) If a resident of this state, obtain and maintain an insurance producer license with ((~~a~~)) the life line of authority and ((~~an appropriate securities license from the Financial Industry Regulatory Authority (FINRA). Upon presentation of satisfactory evidence that the producer has fulfilled this requirement,~~)) the variable life and variable annuity line of authority; or

(c) If a nonresident of this state, obtain and maintain a producer license with the life line of authority and the variable life and variable annuity line of authority in their resident or home state in order to be eligible to apply for and be issued a nonresident license in this state.

(2) The commissioner will only issue a resident or nonresident producer license with ((~~a~~)) the variable life and variable annuity ((~~products~~)) line of authority when satisfactory

evidence has been received that the producer has fulfilled the applicable requirements of subsection (1) of this section.

(((~~(2)~~))) (3) All licensees with the variable life and variable annuity products line of authority are also subject to the licensing requirements set forth in RCW 48.18A.060.

WSR 18-19-098
PROPOSED RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Filed September 19, 2018, 8:42 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-14-107.

Title of Rule and Other Identifying Information: Producer license expiration and renewal time frames for licenses, appointments and affiliations.

Hearing Location(s): On October 25, 2018, at 1:30 p.m., at the Office of the Insurance Commissioner (OIC), 5000 Capitol Boulevard S.E., Tumwater, WA 98501.

Date of Intended Adoption: October 31, 2018.

Submit Written Comments to: Jim Tompkins, P.O. Box 40260, Olympia, WA 98504-0260, email rulescoordinator@oic.wa.gov, fax 360-586-3109, by October 22, 2018.

Assistance for Persons with Disabilities: Contact Lorie Villaflores, phone 360-725-7087, TTY 360-586-0241, email LorieV@oic.wa.gov, by October 22, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The commissioner will consider updating WAC 284-17-423 to link a producer's license expiration to the end of their birth month, not their date of birth. The commissioner will also consider updating WAC 284-17-443 to provide clarification.

Reasons Supporting Proposal: The proposed rule changes under consideration will allow OIC to come into compliance with the National Association of Insurance Commissioners licensing model laws and best practices. The intent is to provide consistency and uniformity with other jurisdictions and to use business practices that will allow for a longer window to review licenses, appointments and affiliations.

Statutory Authority for Adoption: RCW 48.02.060 and 48.17.005.

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

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Jim Tompkins, P.O. Box 40260, Olympia, WA 98504-0260, 360-725-7036; Implementation and Enforcement: Jeff Baughman, P.O. Box 40255, Olympia, WA 98504-0260 [98504-0255], 360-725-7156.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. This rule is exempt from a cost-benefit analysis under RCW 34.05.328 (5)(b)(ii) and (iii).

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules relate only to internal governmental operations that are not subject to violation by a nongovernment party; and rules are adopting or incorporating by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule.

September 19, 2018
Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 09-02-073, filed 1/6/09, effective 7/1/09)

WAC 284-17-423 Term of initial and reinstated individual license. (1) Initial and reinstated individual licenses are valid from their date of issuance until the ((~~date~~)) end of the licensee's next ((~~birthday anniversary~~)) birth month plus one year. Additional licenses issued to the same active licensee will be on the same renewal cycle as the first license issued to that licensee.

(2) The renewal date of a business entity license is based on the date of application. The license is valid for two years. Additional licenses issued to the same active licensee will be on the same renewal cycle as the first license issued to that licensee.

AMENDATORY SECTION (Amending WSR 11-04-067, filed 1/28/11, effective 2/28/11)

WAC 284-17-443 Renewal of appointments or affiliations. (1) ((~~At least sixty days prior to the renewal date, an appointment or affiliation renewal notice will be sent to the insurer or business entity via email.~~

(~~2~~))) When the appointment or affiliation renewal is available online, the insurer or business entity may access and review the list ((~~online, make any changes, and must remit the~~)) of their appointments or affiliations, remove any licensees from their list, and complete the renewal process by remitting the finalized list and correct fees via electronic submission to the commissioner. New appointments or affiliations may not be added until after the renewal process has been completed.

(((~~3~~))) (2) The online appointment or affiliation renewal and payment of fees must be completed no later than the renewal date.

WSR 18-19-099
WITHDRAWL OF PROPOSED RULES
WASHINGTON STATE UNIVERSITY
[Filed September 19, 2018, 9:09 a.m.]

We are withdrawing our proposal, filed as WSR 18-18-093. The purpose of the proposal was to revise the rules regarding standards of conduct for students, chapter 504-26 WAC, and the rules regarding practice and procedure, chapter 504-04 WAC.

We will refile an updated proposal for revision to these chapters at a later time.

For more information, contact Deborah L. Bartlett, Rules Coordinator, Washington State University, P.O. Box 641225, Pullman, WA 99164-1225, phone 509-335-2005, email prf.forms@wsu.edu.

Deborah L. Bartlett
Rules Coordinator

WSR 18-19-101
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed September 19, 2018, 9:38 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-05-067 and 18-11-093.

Title of Rule and Other Identifying Information: The following sections from chapter 182-543 WAC, Medical equipment: WAC 182-543-0500 General, 182-543-1000 Definitions, 182-543-1100 Client eligibility, 182-543-2000 Eligible providers and provider requirements, 182-543-2100 Requests to include new medical equipment and technology, 182-543-2200 Proof of delivery, 182-543-2250 Rental or purchase, 182-543-3100 Covered—Patient lifts/traction, equipment/fracture, and frames/transfer boards, 182-543-4200 Covered—Wheelchairs—Power-drive, 182-543-4300 Covered—Wheelchairs—Modifications, accessories, and repairs, 182-543-4400 Covered—Complex rehabilitation technology, 182-543-5000 Covered—Prosthetics/orthotics, 182-543-5500 Covered—Medical supplies and related services, 182-543-5700 Covered—Medical equipment for clients in skilled nursing facilities, 182-543-7000 Authorization, 182-543-7100 Prior authorization, 182-543-7200 Prior authorization for limits on amount, frequency or duration, 182-543-7300 Expedited prior authorization (EPA), 182-543-8000 Billing general, 182-543-8100 Billing for managed care clients, 182-543-8200 Billing for clients eligible for medicare and medicaid, 182-543-9000 General reimbursement, 182-543-6000 DME and related supplies, medical supplies and related services—Noncovered, 182-543-9100 Reimbursement method—Other DME, 182-543-9200 Reimbursement method—Wheelchairs, 182-543-9250 Reimbursement method—Complex rehabilitation technology, 182-543-9300 Reimbursement method—Prosthetics and orthotics, and 182-543-9400 Reimbursement method—Medical supplies and related services.

Hearing Location(s): On October 23, 2018, at 10:00 a.m., at the Health Care Authority (HCA), Cherry Street Plaza, Pear Conference Room (107), 626 8th Avenue, Olympia, WA 98504. Metered public parking is available street side around building. A map is available at www.hca.wa.gov/documents/directions_to_csp.pdf, or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: Not sooner than October 24, 2018.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by October 23, 2018.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, TTY 800-848-5429 or 711, email amber.lougheed@hca.wa.gov, by October 19, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is amending these rules to align with federal rules under 42 C.F.R. Part 440.70. The proposed rules require that medical supplies, equipment and appliances be prescribed by physicians and that other nonphysician practitioners must document that a face-to-face encounter (related to the primary reason medical equipment is needed) occurred within a reasonable time frame.

The proposed rules use the term "medical equipment" to replace "durable medical equipment" (DME) and the other items formerly listed with DME. The rules provide that if the agency denies a requested service, the client may request an administrative hearing. The agency has removed unnecessary definitions from this chapter. The rules clarify that medical equipment may be used in any setting where normal life activities take place. The rules clarify that prosthetics and orthotics requested beyond stated limits may be prior authorized when medically necessary. The agency considers requests for prior authorization for items meeting the definition of medical equipment, and grants prior authorization when the service is medically necessary. The proposed rules repeal WAC 182-543-6000, which list noncovered DME.

The proposed rules align with section 503 of the Consolidated Appropriations Act, 2016 and section 5002 of the 21st Century Cures Act of 2016, which added section 1903 (i)(27) to the Social Security Act. The proposed rules prohibit reimbursement for certain medical equipment expenditures that are, in the aggregate, in excess of what medicare would have paid for the items. To remove redundancy, WAC 182-543-9000 also includes reimbursement provisions previously contained in WAC 182-543-9100 through 182-543-9400; these rules will be repealed.

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 necessary because of federal law, 42 C.F.R. section 440.70 and section 1903 (i)(27) of the Social Security Act.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Melinda Froud, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1408; Implementation and Enforcement: Erin Mayo, P.O. Box 45506, Olympia, WA 98504-5506, 360-725-1729.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Citation of the specific federal statute or regulation and description of the consequences to the state if the rule is not adopted: 42 C.F.R. section 440.70 provides that physicians prescribe medical supplies, equipment and appliances and that practitioners document a face-to-face encounter within a reasonable time. This section also provides that clients have a right to a hearing, that medical equipment may be used any place where normal life activities take place, and prohibits lists of noncovered items. Section 1903 (i)(27) of the Social Security Act prohibits reimbursement for certain medical equipment that are, in the aggregate, more than medicare would pay for the items.

September 19, 2018
Wendy Barcus
Rules Coordinator

Chapter 182-543 WAC

((~~DURABLE MEDICAL EQUIPMENT AND RELATED SUPPLIES, COMPLEX REHABILITATION TECHNOLOGY, PROSTHETICS, ORTHOTICS, MEDICAL SUPPLIES AND RELATED SERVICES~~)) MEDICAL EQUIPMENT, SUPPLIES, AND APPLIANCES

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-0500 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services~~)) General. (1) The federal government considers ((~~durable~~)) medical equipment (((~~(DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, and medical~~)), supplies ((~~to be optional~~)), and appliances, which the medicaid agency refers to throughout this chapter as medical equipment, services under the medicaid program((~~, except when prescribed as an integral part of an approved plan of treatment under the home health program or required under the early and periodic screening, diagnosis and treatment (EPSDT) program. The medicaid agency may reduce or eliminate coverage for optional services, consistent with legislative appropriations~~)).

(2) The agency ((~~covers the DME and related supplies, CRT, prosthetics, orthotics, and related services~~)) pays for medical equipment, including modifications, accessories, and repairs((~~, and medical supplies listed in this chapter~~)), according to agency rules and subject to the limitations and requirements in this chapter((~~.~~

~~(3) The agency pays for DME and related supplies, CRT, prosthetics, orthotics, and related services including modifications, accessories, and repairs, and medical supplies when they are:~~

~~(a) Covered;~~

~~(b) Within the scope of the client's medical program (see WAC 182-501-0060 and 182-501-0065);~~

~~(c)~~)) when the medical equipment is:

(a) Medically necessary, as defined in WAC 182-500-0070;

(((~~(d) Prescribed by a physician, advanced registered nurse practitioner (ARNP), naturopathic physicians, or physician assistant certified (PAC) within the scope of his or her licensure, except for dual eligible medicare/medicaid clients when medicare is the primary payer and the agency is being billed for a co-pay and/or deductible only;~~

~~(e)~~)) (b) Authorized, as required within this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions and provider notices; and

(((~~(f)~~)) (c) Billed according to this chapter, chapters 182-501 and 182-502 WAC, and the agency's published billing instructions and provider notices((~~; and~~

(((~~(g) Provided and used within accepted medical or physical medicine community standards of practice~~)).

(((~~(4)~~))) (3) For the initiation of medical equipment under WAC 182-551-2122, the face-to-face encounter must be related to the primary reason the client requires medical equipment and must occur no later than six months prior to the start of services.

(4) The face-to-face encounter must be conducted by the ordering physician, a nonphysician practitioner as described in WAC 182-500-0075, or the attending acute, or post-acute physician, for beneficiaries admitted to home health immediately after an acute or post-acute stay.

(5) If a nonphysician practitioner as described in WAC 182-500-0075 (or the attending physician when a client is discharged from an acute hospital stay) performs the face-to-face encounter, the nonphysician practitioner (or attending physician) must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the client's medical record.

(6) The agency requires prior authorization for covered ((~~DME and related supplies, CRT, prosthetics, orthotics, medical supplies, and related services~~)) medical equipment when the clinical criteria set forth in this chapter are not met, including the criteria associated with the expedited prior authorization process.

(a) The agency evaluates requests requiring prior authorization on a case-by-case basis to determine medical necessity as defined in WAC 182-500-0070, according to the process found in WAC 182-501-0165.

(b) Refer to WAC 182-543-7000, 182-543-7100, 182-543-7200, and 182-543-7300 for specific details regarding authorization.

(((~~(5)~~))) (7) The agency bases its determination about which ((~~DME and related supplies, CRT, prosthetics, orthotics, medical supplies, and related services~~)) medical equip-

ment requires prior authorization (PA) or expedited prior authorization (EPA) on utilization criteria (see WAC 182-543-7100 for PA and WAC 182-543-7300 for EPA). The agency considers all of the following when establishing utilization criteria:

(a) Cost;

(b) The potential for utilization abuse;

(c) A narrow therapeutic indication; and

(d) Safety.

(((~~6~~))) (8) The agency evaluates a request for ((~~any item listed as noncovered in this chapter~~)) equipment that does not meet the definition of medical equipment or that is determined not medically necessary under the provisions of WAC 182-501-0160. When early and periodic screening, diagnosis and treatment (EPSDT) applies, the agency evaluates a noncovered service, equipment, or supply according to the process in WAC 182-501-0165 to determine if it is medically necessary, safe, effective, and not experimental (see WAC 182-543-0100 for EPSDT rules).

(((~~7~~))) (9) The agency may terminate a provider's participation with the agency according to WAC 182-502-0030 and 182-502-0040.

(((~~8~~))) (10) The agency evaluates a request for a service that ((~~is in a covered category,~~)) meets the definition of medical equipment but has been determined to be experimental or investigational, under the provisions of WAC 182-501-0165.

(11) If the agency denies a requested service, the agency notifies the client in writing that the client may request an administrative hearing under chapter 182-526 WAC. (For MCO enrollees, see WAC 182-538-110.)

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-1000 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, and orthotics, medical supplies and related services—~~))Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to this chapter.

"By-report (BR)" - See WAC 182-500-0015.

"Complex needs patient" - An individual with a diagnosis or medical condition that results in significant physical or functional needs and capacities.

"Complex rehabilitation technology (CRT)" - Wheelchairs and seating systems classified as durable medical equipment within the medicare program that:

(((~~1~~))) (a) Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities as medically necessary to prevent hospitalization or institutionalization of a complex needs patient;

(((~~2~~))) (b) Are primarily used to serve a medical purpose and generally not useful to a person in the absence of an illness or injury; and

(((~~3~~))) (c) Require certain services necessary to allow for appropriate design, configuration, and use of such item, including patient evaluation and equipment fitting.

"Date of delivery" - The date the client actually took physical possession of an item or equipment.

"Digitized speech" (also referred to as devices with whole message speech output) - Words or phrases that have been recorded by an individual other than the speech generating device (SGD) user for playback upon command of the SGD user.

"Disposable supplies" - Supplies which may be used once, or more than once, but are time limited.

((~~**"Durable medical equipment (DME)"** Equipment that:~~

~~(1) Can withstand repeated use;~~

~~(2) Is primarily and customarily used to serve a medical purpose;~~

~~(3) Generally is not useful to a person in the absence of illness or injury; and~~

~~(4) Is appropriate for use in the client's place of residence.~~))

"EPSDT" - See WAC 182-500-0030.

"Expedited prior authorization (EPA)" - See WAC 182-500-0030.

"Fee-for-service (FFS)" - See WAC 182-500-0035.

"Health care common procedure coding system (HCPCS)" - A coding system established by the Health Care Financing Administration (HCFA) to define services and procedures. HCFA is now known as the Centers for Medicare and Medicaid Services (CMS).

"Home" - For the purposes of this chapter, means location, other than hospital or skilled nursing facility where the client receives care.

"House wheelchair" - A skilled nursing facility wheelchair that is included in the skilled nursing facility's per-patient-day rate under chapter 74.46 RCW.

"Individually configured" - A device has a combination of features, adjustments, or modifications specific to a complex needs patient that a qualified complex rehabilitation technology supplier provides by measuring, fitting, programming, adjusting, or adapting the device as appropriate so that the device is consistent with an assessment or evaluation of the complex needs patient by a health care professional and consistent with the complex needs patient's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

((~~**"Limitation extension"** - A client-specific authorization by the agency for additional covered services beyond the set amount allowed under agency rules. See WAC 182-501-0169.~~))

"Manual wheelchair" - See "Wheelchair - Manual."

"Medical equipment" - Includes medical equipment and appliances, and medical supplies.

"Medical equipment and appliances" - Health care-related items that:

(a) Are primarily and customarily used to serve a medical purpose;

(b) Generally are not useful to a person in the absence of illness or injury;

(c) Can withstand repeated use;

(d) Can be reusable or removable; and

(e) Are suitable for use in any setting where normal life activities take place.

"Medical supplies" - ((~~Supplies~~)) Health care-related items that are:

(((~~(1) Primarily and customarily used to service a medical purpose; and~~

~~(2)~~))) (a) Consumable or disposable or cannot withstand repeated use by more than one person;

(b) Required to address an individual medical disability, illness, or injury;

(c) Suitable for use in any setting which is not a medical institution and in which normal life activities take place; and

(d) Generally not useful to a person in the absence of illness or injury.

"Medically necessary" - See WAC 182-500-0070.

"National provider indicator (NPI)" - See WAC 182-500-0075.

((~~**"Other durable medical equipment (other DME)" - All durable medical equipment, excluding wheelchairs and wheelchair-related items.**~~

~~**"Orthotic device"** or **"orthotic"** - A corrective or supportive device that:~~

~~(1) Prevents or corrects physical deformity or malfunction; or~~

~~(2) Supports a weak or deformed portion of the body.~~

~~**"Personal or comfort item"** - An item or service which primarily serves the comfort or convenience of the client or caregiver.~~)) **"Orthotic device"** or **"orthotic"** - A corrective or supportive device that:

(a) Prevents or corrects physical deformity or malfunction; or

(b) Supports a weak or deformed portion of the body.

"Power-drive wheelchair" - See "Wheelchair - Power."

"Pricing cluster" - A group of manufacturers' list prices for brands/models of ((~~DME, medical supplies and nondurable~~)) medical equipment that the agency considers when calculating the reimbursement rate for a procedure code that does not have a fee established by medicare.

"Prior authorization" - See WAC 182-500-0085.

"Prosthetic device" or **"prosthetic"** - See WAC 182-500-0085.

"Qualified complex rehabilitation technology supplier" - A company or entity that:

(((~~1~~))) (a) Is accredited by a recognized accrediting organization as a supplier of CRT;

(((~~2~~))) (b) Meets the supplier and quality standards established for durable medical equipment suppliers under the medicare program;

(((~~3~~))) (c) For each site that it operates, employs at least one CRT professional, certified by the rehabilitation engineering and assistive technology society of North America as an assistive technology professional, to analyze the needs and capacities of clients, and provide training in the use of the selected covered CRT items;

(((~~4~~))) (d) Has the CRT professional physically present for the evaluation and determination of the appropriate individually configured CRT for the complex needs patient;

(((~~5~~))) (e) Provides service and repairs by qualified technicians for all CRT products it sells; and

(((~~6~~))) (f) Provides written information to the complex needs patient at the time of delivery about how the individual may receive service and repair of the delivered CRT.

"Resource-based relative value scale (RBRVS)" - A scale that measures the relative value of a medical service or intervention, based on the amount of physician resources involved.

"Reusable supplies" - Supplies which are to be used more than once.

"Scooter" - A federally approved, motor-powered vehicle that:

(((~~1~~))) (a) Has a seat on a long platform;

(((~~2~~))) (b) Moves on either three or four wheels;

(((~~3~~))) (c) Is controlled by a steering handle; and

(((~~4~~))) (d) Can be independently driven by a client.

"Specialty bed" - A pressure reducing support surface, such as foam, air, water, or gel mattress or overlay.

"Speech generating device (SGD)" - An electronic device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication. Formerly known as "augmentative communication device (ACD)."

"Synthesized speech" - Is a technology that translates a user's input into device-generated speech using algorithms representing linguistic rules, unlike prerecorded messages of digitized speech. A SGD that has synthesized speech is not limited to prerecorded messages but rather can independently create messages as communication needs dictate.

"Three- or four-wheeled scooter" - A three- or four-wheeled vehicle meeting the definition of scooter (see "scooter") and which has the following minimum features:

(((~~1~~))) (a) Rear drive;

(((~~2~~))) (b) A twenty-four volt system;

(((~~3~~))) (c) Electronic or dynamic braking;

(((~~4~~))) (d) A high to low speed setting; and

(((~~5~~))) (e) Tires designed for indoor/outdoor use.

"Trendelenburg position" - A position in which the patient is lying on his or her back on a plane inclined thirty to forty degrees. This position makes the pelvis higher than the head, with the knees flexed and the legs and feet hanging down over the edge of the plane.

"Usual and customary charge" - See WAC 182-500-0110.

"Warranty-period" - A guarantee or assurance, according to manufacturers' or provider's guidelines, of set duration from the date of purchase.

"Wheelchair - Manual" - A federally approved, nonmotorized wheelchair that is capable of being independently propelled and fits one of the following categories:

(((~~1~~))) (a) Standard:

(((~~a~~))) (i) Usually is not capable of being modified;

(((~~b~~))) (ii) Accommodates a person weighing up to two hundred fifty pounds; and

(((~~c~~))) (iii) Has a warranty period of at least one year.

(((~~2~~))) (b) Lightweight:

(((~~a~~))) (i) Composed of lightweight materials;

(((~~b~~))) (ii) Capable of being modified;

(((~~c~~))) (iii) Accommodates a person weighing up to two hundred fifty pounds; and

(((~~d~~))) (iv) Usually has a warranty period of at least three years.

(((3))) (c) High-strength lightweight:

(((a))) (i) Is usually made of a composite material;

(((b))) (ii) Is capable of being modified;

(((c))) (iii) Accommodates a person weighing up to two hundred fifty pounds;

(((d))) (iv) Has an extended warranty period of over three years; and

(((e))) (v) Accommodates the very active person.

(((4))) (d) Hemi:

(((a))) (i) Has a seat-to-floor height lower than eighteen inches to enable an adult to propel the wheelchair with one or both feet; and

(((b))) (ii) Is identified by its manufacturer as "Hemi" type with specific model numbers that include the "Hemi" description.

(((5))) (e) Pediatric: Has a narrower seat and shorter depth more suited to pediatric patients, usually adaptable to modifications for a growing child.

(((6))) (f) Recliner: Has an adjustable, reclining back to facilitate weight shifts and provide support to the upper body and head.

(((7))) (g) Tilt-in-space: Has a positioning system, which allows both the seat and back to tilt to a specified angle to reduce shear or allow for unassisted pressure releases.

(((8))) (h) Heavy duty:

(((a))) (i) Specifically manufactured to support a person weighing up to three hundred pounds; or

(((b))) (ii) Accommodating a seat width of up to twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(((9))) (i) Rigid: Is of ultra-lightweight material with a rigid (nonfolding) frame.

(((10))) (j) Custom heavy duty:

(((a))) (i) Specifically manufactured to support a person weighing over three hundred pounds; or

(((b))) (ii) Accommodates a seat width of over twenty-two inches wide (not to be confused with custom manufactured wheelchairs).

(((11))) (k) Custom manufactured specially built:

(((a))) (i) Ordered for a specific client from custom measurements; and

(((b))) (ii) Is assembled primarily at the manufacturer's factory.

"Wheelchair - Power" - A federally approved, motorized wheelchair that can be independently driven by a client and fits one of the following categories:

(((1))) (a) Custom power adaptable to:

(((a))) (i) Alternative driving controls; and

(((b))) (ii) Power recline and tilt-in-space systems.

(((2))) (b) Noncustom power: Does not need special positioning or controls and has a standard frame.

(((3))) (c) Pediatric: Has a narrower seat and shorter depth that is more suited to pediatric patients. Pediatric wheelchairs are usually adaptable to modifications for a growing child.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-1100 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services~~))Client eligibility. (1) Refer to the table in WAC 182-501-0060 to see which Washington apple health (((~~WAH~~))) programs include ((~~DME~~)) home health services, including medical equipment and related services, ((~~complex rehabilitation technology (CRT), prosthetics and orthotics, medical supplies and related services~~)) in their benefit package.

(2) For clients eligible under an alien emergency medical (AEM) program, see WAC 182-507-0115.

(3) Clients who are eligible for services under medicare and medicaid (medically needy program-qualified medicare beneficiaries) are eligible for ((~~DME~~)) medical equipment and related services((~~, CRT, prosthetics and orthotics, medical supplies and related services~~)).

(4) Clients who are enrolled in a medicaid agency-contracted managed care organization (MCO) must arrange for ((~~DME and related services, prosthetics and orthotics, medical supplies~~)) medical equipment and related services directly through ((~~his or her~~)) the client's agency-contracted MCO. The agency does not pay for medical equipment ((~~and/or~~)) or services provided to a client who is enrolled in ((~~a~~)) an agency-contracted MCO, but chose not to use one of the MCO's participating providers.

(5) For clients who reside in a skilled nursing facility, see WAC 182-543-5700.

(6) Clients enrolled in the alternative benefits plan (defined in WAC 182-500-0010) are eligible for ((~~DME and related supplies, CRT, prosthetics, orthotics,~~)) medical ((~~supplies, and related~~)) equipment when used as a habilitative service to treat a qualifying condition in accordance with WAC 182-545-400.

AMENDATORY SECTION (Amending WSR 17-15-073, filed 7/14/17, effective 8/14/17)

WAC 182-543-2000 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services~~))Eligible providers and provider requirements. (1) The medicaid agency pays qualified providers for ((~~durable~~)) medical equipment (((~~(DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies,~~)) and repairs((~~, and related services~~)) on a fee-for-service basis as follows:

(a) ((~~DME~~)) Providers who are enrolled with medicare for ((~~DME~~)) medical equipment and related repair services;

(b) Qualified complex rehabilitation technology (CRT) suppliers who are enrolled with medicare ((~~for DME and related repair services~~));

(c) Medical equipment dealers ((~~who are enrolled with medicare,~~)) and pharmacies who are enrolled with medicare, ((~~and home health agencies under their~~)) and have a national provider identifier (NPI) for medical supplies;

(d) Prosthetics and orthotics providers who are licensed by the Washington state department of health in prosthetics and orthotics. Medical equipment dealers and pharmacies

that do not require state licensure to provide selected prosthetics and orthotics may be paid for those selected prosthetics and orthotics only as long as the medical equipment dealers and pharmacies meet the medicare enrollment requirement;

(e) Occupational therapists providing orthotics who are licensed by the Washington state department of health in occupational therapy;

(f) Physicians who provide medical equipment ((~~and supplies~~)) in the office((~~. The agency may pay separately for medical supplies, subject to the provisions in the agency's resource-based relative value scale fee schedule~~)); and

(g) Out-of-state prosthetics and orthotics providers who meet their state regulations.

(2) Providers and suppliers of ((~~DME and related supplies, CRT, prosthetics, orthotics,~~)) medical ((~~supplies and related items~~)) equipment must:

(a) Meet the general provider requirements in chapter 182-502 WAC;

(b) Have the proper business license and be certified, licensed and bonded if required, to perform the services billed to the agency;

(c) Have a valid prescription for the ((~~DME~~)) medical equipment.

(i) To be valid, a prescription must:

(A) Be written on the agency's Prescription Form (HCA 13-794). The agency's electronic forms are available online at((~~: http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx~~)) https://www.hca.wa.gov/billers-providers/forms-and-publications;

(B) Be written by a physician((~~, advanced registered nurse practitioner (ARNP), naturopathic physician, or physician's assistant certified (PAC)~~)) as defined in WAC 182-500-0085 and meet the face-to-face encounter requirements described in WAC 182-551-2040;

(C) Be written, signed (including the prescriber's credentials), and dated by the prescriber on the same day and before delivery of the ((~~supply,~~)) medical equipment((~~, or device~~)). Prescriptions must not be back-dated;

(D) Be no older than one year from the date the prescriber signs the prescription; and

(E) State the specific item or service requested, diagnosis, estimated length of need (weeks, months, or years), and quantity.

(ii) For dual-eligible clients when medicare is the primary payer and the agency is being billed for only the copay, only the deductible, or both, subsection (2)(a) of this section does not apply.

(d) Provide instructions for use of equipment;

(e) Provide only new equipment to clients, which include full manufacturer and dealer warranties. See WAC 182-543-2250(3);

(f) Provide documentation of proof of delivery, upon agency request (see WAC 182-543-2200); and

(g) Bill the agency using only the allowed procedure codes listed in the agency's published ((~~DME and related supplies, prosthetics and orthotics, medical supplies and related items~~)) medical equipment billing ((~~instructions~~)) guide.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-2100 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—~~))Requests to include new ((~~equipment/supplies/technology~~)) medical equipment and technology. (1) An interested party may request the medicaid agency to include new ((~~equipment/supplies~~)) medical equipment in the agency's ((~~durable~~)) medical equipment (((~~(DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies and related services~~)) billing ((~~instructions~~)) guide.

(2) The request ((~~should~~)) must include credible evidence, including but not limited to:

(a) Manufacturer's literature;

(b) Manufacturer's pricing;

(c) Clinical research/case studies (((~~included~~)) including FDA approval, if required);

(d) Proof of certification from the Centers for Medicare and Medicaid Services (CMS), if applicable; and

(e) Any additional information the requester feels would aid the agency in its determination.

((~~(3) Requests should be sent to the DME Program Management Unit, P.O. Box 45505, Olympia WA 98504-5506.~~))

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-2200 ((~~DME and related supplies, complex rehabilitation technology, prosthetics, orthotics, medical supplies and related services—~~))Proof of delivery. (1) When a provider delivers an item directly to the client or the client's authorized representative, the provider must furnish the proof of delivery when the medicaid agency requests that information. All of the following apply:

(a) The agency requires a delivery slip as proof of delivery. The proof of delivery slip must:

(i) Be signed and dated by the client or the client's authorized representative (the date of signature must be the date the item was received by the client);

(ii) Include the client's name and a detailed description of the item(s) delivered, including the quantity and brand name; and

(iii) For ((~~durable~~)) medical equipment (((~~(DME) and complex rehabilitation technology (CRT)~~))) that may require future repairs, include the serial number.

(b) When the provider or supplier submits a claim for payment to the agency, the date of service on the claim must be one of the following:

(i) For a one-time delivery, the date the item was received by the client or the client's authorized representative; or

(ii) For nondurable medical supplies for which the agency has established a monthly maximum, on or after the date the item was received by the client or the client's authorized representative.

(2) When a provider uses a delivery/shipping service to deliver items which are not fitted to the client, the provider must furnish proof of delivery that the client received the

equipment and/or supply, when the agency requests that information.

(a) If the provider uses a delivery/shipping service, the tracking slip is the proof of delivery. The tracking slip must include:

(i) The client's name or a reference to the client's ((~~package(s)~~)) package or packages;

(ii) The delivery service package identification number; and

(iii) The delivery address.

(b) If the provider/supplier does the delivering, the delivery slip is the proof of delivery. The delivery slip must include:

(i) The client's name;

(ii) The shipping service package identification number;

(iii) The quantity, detailed description(s), and brand ((~~name(s)~~)) name or names of the items being shipped; and

(iv) For ((~~DME and CRT~~)) medical equipment that may require future repairs, the serial number.

(c) When billing the agency, use:

(i) ((~~Use~~)) The shipping date as the date of service on the claim if the provider uses a delivery/shipping service; or

(ii) ((~~Use~~)) The actual date of delivery as the date of service on the claim if the provider/supplier does the delivery.

(3) A provider must not use a delivery/shipping service to deliver items which must be fitted to the client.

(4) Providers must obtain prior authorization when required before delivering the item to the client. The item must be delivered to the client before the provider bills the agency.

(5) The agency does not pay for ((~~DME and related supplies, CRT, prostheties and orthoties, medical supplies~~)) medical equipment and related items furnished to the agency's clients when:

(a) The medical professional who provides medical justification to the agency for the item provided to the client is an employee of, has a contract with, or has any financial relationship with the provider of the item; or

(b) The medical professional who performs a client evaluation is an employee of, has a contract with, or has any financial relationship with a provider of ((~~DME and related supplies, CRT, prostheties and orthoties, medical supplies,~~)) medical equipment and related items.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-2250 ((~~DME and related supplies, complex rehabilitation technology, prostheties, orthotics, medical supplies and related services~~))Rental or purchase. (1) The medicaid agency bases its decision to rent or purchase ((~~durable~~)) medical equipment (((~~(DME)~~))) on the length of time the client needs the equipment.

(2) A provider must not bill the agency for the rental or purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

(3) The agency purchases new ((~~DME~~)) medical equipment ((~~and complex rehabilitation technology (CRT)~~)) only.

(a) A new ((~~DME~~)) medical equipment item that is placed with a client initially as a rental item is considered a new item by the agency at the time of purchase.

(b) A used ((~~DME~~)) medical equipment item that is placed with a client initially as a rental item must be replaced by the supplier with a new item prior to purchase by the agency.

(4) The agency requires a dispensing provider to ensure the ((~~DME~~)) medical equipment rented to a client is:

(a) In good working order; and

(b) Comparable to equipment the provider rents to individuals with similar medical equipment needs who are either private pay or who have other third-party coverage.

(5) The agency's minimum rental period for covered ((~~DME~~)) medical equipment is one day.

(6) The agency authorizes rental equipment for a specific period of time. The provider must request authorization from the agency for any extension of the rental period.

(7) The agency's reimbursement amount for rented ((~~DME~~)) medical equipment includes all of the following:

(a) Delivery to the client;

(b) Fitting, set-up, and adjustments;

(c) Maintenance, repair and/or replacement of the equipment; and

(d) Return pickup by the provider.

(8) The agency considers rented equipment to be purchased after twelve months' rental unless the equipment is restricted as rental only.

(9) ((~~DME and related supplies, CRT, prostheties, and orthoties~~)) Medical equipment purchased by the agency for a client ((~~are~~)) is the client's property.

(10) The agency rents, but does not purchase, certain ((~~DME~~)) medical equipment for clients. This includes, but is not limited to, the following:

(a) Bilirubin lights for newborns ((~~at home~~)) with jaundice in any setting where normal life activities take place; and

(b) Electric hospital-grade breast pumps.

(11) The agency stops paying for any rented medical equipment effective the date of a client's death. The agency prorates monthly rentals as appropriate.

(12) For a client who is eligible for both medicare and medicaid, the agency only pays ((~~only~~)) the client's coinsurance and deductibles. The agency discontinues paying client's coinsurance and deductibles for rental medical equipment covered by medicare when either of the following applies:

(a) The reimbursement amount reaches medicare's reimbursement cap for the medical equipment; or

(b) Medicare considers the medical equipment purchased.

(13) The agency does not obtain or pay for insurance coverage against liability, loss and/or damage to rental equipment that a provider supplies to a client.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-3100 Covered—Patient lifts/traction, equipment/fracture, and frames/transfer boards. The

medicaid agency covers the purchase of the following, with the stated limitations, without prior authorization:

(1) Patient lift, hydraulic, with seat or sling - One per client in a five-year period.

(2) Traction equipment - One per client in a five-year period.

(3) Trapeze bars - One per client in a five-year period. The agency requires prior authorization for rental.

(4) Fracture frames - One per client in a five-year period. The agency requires prior authorization for rental.

(5) Transfer board or devices - One per client in a five-year period.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-4200 Covered—Wheelchairs—Power-drive. (1) The medicaid agency ((~~covers~~)) pays for power-drive wheelchairs when the prescribing physician certifies that ((~~the following clinical criteria are met~~)):

(a) The client can independently and safely operate a power-drive wheelchair;

(b) The client's medical condition negates ((~~his or her~~)) the client's ability to self-propel any of the wheelchairs listed in the manual wheelchair category in any setting where normal life activities take place; and

(c) A power-drive wheelchair will:

(i) Provide the client the only means of independent mobility in any setting where normal life activities take place; or

(ii) Enable a child to achieve age-appropriate independence and developmental milestones.

(2) ((~~The following additional information is required~~)) Additionally, for a three or four-wheeled power-drive scooter/power-operated vehicle (POV)((~~:~~

~~(a)~~)), the prescribing physician ((~~certifies that the client's condition is stable; and~~

~~(b) The client~~)) must certify the client's condition is unlikely to require a standard power-drive wheelchair within the next two years.

(3) When the agency approves a power-drive wheelchair for a client who already has a manual wheelchair, the power-drive wheelchair becomes the client's primary chair, unless the client meets the criteria in subsection (5) of this section.

(4) The agency pays to maintain only the client's primary wheelchair, unless the conditions of subsection (6) of this section apply.

(5) The agency pays for one manual wheelchair and one power-drive wheelchair for noninstitutionalized clients only when one of the following circumstances applies:

(a) The architecture of locations where the client's ((~~home is~~)) normal life activities take place are completely unsuitable for a power-drive wheelchair, due to conditions such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radius;

(b) The architecture of the bathroom in locations where the client's ((~~home bathroom~~)) normal life activities take place is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness; or

(c) The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities. In this case, the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. The agency requires the client's situation to meet the following conditions:

(i) The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home or along a pathway that does not provide for safe use of a power wheelchair; and

(ii) Cabulance, public buses, or personal transit are not available, practical, or possible for financial or other reasons.

(6) When the agency approves both a manual wheelchair and a power-drive wheelchair for a noninstitutionalized client who meets one of the circumstances in subsection (5) of this section, the agency pays to maintain both wheelchairs.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-4300 Covered—Wheelchairs—Modifications, accessories, and repairs. (1) The medicaid agency covers, with prior authorization, wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line item charges. To receive payment, providers must submit the following to the agency:

(a) A completed General Information for Authorization form (HCA 13-835). The agency's electronic forms are available online (see WAC 182-543-7000, Authorization);

(b) A completed Prescription Form (HCA 13-794);

(c) A completed Medical Necessity for Wheelchair Purchase (for home clients only) form (HCA 13-727). The date on this form (HCA 13-727) must not be dated prior to the date on the Prescription Form (HCA 13-794);

(d) The make, model, and serial number of the wheelchair to be modified;

(e) The modification requested; and

(f) Any specific information regarding the client's medical condition that necessitates the modification.

(2) The agency pays for transit option restraints only when used for client-owned vehicles.

(3) The agency covers, with prior authorization, wheelchair repairs. To receive payment, providers must submit the following to the agency:

(a) General Information for Authorization form (HCA 13-835). The agency's electronic forms are available online (see WAC 182-543-7000);

(b) A completed Medical Necessity for Wheelchair Purchase form (for home clients only) (HCA 13-727);

(c) The make, model, and serial number of the wheelchair to be repaired; and

(d) The repair requested.

(4) Prior authorization is required for the repair and modification of client-owned equipment.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-4400 Covered—Complex rehabilitation technology. (1) The medicaid agency covers, with prior authorization, individually configured, complex rehabilitation technology (CRT) products.

(2) CRT must be supplied by a CRT supplier with the appropriate taxonomy number to bill for the items.

(3) Each site that a company operates must employ at least one CRT professional who has been certified by the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

(4) The client must be evaluated by a licensed health care provider who performs specialty evaluations within their scope of practice (occupational or physical therapists) and who does not have a financial relationship with the supplier.

(a) At the evaluation, a CRT professional must also be present from the company ordering the equipment; or

(b) The CRT provider must be present at the evaluation to:

(i) Assist in selection of the appropriate CRT item(s); and

(ii) Provide training in the use of the selected items.

(5) The CRT provider must:

(a) Provide service and repairs by qualified technicians for all CRT products it sells; and

(b) Provide written information to the client at the time of delivery as to how the client may receive services and repairs.

AMENDATORY SECTION (Amending WSR 17-15-073, filed 7/14/17, effective 8/14/17)

WAC 182-543-5000 Covered—Prosthetics/orthotics. (1) The medicaid agency covers, without prior authorization (PA), the following prosthetics and orthotics. Items that meet the definition of medical equipment may be covered under the requirements for medical equipment. Prosthetics and orthotics that do not meet those definitions are covered, with stated limitations:

(a) Thoracic-hip-knee-ankle orthosis (THKAO) standing frame - One every five years.

(b) Preparatory, above knee "PTB" type socket, nonalignable system, pylon, no cover, SACH foot plaster socket, molded to model - One per lifetime, per limb.

(c) Preparatory, below knee "PTB" type socket, nonalignable system, pylon, no cover, SACH foot thermoplastic or equal, direct formed - One per lifetime, per limb.

(d) Socket replacement, below the knee, molded to patient model - One per twelve-month period, per limb.

(e) Socket replacement, above the knee/knee disarticulation, including attachment plate, molded to patient model - One per twelve-month period, per limb.

(f) All other prosthetics and orthotics are limited to one per twelve-month period per limb.

(g) Prosthetics and orthotics beyond these limits may be prior authorized when medically necessary, as defined in WAC 182-500-0070.

(2) The agency pays only licensed prosthetic and orthotic providers to supply prosthetics and orthotics. This licensure requirement does not apply to the following:

(a) Providers who are not required to have specialized skills to provide select orthotics, but meet ((~~DME~~)) medical equipment and pharmacy provider licensure requirements;

(b) Occupational therapists providing orthotics who are licensed by the Washington state department of health in occupational therapy; and

(c) Out-of-state providers, who must meet the licensure requirements of that state.

(3) The agency pays only for prosthetics or orthotics that are listed as such by the Centers for Medicare and Medicaid Services (CMS), that meet the definition of prosthetic or orthotic in WAC 182-543-1000 and are prescribed under WAC 182-543-1100 ((~~and 182-543-1200~~)).

(4) The agency pays for repair or modification of a client's current prosthesis. To receive payment, all of the following must be met:

(a) All warranties are expired;

(b) The cost of the repair or modification is less than fifty percent of the cost of a new prosthesis and the provider has submitted supporting documentation; and

(c) The repair must have a warranty for a minimum of ninety days.

(5) Clients are responsible for routine maintenance of their prosthetic or orthotic. If a client does not have the physical or mental ability to perform this task, the client's caregiver is responsible for routine maintenance of the prosthetic or orthotic. The agency requires PA for extensive maintenance to a prosthetic or orthotic.

(((~~(6) For prosthetics dispensed for cosmetic reasons only, see WAC 182-543-6000 DME and related supplies, medical supplies and related services—Noncovered.~~)))

AMENDATORY SECTION (Amending WSR 12-07-022, filed 3/12/12, effective 4/12/12)

WAC 182-543-5500 Covered—Medical supplies and related services. The medicaid agency ((~~covers, without prior authorization unless otherwise specified,~~)) pays for the following medical supplies and related services without prior authorization unless otherwise specified:

(1) Antiseptics and germicides:

(a) Alcohol (isopropyl) or peroxide (hydrogen) - One pint per month;

(b) Alcohol wipes (box of two hundred) - One box per month;

(c) Betadine or pHisoHex solution - One pint per month;

(d) Betadine or iodine swabs/wipes (box of one hundred) - One box per month;

(2) Bandages, dressings, and tapes;

(3) Batteries - Replacement batteries:

(a) The agency pays for the purchase of replacement batteries for wheelchairs with prior authorization.

(b) The agency does not pay for wheelchair replacement batteries that are used for speech generating devices (SGDs) or ventilators. ((~~See WAC 182-543-3400 for speech generating devices and chapter 182-548 WAC for ventilators.~~))

(4) Blood monitoring/testing supplies:

(a) Replacement battery of any type, used with a client-owned, medically necessary ((~~home~~)) or specialized blood glucose monitor - One in a three-month period;

(b) Spring-powered device for lancet - One in a six-month period;

(c) Diabetic test strips as follows:

(i) For clients((~~, twenty years of~~)) age twenty and younger, as follows:

(A) Insulin dependent, three hundred test strips and three hundred lancets per client, per month.

(B) For noninsulin dependent, one hundred test strips and one hundred lancets per client, per month.

(ii) For clients((~~,~~)) age twenty-one ((~~years of age~~)) and older:

(A) Insulin dependent, one hundred test strips and one hundred lancets per client, per month.

(B) For noninsulin dependent, one hundred test strips and one hundred lancets per client, every three months.

(iii) For pregnant ((~~women~~)) people with gestational diabetes, the agency pays for the quantity necessary to support testing as directed by the client's physician, up to sixty days postpartum.

(d) See WAC 182-543-5500(12) for blood glucose monitors.

(5) Braces, belts, and supportive devices:

(a) Knee brace (neoprene, nylon, elastic, or with a hinged bar) - Two per twelve-month period;

(b) Ankle, elbow, or wrist brace - Two per twelve-month period;

(c) Lumbosacral brace, rib belt, or hernia belt - One per twelve-month period;

(d) Cervical head harness/halter, cervical pillow, pelvic belt/harness/boot, or extremity belt/harness - One per twelve-month period.

(6) Decubitus care products:

(a) Cushion (gel, sacroiliac, or accuback) and cushion cover (any size) - One per twelve-month period;

(b) Synthetic or lamb's wool sheepskin pad - One per twelve-month period;

(c) Heel or elbow protectors - Four per twelve-month period.

(7) Ostomy supplies:

(a) Adhesive for ostomy or catheter: Cement; powder; liquid (e.g., spray or brush); or paste (any composition, e.g., silicone or latex) - Four total ounces per month.

(b) Adhesive or nonadhesive disc or foam pad for ostomy pouches - Ten per month.

(c) Adhesive remover or solvent - Three ounces per month.

(d) Adhesive remover wipes, fifty per box - One box per month.

(e) Closed pouch, with or without attached barrier, with a one- or two-piece flange, or for use on a faceplate - Sixty per month.

(f) Closed ostomy pouch with attached standard wear barrier, with built-in one-piece convexity - Ten per month.

(g) Continent plug for continent stoma - Thirty per month.

(h) Continent device for continent stoma - One per month.

(i) Drainable ostomy pouch, with or without attached barrier, or with one- or two-piece flange - Twenty per month.

(j) Drainable ostomy pouch with attached standard or extended wear barrier, with or without built-in one-piece convexity - Twenty per month.

(k) Drainable ostomy pouch for use on a plastic or rubber faceplate (only one type of faceplate allowed) - Ten per month.

(l) Drainable urinary pouch for use on a plastic, heavy plastic, or rubber faceplate (only one type of faceplate allowed) - Ten per month.

(m) Irrigation bag - Two every six months.

(n) Irrigation cone and catheter, including brush - Two every six months.

(o) Irrigation supply, sleeve - One per month.

(p) Ostomy belt (adjustable) for appliance - Two every six months.

(q) Ostomy convex insert - Ten per month.

(r) Ostomy ring - Ten per month.

(s) Stoma cap - Thirty per month.

(t) Ostomy faceplate - Ten per month. The agency does not pay for either of the following when billed in combination with an ostomy faceplate:

(i) Drainable pouches with plastic face plate attached; or

(ii) Drainable pouches with rubber face plate.

(8) Syringes and needles;

(9) Urological supplies - Diapers and related supplies:

(a) The standards and specifications in this subsection apply to all disposable incontinent products (e.g., briefs, diapers, pull-up pants, underpads for beds, liners, shields, guards, pads, and undergarments). See subsections (b), (c), (d), and (e) of this section for additional standards for specific products. All of the following apply to all disposable incontinent products:

(i) All materials used in the construction of the product must be safe for the client's skin and harmless if ingested;

(ii) Adhesives and glues used in the construction of the product must not be water-soluble and must form continuous seals at the edges of the absorbent core to minimize leakage;

(iii) The padding must provide uniform protection;

(iv) The product must be hypoallergenic;

(v) The product must meet the flammability requirements of both federal law and industry standards; and

(vi) All products are covered for client personal use only.

(b) In addition to the standards in subsection (a) of this section, diapers must meet all the following specifications. They must:

(i) Be hourglass shaped with formed leg contours;

(ii) Have an absorbent filler core that is at least one-half inch from the elastic leg gathers;

(iii) Have leg gathers that consist of at least three strands of elasticized materials;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have a back sheet that is moisture impervious and is at least 1.00 mm thick, designed to protect clothing and linens;

(vi) Have a top sheet that resists moisture returning to the skin;

(vii) Have an inner lining that is made of soft, absorbent material; and

(viii) Have either a continuous waistband, or side panels with a tear-away feature, or refastenable tapes, as follows:

(A) For child diapers, at least two tapes, one on each side.

(B) The tape adhesive must release from the back sheet without tearing it, and permit a minimum of three fastening/unfastening cycles.

(c) In addition to the standards in subsection (a) of this section, pull-up pants and briefs must meet the following specifications. They must:

(i) Be made like regular underwear with an elastic waist or have at least four tapes, two on each side or two large tapes, one on each side;

(ii) Have an absorbent core filler that is at least one-half inch from the elastic leg gathers;

(iii) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling;

(iv) Have leg gathers that consist of at least three strands of elasticized materials;

(v) Have a back sheet that is moisture impervious, is at least 1.00 mm thick, and is designed to protect clothing and linens;

(vi) Have an inner lining made of soft, absorbent material; and

(vii) Have a top sheet that resists moisture returning to the skin.

(d) In addition to the standards in subsection (a) of this section, underpads are covered only for incontinent purposes in a client's bed and must meet the following specifications:

(i) Have an absorbent layer that is at least one and one-half inches from the edge of the underpad;

(ii) Be manufactured with a waterproof backing material;

(iii) Be able to withstand temperatures not to exceed one hundred-forty degrees Fahrenheit;

(iv) Have a covering or facing sheet that is made of nonwoven, porous materials that have a high degree of permeability, allowing fluids to pass through and into the absorbent filler. The patient contact surface must be soft and durable;

(v) Have filler material that is highly absorbent. It must be heavy weight fluff filler or the equivalent; and

(vi) Have four-ply, nonwoven facing, sealed on all four sides.

(e) In addition to the standards in subsection (a) of this section, liners, shields, guards, pads, and undergarments are covered for incontinence only and must meet the following specifications:

(i) Have channels to direct fluid throughout the absorbent area, and leg gathers to assist in controlling leakage, and/or be contoured to permit a more comfortable fit;

(ii) Have a waterproof backing designed to protect clothing and linens;

(iii) Have an inner liner that resists moisture returning to the skin;

(iv) Have an absorbent core that consists of cellulose fibers mixed with absorbent gelling materials;

(v) Have pressure-sensitive tapes on the reverse side to fasten to underwear; and

(vi) For undergarments only, be contoured for good fit, have at least three elastic leg gathers, and may be belted or unbelted.

(f) The agency pays for urological products when they are used alone. The following are examples of products ((~~which~~)) the agency does not pay for when used in combination with each other:

(i) Disposable diapers;

(ii) Disposable pull-up pants and briefs;

(iii) Disposable liners, shields, guards, pads, and undergarments;

(iv) Rented reusable diapers (e.g., from a diaper service); and

(v) Rented reusable briefs (e.g., from a diaper service), or pull-up pants.

(g) The agency approves a client's use of a combination of products only when the client uses different products for daytime and nighttime use. Example: pull-up pants for daytime use and disposable diapers for nighttime use. The total quantity of all products in this section used in combination cannot exceed the monthly limitation for the product with the highest limit.

(h) Purchased disposable diapers (any size) are limited to two hundred per month for clients age three ((~~years of age~~)) and older.

(i) Reusable cloth diapers (any size) are limited to:

(i) Purchased - Thirty-six per year; and

(ii) Rented - Two hundred per month.

(j) Disposable briefs and pull-up pants (any size) are limited to:

(i) Two hundred per month for a client age three ((~~to~~)) through age eighteen ((~~years of age~~)); and

(ii) One hundred fifty per month for a client age nineteen ((~~years of age~~)) and older.

(k) Reusable briefs, washable protective underwear, or pull-up pants (any size) are limited to:

(i) Purchased - Four per year.

(ii) Rented - One hundred fifty per month.

(l) Disposable pant liners, shields, guards, pads, and undergarments are limited to two hundred per month.

(m) Underpads for beds are limited to:

(i) Disposable (any size) - One hundred eighty per month.

(ii) Purchased, reusable (large) - Forty-two per year.

(iii) Rented, reusable (large) - Ninety per month.

(10) Urological supplies - Urinary retention:

(a) Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube - Two per month. The agency does not pay for these when billed in combination with any of the following:

(i) With extension drainage tubing for use with urinary leg bag or urostomy pouch (any type, any length), with connector/adapter; and/or

(ii) With an insertion tray with drainage bag, and with or without catheter.

(b) Bedside drainage bottle, with or without tubing - Two per six month period.

(c) Extension drainage tubing (any type, any length), with connector/adapter, for use with urinary leg bag or urostomy pouch. The agency does not pay for these when billed

in combination with a vinyl urinary leg bag, with or without tube.

(d) External urethral clamp or compression device (not be used for catheter clamp) - Two per twelve-month period.

(e) Indwelling catheters (any type) - Three per month.

(f) Insertion trays:

(i) Without drainage bag and catheter - One hundred and twenty per month. The agency does not pay for these when billed in combination with other insertion trays that include drainage bag, catheters, and/or individual lubricant packets.

(ii) With indwelling catheters - Three per month. The agency does not pay for these when billed in combination with other insertion trays without drainage bag and/or indwelling catheter, individual indwelling catheters, and/or individual lubricant packets.

(g) Intermittent urinary catheter - One hundred twenty per month. The agency does not pay for these when billed in combination with an insertion tray with or without drainage bag and catheter((;)), or other individual intermittent urinary catheters.

(h) Irrigation syringe (bulb or piston). The agency does not pay for these when billed in combination with irrigation tray or tubing.

(i) Irrigation tray with syringe (bulb or piston) - Thirty per month. The agency does not pay for these when billed in combination with irrigation syringe (bulb or piston), or irrigation tubing set.

(j) Irrigation tubing set - Thirty per month. The agency does not pay for these when billed in combination with an irrigation tray or irrigation syringe (bulb or piston).

(k) Leg straps (latex foam and fabric), replacement only.

(l) Male external catheter, specialty type, or with adhesive coating or adhesive strip - Sixty per month.

(m) Urinary suspensory with leg bag, with or without tube - Two per month. The agency does not pay for these when billed in combination with a latex urinary leg bag, urinary suspensory without leg bag, extension drainage tubing, or a leg strap.

(n) Urinary suspensory without leg bag, with or without tube - Two per month.

(o) Urinary leg bag, vinyl, with or without tube - Two per month. The agency does not pay for these when billed in combination with drainage bag and without catheter.

(p) Urinary leg bag, latex - One per month. The agency does not pay for these when billed in combination with or without catheter.

(11) Miscellaneous supplies:

(a) Bilirubin light therapy supplies when provided with a bilirubin light which the agency prior authorized - Five days supply.

(b) Continuous passive motion (CPM) softgoods kit - One, with rental of CPM machine.

(c) Eye patch with elastic, tied band, or adhesive, to be attached to an eyeglass lens - One box of twenty.

(d) Eye patch (adhesive wound cover) - One box of twenty.

(e) Nontoxic gel (e.g., LiceOff TM) for use with lice combs - One bottle per twelve-month period.

(f) Nonsterile gloves - Two hundred, per client, per month.

(i) For clients residing in an assisted living facility, the agency pays, with prior authorization, for additional nonsterile gloves up to the quantity necessary as directed by the client's physician, not to exceed a total of four hundred per client, per month.

(ii) Prior authorization requests must include a completed:

(A) General Information for Authorization form (HCA 13-835). The agency's electronic forms are available online (see WAC 182-543-7000 Authorization); and

(B) Limitation Extension Request Incontinent Supplies and Gloves form (HCA 13-870).

(g) Sterile gloves - Thirty pair, per client, per month.

(12) Miscellaneous ((~~DME~~)) medical equipment:

(a) Bilirubin light or light pad - Five days rental per twelve-month period for at-home newborns with jaundice.

(b) Blood glucose monitor (((~~specialized or home~~))) - One in a three-year period. See WAC 182-543-5500(4) for blood monitoring/testing supplies. The agency does not pay for continuous glucose monitoring systems including related equipment and supplies under the durable medical equipment benefit. See WAC 182-553-500 home infusion therapy/parenteral nutrition program.

(c) Continuous passive motion (CPM) machine - Up to ten days rental and requires prior authorization.

(d) Lightweight protective helmet/soft shell (including adjustable chin/mouth strap) - Two per twelve-month period.

(e) Lightweight ventilated hard-shell helmet (including unbreakable face bar, woven chin strap with adjustable buckle and snap fastener, and one set of cushion pads for adjusting fit to head circumference) - Two per twelve-month period.

(f) Pneumatic compressor - One in a five-year period.

(g) Positioning car seat - One in a five-year period.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-5700 Covered—((~~DME and related supplies and complex rehabilitation technology~~)) Medical equipment for clients in skilled nursing facilities. (1) The medicaid agency's skilled nursing facility per diem rate, established in chapters 74.46 RCW, 388-96, and 388-97 WAC, includes any reusable and disposable medical supplies that may be required for a skilled nursing facility client, unless otherwise specified within this section.

(2) The agency pays for the following ((~~covered DME and related supplies and complex rehabilitation technology (CRT)~~)) medical equipment outside of the skilled nursing facility per diem rate, subject to the limitations in this section:

(a) Manual or power-drive wheelchairs (including CRT);

(b) Speech generating devices (SGD); and

(c) Specialty beds.

(3) The agency pays for one manual or one power-drive wheelchair for clients who reside in a skilled nursing facility, with prior authorization, according to the requirements in WAC 182-543-4100, 182-543-4200, and 182-543-4300. Requests for prior authorization must:

(a) Be for the exclusive full-time use of a skilled nursing facility resident;

(b) Not be included in the skilled nursing facility's per diem rate;

(c) Include a completed General Information for Authorization form (HCA 13-835);

(d) Include a copy of the telephone order, signed by the physician, for the wheelchair assessment;

(e) Include a completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (HCA 13-729).

(4) The agency pays for wheelchair accessories and modifications that are specifically identified by the manufacturer as separate line item charges, with prior authorization. To receive payment, providers must submit the following to the agency:

(a) A copy of the telephone order, signed by the physician for the wheelchair accessories and modifications;

(b) A completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (HCA 13-729). The date on this form (HCA 13-729) must not be prior to the date on the telephone order. The agency's electronic forms are available online (see WAC 182-543-7000, Authorization);

(c) The make, model, and serial number of the wheelchair to be modified;

(d) The modification requested; and

(e) Specific information regarding the client's medical condition that necessitates modification.

(5) The agency pays for wheelchair repairs((~~,~~)) with prior authorization. To receive payment, providers must submit the following to the agency:

(a) A completed Medical Necessity for Wheelchair Purchase for Nursing Facility Clients form (HCA 13-729). The agency's electronic forms are available online (see WAC 182-543-7000, Authorization);

(b) The make, model, and serial number of the wheelchair to be repaired; and

(c) The repair requested.

(6) Prior authorization is required for the repair and modification of client-owned equipment.

(7) The skilled nursing facility must provide a house wheelchair as part of the per diem rate, when the client resides in a skilled nursing facility.

(8) When the client is eligible for both medicare and medicaid and is residing in a skilled nursing facility in lieu of hospitalization, the agency does not reimburse for ((~~DME and related supplies, CRT, prosthetics, orthotics,~~)) medical ((~~supplies~~)) equipment, related services, or related repairs or labor charges under fee-for-service (FFS).

(9) The agency pays for the purchase and repair of a speech generating device (SGD), with prior authorization. The agency pays for replacement batteries for SGDs in accordance with WAC 182-543-5500(3).

(10) The agency pays for the purchase or rental of a specialty bed (a heavy duty bariatric bed is not a specialty bed), with prior authorization, when:

(a) The specialty bed is intended to help the client heal; and

(b) The client's nutrition and laboratory values are within normal limits.

(11) The agency considers decubitus care products to be included in the skilled nursing facility per diem rate and does not reimburse for these separately.

(12) See WAC ((~~182-543-9200~~)) 182-543-9000 for reimbursement for wheelchairs and ((~~WAC 182-543-9250 for reimbursement for~~)) CRT.

(13) The agency pays for the following medical supplies for a client in a skilled nursing facility outside the skilled nursing facility per diem rate:

(a) Medical supplies or services that replace all or part of the function of a permanently impaired or malfunctioning internal body organ. This includes, but is not limited to, the following:

(i) Colostomy and other ostomy bags and necessary supplies (see WAC 388-97-1060(3)); and

(ii) Urinary retention catheters, tubes, and bags, excluding irrigation supplies.

(b) Supplies for intermittent catheterization programs, for the following purposes:

(i) Long term treatment of atonic bladder with a large capacity; and

(ii) Short term management for temporary bladder atony.

(c) Surgical dressings required as a result of a surgical procedure, for up to six weeks post-surgery.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-7000 Authorization. (1) The medicaid agency requires providers to obtain authorization for ((~~covered durable~~)) medical ((~~equipment (DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies and related~~)) equipment as required in this chapter, in chapters 182-501 and 182-502 WAC, and in published billing ((~~instructions and/or~~)) guides and provider notices or when the clinical criteria required in this chapter are not met.

(a) The agency considers requests for prior authorization (PA) for any item meeting the definition of medical equipment, and PA is granted when the service is medically necessary as defined in WAC 182-500-0070.

(b) For prior authorization (PA), a provider must submit a written request to the agency as specified in the agency's published billing ((~~instructions~~)) guides (see WAC 182-543-7100). All requests for prior authorization must be accompanied by a completed General Information for Authorization form (HCA 13-835) in addition to any program specific forms as required within this chapter. The agency's electronic forms are available online at((~~:~~)) http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx.

((~~(b)~~)) (c) For expedited prior authorization (EPA), a provider must meet the clinically appropriate EPA criteria outlined in the agency's published billing ((~~instructions~~)) guides. The appropriate EPA number must be used when the provider bills the agency (see WAC 182-543-7200).

(2) When a service requires authorization, the provider must properly request authorization in accordance with the agency's rules, billing ((~~instructions~~)) guides, and provider notices.

(3) The agency's authorization of ((~~service(s)~~)) services does not necessarily guarantee payment.

(4) When authorization is not properly requested, the agency rejects and returns the request to the provider for further action. The agency does not consider the rejection of the request to be a denial of service.

(5) Authorization requirements in this chapter are not a denial of service to the client.

(6) The agency may recoup any payment made to a provider if the agency later determines that the service was not properly authorized or did not meet the EPA criteria. Refer to WAC 182-502-0100 (1)(c).

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-7100 Prior authorization. (1) The medicaid agency requires providers to obtain prior authorization for certain ((~~items~~)) medical equipment and services before delivering ((~~that item~~)) the equipment or service to the client, except for dual-eligible medicare/medicaid clients when medicare is the primary payer. The ((~~item~~)) equipment or service must also be delivered to the client before the provider bills the agency.

(2) All prior authorization requests must be accompanied by a completed General Information for Authorization form (HCA 13-835), in addition to any program specific agency forms as required within this chapter. Agency forms are available online at http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx.

(3) When the agency receives the initial request for prior authorization, the ((~~prescription(s) for those items~~)) prescription for the medical equipment or services must not be older than ((~~three~~)) six months from the date the agency receives the request.

(4) The agency requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to((~~, the following~~)):

(a) The manufacturer's name;

(b) The equipment model and serial number;

(c) A detailed description of the item; and

(d) Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

(5) For prior authorization requests, the agency requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. The agency does not accept general standards of care or industry standards for generalized equipment as justification.

(6) The agency considers requests for ((~~new durable~~)) medical equipment ((~~(DME) and related supplies, complex rehabilitation technology (CRT), prosthetics, orthotics, medical supplies and related equipment~~)) that ((~~do~~)) does not have assigned health care common procedure coding system (HCPCS) codes and are not listed in the agency's published issuances, including billing instructions or provider notices. These items require prior authorization. The provider must furnish all of the following information to the agency to establish medical necessity:

(a) A detailed description of the ((~~item(s) or service(s)~~)) equipment or service to be provided;

(b) The cost or charge for the ((~~item(s)~~)) equipment;

(c) A copy of the manufacturer's invoice, price-list or catalog with the product description for the ((~~item(s)~~)) equipment being provided; and

(d) A detailed explanation of how the requested ((~~item(s)~~)) equipment differs from an already existing code description.

(7) The agency does not pay for the purchase, rental, or repair of medical equipment that duplicates equipment that the client already owns, rents, or that the agency has authorized for the client. If the provider believes the purchase, rental, or repair of medical equipment is not duplicative, the provider must request prior authorization and submit the following to the agency:

(a) Why the existing equipment no longer meets the client's medical needs; or

(b) Why the existing equipment could not be repaired or modified to meet the client's medical needs.

(c) Upon request, documentation showing how the client's condition met the criteria for PA or EPA.

(8) A provider may resubmit a request for prior authorization for ((~~an item~~)) equipment or services that the agency has denied. The agency requires the provider to include new documentation that is relevant to the request.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-7200 ((~~Limitation extension (LE).~~)) Prior authorization for limits on amount, frequency, or duration. (1) The medicaid agency limits the amount, frequency, or duration of certain ((~~covered medical supplies and equipment (MSE), durable~~)) medical equipment ((~~(DME), and related supplies, prosthetics, orthotics, medical supplies,~~)) and related services, and reimburses up to the stated limit without requiring prior authorization.

(2) Certain ((~~covered~~)) items have limitations on quantity and frequency. These limits are designed to avoid the need for prior authorization for items normally considered medically necessary and for quantities sufficient for a thirty-day supply for one client.

(3) The agency requires a provider to request prior authorization ((~~for a limitation extension (LE)~~)) in order to exceed the stated limits for ((~~nondurable~~)) medical equipment and ((~~medical~~)) supplies that do not require prior authorization. All requests for prior authorization must be accompanied by a completed General Information for Authorization form (HCA 13-835) in addition to any program specific forms as required within this chapter. Agency forms are available online at http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx.

(4) The agency evaluates such requests ((~~for LE~~)) under the provisions of WAC 182-501-0169, and grants prior authorization when it is medically necessary, as defined in WAC 182-500-0070.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-7300 Expedited prior authorization (EPA). (1) The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected ((~~durable~~)) medical equipment (((~~(DME)~~))) procedure codes.

(2) The medicaid agency requires a provider to create an authorization number for EPA for selected ((~~DME~~)) medical equipment procedure codes. The process and criteria used to create the authorization number is explained in the agency published ((~~DME-related~~)) medical equipment-related billing ((~~instructions~~)) guide. The authorization number must be used when the provider bills the agency.

(3) Upon request, a provider must provide documentation to the agency showing how the client's condition met the criteria for EPA.

(4) A written or telephone request for prior authorization is required when a situation does not meet the EPA criteria for selected ((~~DME~~)) medical equipment procedure codes.

(5) The agency may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-8000 ((~~DME~~))Billing general. (1) A provider must not bill the medicaid agency for the rental or purchase of medical equipment supplied to the provider at no cost by ((~~suppliers/manufacturers~~)) suppliers or manufacturers.

(2) The agency does not pay a ((~~durable~~)) medical equipment (((~~(DME)~~))) provider for medical supplies used in conjunction with a physician office visit. The agency pays the office physician for these supplies when appropriate. Refer to the agency's physician-related ((~~services/health care~~)) professional services billing ((~~instructions~~)) guide.

(3) The agency does not pay for any prosthetics and orthotics required for surgery or placed during the hospital stay under this chapter. See chapter 182-550 WAC. In this situation, the prosthetics and orthotics are included in the hospital reimbursement rate.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-8100 ((~~DME~~))Billing for managed care clients. If a fee-for-service (FFS) client enrolls in a medicaid agency-contracted managed care organization (MCO), the following apply:

(1) The agency stops paying for any rented medical equipment on the last day of the month preceding the month in which the client becomes enrolled in the MCO.

(2) The plan determines the client's continuing need for the medical equipment and is responsible for paying the provider.

(3) A client may become an MCO enrollee before the agency completes the purchase of prescribed medical equipment. The agency considers the purchase complete when the product is delivered and the agency is notified of the serial number. If the client becomes an MCO enrollee before the agency completes the purchase:

(a) The agency rescinds the agency's authorization with the vendor until the MCO's primary care provider (PCP) evaluates the client; then

(b) The agency requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 182-500-0070; then

(c) The MCO's applicable reimbursement policies apply to the purchase or rental of the equipment.

(4) If a client is disenrolled from an MCO and placed into fee-for-service before the MCO completes the purchase of prescribed medical equipment:

(a) The agency rescinds the MCO's authorization with the vendor until the client's primary care provider (PCP) evaluates the client; then

(b) The agency requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary as defined in WAC 182-500-0070; then

(c) The agency does not pay for medical equipment and services provided to a client who is enrolled in an agency-contracted managed care organization (MCO), but who did not use one of the MCO's participating providers.

(d) The agency's applicable reimbursement policies apply to the purchase or rental of the equipment.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-8200 Billing for clients eligible for medicare and medicaid. If a client is eligible for both medicare and medicaid((~~, the following apply~~)):

(1) The medicaid agency requires a provider to accept medicare assignment before any medicaid reimbursement;

(2) In accordance with WAC 182-502-0110(3):

(a) If the service provided is covered by medicare and medicaid, the agency pays only the deductible ((~~and/or~~)) or coinsurance up to medicare's or medicaid's allowed amount, whichever is less.

(b) If the service provided is covered by medicare but is not covered by the agency, the agency pays only the deductible ((~~and/or~~)) or coinsurance up to medicare's allowed amount.

AMENDATORY SECTION (Amending WSR 14-08-035, filed 3/25/14, effective 4/25/14)

WAC 182-543-9000 ((~~DME and related supplies, complex rehabilitation, prosthetics, orthotics, medical supplies and related services~~))General reimbursement. (1) The medicaid agency pays qualified providers who meet all ((~~of the~~)) conditions in WAC 182-502-0100((~~, for durable~~)) for medical equipment (((~~(DME), supplies~~)), repairs, and related services provided on a fee-for-service (FFS) basis as follows:

(a) To agency-enrolled ((~~DME~~)) medical equipment providers, qualified complex rehabilitation technology (CRT) suppliers, pharmacies, and home health agencies under their national provider identifier (NPI) numbers, subject to the limitations of this chapter, and according to the procedures and

codes in the agency's current ((~~DME~~)) medical equipment billing ((~~instructions; and~~)) guide;

(b) In accordance with the health care common procedure coding system (HCPCS) guidelines for product classification and code assignation; and

(c) Providers must code the specific brand and model of wheelchair or CRT products dispensed according to the centers for medicare and medicaid services' (CMS) pricing, data analysis, and coding (PDAC) web site.

(2) The agency sets, evaluates, and updates the maximum allowable fees for ((~~DME and related supplies, CRT, prosthetics, orthotics,~~)) medical ((~~supplies~~)) equipment and related services at least once yearly ((~~using available published information, including but not limited to~~)), unless otherwise directed by the legislature or determined necessary by the agency.

(3) The agency sets the rates for medical equipment codes subject to the federal financial participation (FFP) limitation at the lesser of medicare's prevailing payment rates in the Durable Medical Equipment Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule or Competitive Bid Area (CBA) rate. For all other procedure codes, the agency sets rates using one of the following:

(a) ((~~Commercial databases;~~

~~(b) Manufacturers' catalogs;~~

~~(c)~~)) Medicare fee schedules; ((~~and~~

~~(d) Wholesale prices.~~

~~(3)~~)) (b) Legislative direction;

(c) Input from stakeholders or relevant sources that the agency determines to be reliable and appropriate;

(d) Pricing clusters; or

(e) A by-report (BR) basis.

(4) The medicaid agency evaluates a by-report (BR) item, procedure, or service for its medical necessity, appropriateness and reimbursement value on a case-by-case basis. The agency's reimbursement rate is a percentage of the manufacturer's list or manufacturer's suggested retail price (MSRP), or a percentage of the wholesale acquisition cost (AC). The agency uses the following percentages:

(a) For basic standard wheelchairs, sixty-five percent of MSRP or one hundred forty percent of AC;

(b) For wheelchair parts and add-on CRT accessories and parts, eighty-four percent of MSRP or one hundred forty percent of AC;

(c) For wheelchair seat and back cushions, CRT manual wheelchair base, and up-charge modifications and seating systems, eighty percent of MSRP or one hundred forty percent of AC;

(d) For CRT power-drive wheelchair base, eighty-five percent of MSRP or one hundred forty percent of AC;

(e) For prosthetics and orthotics and medical supplies and related services, eighty-five percent of MSRP or one hundred twenty-five percent of AC;

(f) For other medical equipment, eighty percent of MSRP or one hundred twenty-five percent of AC;

(g) For medical supplies, eighty-five percent of MSRP or one hundred twenty-five percent of AC.

(5) When establishing reimbursement rates for medical equipment based on pricing clusters for a specific HCPCS code, the maximum allowable fee is the median or average amount of all items in the cluster. The pricing cluster is comprised of all the brands/models for which the agency obtains pricing information. However, the agency may limit the number of brands/models included in the pricing cluster due to:

(a) A client's medical needs;

(b) Product quality;

(c) Introduction, substitution or discontinuation of certain brands/models; and/or

(d) Cost.

(6) When there is only a rental rate on the DMEPOS fee schedule, the agency sets the maximum allowable purchase rate at either the DMEPOS rate divided by 0.15 or multiplied by ten. The agency sets the maximum allowable fee for daily rental at one-three-hundredth of the new purchase price or one-thirtieth of the monthly rental rate on the DMEPOS fee schedule;

(7) The agency may adopt policies, procedure codes, and/or rates that are inconsistent with those set by medicare if the agency determines that such actions are necessary((~~.~~

~~(4) The agency updates the maximum allowable fees for DME and related supplies, CRT, prosthetics, orthotics, medical supplies and related services at least once per year, unless otherwise directed by the legislature or deemed necessary by the agency.~~

~~(5)~~)) to:

(a) Assure that payments are sufficient to enlist providers and maintain access to care and services; or

(b) Comply with legislative budget directives.

(8) The agency's maximum payment for ((~~DME and related supplies, CRT, prosthetics, orthotics, medical supplies~~)) medical equipment and related services is the lesser of either ((~~of the following~~)) the:

(a) Providers' usual and customary charges; or

(b) Established rates, except as provided in WAC 182-543-8200.

(((~~6~~))) (9) The agency is the payor of last resort for clients with medicare or third-party insurance.

(((~~(7) The agency does not pay for medical equipment and/or services provided to a client who is enrolled in an agency-contracted managed care plan, but who did not use one of the plan's participating providers.~~

~~(8)~~)) (10) The agency's reimbursement for a prosthetic or orthotic includes the cost of any necessary molds, fitting, shipping, handling or any other administrative expenses related to provision of the prosthetic or orthotic to the client.

(11) The agency's reimbursement rate for purchased or rented covered ((~~DME and related supplies, prosthetics, orthotics, medical supplies~~)) medical equipment and related services includes all of the following:

(a) Any adjustments or modifications to the medical equipment ((~~that are~~)) required within three months of the date of delivery or ((~~are~~)) covered under the manufacturer's warranty. This does not apply to adjustments required because of changes in the client's medical condition;

(b) Any pick-up ((~~and/or~~)) or delivery fees or associated costs (e.g., mileage, travel time, gas, etc.);

(c) Telephone calls;

(d) Shipping, handling, and/or postage;

(e) Routine maintenance ((~~of DME~~)) that includes testing, cleaning, regulating, and assessing the client's equipment;

(f) Fitting ((~~and/or~~)) and set-up; and

(g) Instruction to the client or client's caregiver in the appropriate use of the medical equipment((~~, device, and/or supplies~~)).

(((~~(9) DME, supplies, repairs,~~)) (12) Medical equipment and related services supplied to eligible clients under the following reimbursement methodologies are included in those methodologies and are not reimbursed under fee-for-service:

(a) Hospice providers' per diem reimbursement;

(b) Hospitals' diagnosis-related group (DRG) reimbursement;

(c) Managed care plans' capitation rate;

(d) Skilled nursing facilities' per diem rate; and

(e) Professional services' resource-based relative value system reimbursement (RBRVS) rate.

(((~~(10)~~))) (13) The provider must make warranty information, including date of purchase, applicable serial number, model number or other unique identifier of the equipment, and warranty period, available to the agency upon request.

(((~~(11)~~))) (14) The dispensing provider who furnishes the medical equipment((~~, supply or device~~)) to a client is responsible for any costs incurred to have a different provider repair the equipment when:

(a) Any medical equipment ((~~that~~)) the agency considers purchased requires repair during the applicable warranty period;

(b) The provider refuses or is unable to fulfill the warranty; and

(c) The equipment((~~, supply or device~~)) continues to be medically necessary.

(((~~(12)~~))) (15) If the rental medical equipment((~~, supply or device~~)) must be replaced during the warranty period, the agency recoups fifty percent of the total amount previously paid toward rental and eventual purchase of the medical equipment((~~, supply or device~~)) delivered to the client if:

(a) The provider is unwilling or unable to fulfill the warranty; and

(b) The equipment((~~, supply or device~~)) continues to be medically necessary.

(((~~(13) See WAC 182-543-9100, 182-543-9200, 182-543-9300, and 182-543-9400 for other reimbursement methodologies.~~)) (16) The agency does not reimburse for medical equipment, related services, and related repairs and labor charges under fee-for-service when the client is:

(a) An inpatient hospital client;

(b) Eligible for both medicare and medicaid, and is staying in a skilled nursing facility in lieu of hospitalization;

(c) Terminally ill and receiving hospice care; or

(d) Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

(17) The agency rescinds any purchase order for a prescribed item if the equipment was not delivered to the client before the client:

(a) Dies;

(b) Loses medical eligibility;

(c) Becomes covered by a hospice agency; or

(d) Becomes covered by a managed care organization.

(18) A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded in subsection (7) of this section, the agency may pay the provider an amount it considers appropriate to help defray these extra costs. The agency requires the provider to submit justification sufficient to support such a claim.

(19) For clients residing in skilled nursing facilities, see WAC 182-543-5700.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-543-6000	DME and related supplies, medical supplies and related services—Noncovered.
WAC 182-543-9100	Reimbursement method—Other DME.
WAC 182-543-9200	Reimbursement method—Wheelchairs.
WAC 182-543-9250	Reimbursement method—Complex rehabilitation technology.
WAC 182-543-9300	Reimbursement method—Prosthetics and orthotics.
WAC 182-543-9400	Reimbursement method—Medical supplies and related services.

WSR 18-19-102
PROPOSED RULES
HEALTH CARE AUTHORITY

[Filed September 19, 2018, 9:39 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-05-068 and 18-05-066.

Title of Rule and Other Identifying Information: WAC 182-551-2000 General, 182-551-2010 Definitions, 182-551-2020 Eligibility, 182-551-2030 Skilled services—Requirements, 182-551-2040 Face-to-face encounter requirements, 182-551-2100 Covered skilled nursing services, 182-551-2110 Covered specialized therapy, 182-551-2120 Covered aide services, 182-551-2122 Medical supplies, equipment, and appliances, 182-551-2125 Delivered through telemedicine, 182-551-2130 Noncovered services, 182-551-2140 Exceptions, 182-551-2200 Eligible providers, 182-551-2210 Provider requirements, 182-551-2220 Provider payments, and 182-500-0075 Medical definitions—N.

Hearing Location(s): On October 23, 2018, at 10:00 a.m., at the Health Care Authority (HCA), Cherry Street Plaza, Pear Conference Room (107), 626 8th Avenue, Olympia, WA 98504. Metered public parking is available street side around building. A map is available at www.hca.wa.gov/documents/directions_to_csp.pdf, or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: Not sooner than October 24, 2018.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by October 23, 2018.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, TTY 800-848-5429 or 711, email amber.lougheed@hca.wa.gov, by October 19, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is amending these rules as a result of federal regulations published in February 2016 under 42 C.F.R. 440.70, requiring that physicians document the occurrence of a face-to-face encounter (including through the use of telemedicine) within reasonable time frames when ordering home health services for medicaid eligible clients.

Nonphysician practitioners, including advanced registered nurse practitioners (ARNP), may perform the face-to-face encounter to determine the need for home health services, which must be documented by a physician. Only physicians may sign orders for home health services. Nonphysicians, including ARNPs, may no longer sign orders for these services.

The agency is also aligning these rules with the federal regulations to clarify that home health services are not restricted to clients who are homebound or to services furnished solely in the home. Services may be provided in any setting where normal life activities take place.

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 necessary because of federal law, 42 C.F.R. section 440.70.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Melinda Froud, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1408; Implementation and Enforcement: Nancy Hite, P.O. Box 45506, Olympia, WA 98504-5506, 360-725-1611.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Citation of the specific federal statute or regulation and description of the consequences to the state if the rule is not adopted: 42 C.F.R section 440.70 provides that only physicians may sign orders for home health services and does not restrict these services to clients who are homebound or to services provided solely in the home.

September 19, 2018
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-19-037, filed 9/11/13, effective 10/12/13)

WAC 182-500-0075 ((~~Medical assistance~~)) Definitions—N. "National correct coding initiative (NCCI)" is a national standard for the accurate and consistent description of medical goods and services using procedural codes. The standard is based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT®) manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. The Centers for Medicare and Medicaid Services (CMS) maintain NCCI policy. Information can be found at: http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

"National provider indicator (NPI)" is a federal system for uniquely identifying all providers of health care services, supplies, and equipment.

"NCCI edit" is a software step used to determine if a claim is billing for a service that is not in accordance with federal and state statutes, federal and state regulations, agency or the agency's designee's fee schedules, billing instructions, and other publications. The agency or the agency's designee has the final decision whether the NCCI edits allow automated payment for services that were not billed in accordance with governing law, NCCI standards or agency or agency's designee policy.

"Nonapplying spouse" see "spouse" in WAC 182-500-0100.

"Nonbilling provider" is a health care professional enrolled with the agency only as an ordering, referring, prescribing provider for the Washington medicaid program and who is not otherwise enrolled as a medicaid provider with the agency.

"Noncovered service" see "covered service" in WAC 182-500-0020.

"Nonphysician practitioner" means the following professionals who work in collaboration with an ordering physician: A nurse practitioner, clinical nurse specialist, certified nurse midwife, or a physician assistant.

"Nursing facility" see "institution" in WAC 182-500-0050.

"Nursing facility long-term care services" are services in a nursing facility when a person does not meet the criteria for rehabilitation. Most long-term care assists people with support services. (Also called custodial care.)

"Nursing facility rehabilitative services" are the planned interventions and procedures which constitute a continuing and comprehensive effort to restore a person to the person's former functional and environmental status, or alternatively, to maintain or maximize remaining function.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2000 ((~~Home health services—~~))General. (1) The purpose of the medicaid agency's home health

program is to reduce the costs of health care services by providing equally effective, less restrictive quality care to the client in ((~~the client's residence~~)) any setting where normal life activities take place, subject to the restrictions and limitations in subchapter II.

(2) A client does not have to be homebound or need nursing or therapy services to receive services under this chapter.

(3) Home health skilled services are provided for acute, intermittent, short-term, and intensive courses of treatment. See chapters 182-514 and 388-71 WAC for programs administered to clients who need chronic, long-term maintenance care.

(4) Home health services include the following services and items:

(a) Nursing service, see WAC 182-551-2100;

(b) Home health aide service, see WAC 182-551-2120;

(c) Medical supplies, equipment, and appliances suitable for use in any setting where normal life activities take place, see chapter 182-543 WAC; and

(d) Physical therapy, occupational therapy, or speech therapy, see WAC 182-551-2110, and audiology services, see WAC 182-531-0375.

(5) The agency evaluates medical equipment requests for medical necessity according to WAC 182-501-0165.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2010 ((~~Home health services~~))Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to subchapter II:

"Acute care" means care provided by a home health agency for clients who are not medically stable or have not attained a satisfactory level of rehabilitation. These clients require frequent intervention by a registered nurse or licensed therapist.

"Brief skilled nursing visit" means a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs only one of the following activities during a visit to a client:

(a) An injection;

(b) Blood draw; or

(c) Placement of medications in containers.

"Chronic care" means long-term care for medically stable clients.

"Full skilled nursing visit" means a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, performs one or more of the following activities during a visit to a client:

(a) Observation;

(b) Assessment;

(c) Treatment;

(d) Teaching;

(e) Training;

(f) Management; and

(g) Evaluation.

"Home health agency" means an agency or organization certified under medicare to provide comprehensive health care on an intermittent or part-time basis to a patient in any setting where the patient's normal life activities take place ((~~of residence~~)).

"Home health aide" means a person registered or certified as a nursing assistant under chapter 18.88 RCW who, under the direction and supervision of a registered nurse or licensed therapist, assists in the delivery of nursing or therapy related activities, or both.

"Home health aide services" means services provided by a home health aide only when a client has an acute, intermittent, short-term need for the services of a registered nurse, physical therapist, occupational therapist, or speech therapist who is employed by or under contract with a home health agency. These services are provided under the supervision of the previously identified authorized practitioners and include, but are not limited to, ambulation and exercise, assistance with self-administered medications, reporting changes in a client's condition and needs, and completing appropriate records.

"Home health skilled services" means skilled health care (nursing, specialized therapy, and home health aide) services provided ((~~in the client's residence~~)) on an intermittent or part-time basis by a medicare-certified home health agency with a current provider number in any setting where the client's normal life activities take place. See also WAC 182-551-2000.

"Long-term care" is a generic term referring to various programs and services, including services provided in home and community settings, administered directly or through contract by the department of social and health services' (DSHS) division of developmental disabilities (DDD) or aging and long-term support administration (ALTSA) through home and community services (HCS).

"Plan of care (POC)" (also known as **"plan of treatment (POT)"**) means a written plan of care that is established and periodically reviewed and signed by both an ordering ((~~licensed practitioner~~)) physician and a home health agency provider. The plan describes the home health care to be provided ((~~at the client's residence~~)) in any setting where the client's normal life activities take place. See WAC 182-551-2210.

((~~**"Residence"** means a client's home or place of living. (See WAC 182-551-2030 (2)(g)(ii) for clients in residential facilities whose home health services are not covered through the medicaid agency's home health program.)~~))

"Review period" means the three-month period the medicaid agency assigns to a home health agency, based on the address of the agency's main office, during which the medicaid agency reviews all claims submitted by that home health agency.

"Specialized therapy" means skilled therapy services provided to clients that include:

(a) Physical;

(b) Occupational; or

(c) Speech/audiology services.

(See WAC 182-551-2110.)

"Telemedicine" - For the purposes of WAC 182-551-2000 through 182-551-2220, means the use of telemonitoring to enhance the delivery of certain home health skilled nursing services through:

(a) The collection and transmission of clinical data between a patient at a distant location and the home health provider through electronic processing technologies. Objective clinical data that may be transmitted includes, but is not limited to, weight, blood pressure, pulse, respirations, blood glucose, and pulse oximetry; or

(b) The provision of certain education related to health care services using audio, video, or data communication instead of a face-to-face visit.

AMENDATORY SECTION (Amending WSR 14-07-042, filed 3/12/14, effective 4/12/14)

WAC 182-551-2020 ((~~Home health services—Eligible persons.~~)) Eligibility. (1) ((~~Persons~~)) Clients in the Washington apple health ((~~(WAH) fee-for-service~~)) programs listed in the table in WAC 182-501-0060 are eligible to receive home health services subject to the ((~~limitations described~~)) provisions in this chapter. ((~~Persons~~)) Clients enrolled in an agency-contracted managed care organization (MCO) receive all home health services through their designated plan.

(2) The agency ((~~does not~~)) covers home health services ((~~under the home health program~~)) for ((~~persons~~)) clients in the ((~~CNP-emergency~~)) alien emergency medical ((~~only and LCP-MNP-emergency medical only programs. The agency or its designee evaluates a request for home health skilled nursing visits on a case-by-case basis under the provisions of WAC 182-501-0165, and may cover up to two skilled nursing visits within the eligibility enrollment period if the following criteria are met:~~

~~(a) The person requires hospital care due to an emergency medical condition as described in WAC 182-500-0030; and~~

~~(b) The agency or its designee authorizes up to two skilled nursing visits for follow-up care related to the emergent medical condition~~)) program under WAC 182-507-0120.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2030 ((~~Home health~~)) Skilled services—Requirements. (1) The medicaid agency ((~~reimburses for covered~~)) covers home health skilled services provided to eligible clients, subject to the restrictions or limitations in this section and other applicable published WAC.

(2) Home health skilled services provided to eligible clients must:

(a) Meet the definition of "acute care" in WAC 182-551-2010.

(b) Provide for the treatment of an illness, injury, or disability.

(c) Be medically necessary as defined in WAC 182-500-0070.

(d) Be reasonable, based on the community standard of care, in amount, duration, and frequency.

(e) Meet face-to-face requirements described in WAC 182-551-2040.

(f) Be provided under a plan of care (POC), as defined in WAC 182-551-2010 and described in WAC 182-551-2210. Any statement in the POC must be supported by documentation in the client's medical records.

(((~~f~~))) (g) Be used to prevent placement in a more restrictive setting. In addition, the client's medical records must justify the medical ((~~reason(s)~~)) reason or reasons that the services should be provided ((~~in the client's residence~~)) and why instructing the client would be most effectively done in any setting where the client's normal life activities take place instead of at an ordering ((~~licensed practitioner's~~)) physician's office, clinic, or other outpatient setting. ((~~This includes justification for services for a client's medical condition that requires teaching that would be most effectively accomplished in the client's home on a short-term basis.~~

~~(g)~~)) (h) Be provided in ((~~the client's residence~~)) any setting where normal life activities take place.

(i) The medicaid agency does not ((~~reimburse~~)) pay for services ((~~if~~)) provided at ((~~the workplace, school, child day care~~)) a hospital, adult day care, skilled nursing facility, intermediate care facility for individuals with intellectual disabilities, or any ((~~other place that is not the client's place of residence~~)) setting in which payment is or could be made under medicaid for inpatient services that include room and board.

(ii) Clients in residential facilities contracted with the state and paid by other programs, such as home and community programs to provide limited skilled nursing services, are not eligible for medicaid agency-funded, limited skilled nursing services unless the services are prior authorized under WAC 182-501-0165.

(((~~h~~))) (i) Be provided by:

(i) A home health agency that is Title XVIII (medicare)-certified;

(ii) A registered nurse (RN) prior authorized by the medicaid agency when no home health agency exists in the area where a client resides; or

(iii) An RN authorized by the medicaid agency when the RN cannot contract with a medicare-certified home health agency.

NEW SECTION

WAC 182-551-2040 Face-to-face encounter requirements. (1) The medicaid agency pays for home health services provided under this chapter only when the face-to-face encounter requirements in this section are met.

(2) For initiation of home health services, with the exception of medical equipment under WAC 182-551-2122, the face-to-face encounter must be related to the primary reason the client requires home health services and must occur within ninety days before or within the thirty days after the start of the services.

(3) For the initiation of medical equipment under WAC 182-551-2122, the face-to-face encounter must be related to the primary reason the client requires medical equipment and must occur no later than six months prior to the start of services.

(4) The face-to-face encounter may be conducted by the ordering physician, a nonphysician practitioner as described in WAC 182-500-0075, or the attending acute, or post-acute physician, for beneficiaries admitted to home health immediately after an acute or post-acute stay.

(5) If a nonphysician practitioner as described in WAC 182-500-0075 (or the attending physician when a client is discharged from an acute hospital stay) performs the face-to-face encounter, the nonphysician practitioner (or attending physician) must communicate the clinical findings of that face-to-face encounter to the ordering physician. Those clinical findings must be incorporated into a written or electronic document included in the client's medical record.

(6) For all home health services except medical equipment under WAC 182-551-2122, the physician responsible for ordering the services must:

(a) Document that the face-to-face encounter, which is related to the primary reason the client requires home health services, occurred within the required time frames described in subsection (2) of this section prior to the start of home health services; and

(b) Indicate the practitioner who conducted the encounter, and the date of the encounter.

(7) For medical equipment under WAC 182-551-2122, except as provided in (b) of this subsection, an ordering physician, a nonphysician practitioner as described in WAC 182-500-0075, except for certified nurse midwives, or the attending physician when a client is discharged from an acute hospital stay, must:

(a) Document that the face-to-face encounter, which is related to the primary reason the client requires home health services, occurred within the required time frames described in subsection (3) of this section prior to the start of home health services; and

(b) Indicate the practitioner who conducted the encounter, and the date of the encounter.

(8) The face-to-face encounter may occur through telemedicine. See WAC 182-551-2125.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2100 ((~~Home health services—~~))Covered skilled nursing services. (1) The medicaid agency covers the home health acute care skilled nursing services ((~~listed~~)) subject to the limitations in this section ((~~when~~)). The agency evaluates a request for covered home health acute care skilled nursing services that are:

(a) In excess of the home health care program's limitations or restrictions, according to WAC 182-501-0169; and

(b) Listed as noncovered, according to WAC 182-501-0160.

(2) The home health acute care skilled nursing services must be furnished by a qualified provider((~~. The medicaid agency evaluates a request for covered services that are subject to limitations or restrictions, and approves the services beyond those limitations or restrictions when medically necessary, under the standard for covered services in WAC 182-501-0165~~)) in any setting where normal life activities take place.

(((~~2~~))) (3) The medicaid agency covers the following home health acute care skilled nursing services, subject to the ((~~limitations~~)) provisions in this section:

(a) Full skilled nursing services that require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, if the services involve one or more of the following:

(i) Observation;

(ii) Assessment;

(iii) Treatment;

(iv) Teaching;

(v) Training;

(vi) Management; and

(vii) Evaluation.

(b) A brief skilled nursing visit if only one of the following activities is performed during the visit:

(i) An injection;

(ii) Blood draw; or

(iii) Placement of medications in containers (e.g., envelopes, cups, medisets).

(c) Home infusion therapy only if the client:

(i) Is willing and capable of learning and managing the client's infusion care; or

(ii) Has a volunteer caregiver willing and capable of learning and managing the client's infusion care.

(d) Infant phototherapy for an infant diagnosed with hyperbilirubinemia:

(i) When provided by a medicaid agency-approved infant phototherapy agency; and

(ii) For up to five skilled nursing visits per infant.

(e) Limited high-risk obstetrical services:

(i) For a medical diagnosis that complicates pregnancy and may result in a poor outcome for the mother, unborn, or newborn;

(ii) For up to three home health visits per pregnancy if((~~:~~ ~~(A) Enrollment~~)) enrolled in or ((~~referral to the following providers of first steps has been verified:~~

~~(I) Maternity support services (MSS); or~~

~~(II) Maternity case management (MCM); and~~

~~(B)~~)) referred to a first steps maternity support services (MSS) provider. The visits are provided by a registered nurse who has either:

(((~~I~~))) (A) National perinatal certification; or

(((~~II~~))) (B) A minimum of one year of labor, delivery, and postpartum experience at a hospital within the last five years.

(((~~3~~))) (4) The medicaid agency limits skilled nursing visits provided to eligible clients to two per day.

AMENDATORY SECTION (Amending WSR 16-04-026, filed 1/25/16, effective 3/1/16)

WAC 182-551-2110 ((~~Home health services—~~))Covered specialized therapy. The medicaid agency covers outpatient rehabilitation and habilitative services ((~~in an in-home setting~~)) provided by a home health agency in any setting where normal life activities take place. Outpatient rehabilitation and habilitative services are described in chapter 182-545 WAC. Specialized therapy is defined in WAC 182-551-2010.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2120 ((~~Home health services —~~))Covered aide services. (1) The medicaid agency pays for one home health aide visit, per client per day. Additional services require prior authorization and are granted if medically necessary, as defined in WAC 182-500-0070.

(2) The medicaid agency ((~~reimburses~~)) pays for home health aide services, as defined in WAC 182-551-2010, only when the services are provided under the supervision of, and in conjunction with, practitioners who provide:

(a) Skilled nursing services; or

(b) Specialized therapy services.

(3) The medicaid agency covers home health aide services only when a registered nurse or licensed therapist visits the ((~~client's residence~~)) client at least once every fourteen days to monitor or supervise home health aide services, with or without the presence of the home health aide, in any setting where normal life activities take place.

NEW SECTION

WAC 182-551-2122 Medical supplies, equipment, and appliances. The medical agency's home health program covers medical supplies, equipment, and appliances, as defined and described in chapter 182-543 WAC, that are suitable for use in any setting in which normal life activities take place.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2125 ((~~Home health services —~~))Delivered through telemedicine. (1) The medicaid agency covers the delivery of home health services through telemedicine for clients who have been diagnosed with an unstable condition who may be at risk for hospitalization or a more costly level of care. The client must have a ((~~diagnosis(es)~~)) diagnosis or diagnoses where there is a high risk of sudden change in clinical status which could compromise health outcomes.

(2) The medicaid agency pays for one telemedicine interaction, per eligible client, per day, based on the ordering ((~~licensed practitioner's~~)) physician's home health plan of care.

(3) To receive payment for the delivery of home health services through telemedicine, the services must involve:

(a) An assessment, problem identification, and evaluation which includes:

(i) Assessment and monitoring of clinical data including, but not limited to, vital signs, pain levels and other biometric measures specified in the plan of care. Also includes assessment of response to previous changes in the plan of care; and

(ii) Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care; and

(b) Implementation of a management plan through one or more of the following:

(i) Teaching regarding medication management as appropriate based on the telemedicine findings for that encounter;

(ii) Teaching regarding other interventions as appropriate to both the patient and the caregiver;

(iii) Management and evaluation of the plan of care including changes in visit frequency or addition of other skilled services;

(iv) Coordination of care with the ordering ((~~licensed practitioner~~)) physician regarding telemedicine findings;

(v) Coordination and referral to other medical providers as needed; and

(vi) Referral to the emergency room as needed.

(4) The medicaid agency does not require prior authorization for the delivery of home health services through telemedicine.

(5) The medicaid agency does not pay for the purchase, rental, or repair of telemedicine equipment.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2130 ((~~Home health services —~~))Noncovered services. (1) The medicaid agency does not cover the following home health services under the home health program, unless otherwise specified:

(a) Chronic long-term care skilled nursing visits or specialized therapy visits for a medically stable client when a long-term care skilled nursing plan or specialized therapy plan is in place through the department of social and health services' aging and ((~~disability services~~)) long-term support administration (((~~ADSA~~))) (ALTSA).

(i) The medicaid agency considers requests for interim chronic long-term care skilled nursing services or specialized therapy services for a client while the client is waiting for ((~~ADSA~~)) ALTSA to implement a long-term care skilled nursing plan or specialized therapy plan; and

(ii) On a case-by-case basis, the medicaid agency may authorize long-term care skilled nursing visits or specialized therapy visits for a client for a limited time until a long-term care skilled nursing plan or specialized therapy plan is in place. Any services authorized are subject to the restrictions and limitations in this section and other applicable published WAC.

(b) Social work services.

(c) Psychiatric skilled nursing services.

(d) Pre- and postnatal skilled nursing services, except as listed under WAC 182-551-2100 (2)(e).

(e) Well-baby follow-up care.

(f) Services performed in hospitals, correctional facilities, skilled nursing facilities, or a residential facility with skilled nursing services available.

(g) Home health aide services that are not provided in conjunction with skilled nursing or specialized therapy services.

(h) Health care for a medically stable client (e.g., one who does not have an acute episode, a disease exacerbation, or treatment change).

(i) Home health specialized therapies and home health aide visits for clients that are covered under the AEM cate-

gorically needy and medically needy programs and are in the following programs:

(i) ((~~CNP~~)) Categorically needy - Emergency medical only; and

(ii) ((~~LCP-MNP~~)) Medically needy - Emergency medical only.

(j) Skilled nursing visits for a client when a home health agency cannot safely meet the medical needs of that client within home health services program limitations (e.g., for a client to receive infusion therapy services, the caregiver must be willing and capable of managing the client's care).

(k) More than one of the same type of specialized therapy ((~~and/or~~)) and home health aide visit per day.

(l) The medicaid agency does not ((~~reimburse~~)) pay for duplicate services for any specialized therapy for the same client when both providers are performing the same or similar ((~~procedure(s)~~)) procedure or procedures.

(m) Home health visits made without a written ((~~licensed practitioner's~~)) physician's order, unless the verbal order is:

(i) Documented before the visit; and

(ii) The document is signed by the ordering ((~~licensed practitioner~~)) physician within forty-five days of the order being given.

(2) The medicaid agency does not cover additional administrative costs billed above the visit rate (these costs are included in the visit rate and will not be paid separately).

(3) The medicaid agency evaluates a request for any service that is listed as noncovered under WAC 182-501-0160.

NEW SECTION

WAC 182-551-2140 Exceptions. The following services are not included in the home health benefit:

(1) More than one of the same type of specialized therapy and home health aide visit per day.

(2) Duplicate services for any specialized therapy for the same client when both providers are performing the same or similar procedure or procedures.

(3) Home health visits made without a written physician's order, unless the verbal order is:

(a) Documented before the visit; and

(b) The document is signed by the ordering physician within forty-five days of the order being given.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2200 ((~~Home health services —~~))Eligible providers. The following may contract with the medicaid agency to provide home health services through the home health program, subject to the restrictions or limitations in this section and other applicable published WAC:

(1) A home health agency that:

(a) Is Title XVIII (medicare)-certified;

(b) Is department of health (DOH) licensed as a home health agency;

(c) Submits a completed, signed core provider agreement to the medicaid agency; and

(d) Is assigned a provider number.

(2) A registered nurse (RN) who:

(a) Is prior authorized by the medicaid agency to provide intermittent nursing services when no home health agency exists in the area ((~~a client resides~~)) where the client's normal life activities take place;

(b) Cannot contract with a medicare-certified home health agency;

(c) Submits a completed, signed core provider agreement to the medicaid agency; and

(d) Is assigned a provider number.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2210 ((~~Home health services —~~))Provider requirements. For any delivered home health service to be payable, the medicaid agency requires home health providers to develop and implement an individualized plan of care (POC) for the client.

(1) The POC must:

(a) Be documented in writing and be located in the client's home health medical record;

(b) Be developed, supervised, and signed by a licensed registered nurse or licensed therapist;

(c) Reflect the ordering ((~~licensed practitioner's~~)) physician's orders and client's current health status;

(d) Contain specific goals and treatment plans;

(e) Be reviewed and revised by an ordering ((~~licensed practitioner~~)) physician at least every sixty calendar days, signed by the ordering ((~~licensed practitioner~~)) physician within forty-five days of the verbal order, and returned to the home health agency's file; and

(f) Be available to medicaid agency staff or its designated contractor(s) on request.

(2) The provider must include all the following in the POC:

(a) The client's name, date of birth, and address (to include name of residential care facility, if applicable);

(b) The primary diagnosis (the diagnosis that is most related to the reason the client qualifies for home health services) or the diagnosis that is the reason for the visit frequency;

(c) All secondary medical diagnoses, including ((~~date(s)~~)) date or dates of onset or exacerbation;

(d) The prognosis;

(e) The ((~~type(s)~~)) type or types of equipment required, including telemedicine as appropriate;

(f) A description of each planned service and goals related to the services provided;

(g) Specific procedures and modalities;

(h) A description of the client's mental status;

(i) A description of the client's rehabilitation potential;

(j) A list of permitted activities;

(k) A list of safety measures taken on behalf of the client; and

(l) A list of medications which indicates:

(i) Any new prescription; and

(ii) Which medications are changed for dosage or route of administration.

(3) The provider must include in or attach to the POC:

(a) A description of the client's functional limits and the effects;

(b) Documentation that justifies why the medical services should be provided in ((~~the client's residence~~)) any setting where the client's life activities take place instead of an ordering ((~~licensed practitioner's~~)) physician's office, clinic, or other outpatient setting;

(c) Significant clinical findings;

(d) Dates of recent hospitalization;

(e) Notification to the department of social and health services (DSHS) case manager of admittance;

(f) A discharge plan, including notification to the DSHS case manager of the planned discharge date and client disposition at time of discharge; and

(g) Order for the delivery of home health services through telemedicine, as appropriate.

(4) The individual client medical record must comply with community standards of practice, and must include documentation of:

(a) Visit notes for every billed visit;

(b) Supervisory visits for home health aide services as described in WAC 182-551-2120(3);

(c) All medications administered and treatments provided;

(d) All ((~~licensed practitioner's~~)) physician's orders, new orders, and change orders, with notation that the order was received before treatment;

(e) Signed ((~~licensed practitioner's~~)) physician's new orders and change orders;

(f) Home health aide services as indicated by a registered nurse or licensed therapist in a home health aide care plan;

(g) Interdisciplinary and multidisciplinary team communications;

(h) Inter-agency and intra-agency referrals;

(i) Medical tests and results;

(j) Pertinent medical history; and

(k) Notations and charting with signature and title of writer.

(5) The provider must document at least the following in the client's medical record:

(a) Skilled interventions per the POC;

(b) Client response to the POC;

(c) Any clinical change in client status;

(d) Follow-up interventions specific to a change in status with significant clinical findings;

(e) Any communications with the attending ordering ((~~licensed practitioner~~)) physician; and

(f) Telemedicine findings, as appropriate.

(6) The provider must include the following documentation in the client's visit notes when appropriate:

(a) Any teaching, assessment, management, evaluation, client compliance, and client response;

(b) Weekly documentation of wound care, size (dimensions), drainage, color, odor, and identification of potential complications and interventions provided;

(c) If a client's wound is not healing, the client's ordering ((~~licensed practitioner~~)) physician has been notified, the client's wound management program has been appropriately altered and, if possible, the client has been referred to a wound care specialist; and

(d) The client's physical system assessment as identified in the POC.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-2220 ((~~Home health services~~))Provider payments. (1) To be reimbursed, the home health provider must bill the medicaid agency according to the conditions of payment under WAC 182-502-0150 and other issuances.

(2) Payment to home health providers is:

(a) A set rate per visit for each discipline provided to a client;

(b) Based on the county location of the providing home health agency; and

(c) Updated by general vendor rate changes.

(3) For clients eligible for both medicaid and medicare, the medicaid agency may pay for services described in this chapter only when medicare does not cover those services. The maximum payment for each service is medicaid's maximum payment.

(4) Providers must submit documentation to the medicaid agency during the home health agency's review period. Documentation includes, but is not limited to, the requirements listed in WAC 182-551-2210.

(5) After the medicaid agency receives the documentation, the medicaid agency's medical director or designee reviews the client's medical records for program compliance and quality of care.

(6) The medicaid agency may take back or deny payment for any insufficiently documented home health care service when the ((~~department's~~)) medicaid agency's medical director or designee determines that:

(a) The service did not meet the conditions described in WAC 182-550-2030; or

(b) The service was not in compliance with program policy.

(7) Covered home health services for clients enrolled in ((~~a Healthy Options~~)) an agency-contracted managed care ((~~plan~~)) organization (MCO) are paid for by that ((~~plan~~)) MCO.

WSR 18-19-104
PROPOSED RULES
GAMBLING COMMISSION
[Filed September 19, 2018, 11:41 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-09-002.

Title of Rule and Other Identifying Information: Amends WAC 230-15-610 Preparing to do a count and 230-15-615 Conducting the count.

Hearing Location(s): On November 15, 2018, at 11:00 a.m., at the Hampton Inn & Suites, 4301 Martin Way East, Olympia, WA 98516. Hearing will take place at the November commission meeting. The meeting dates and times are tentative. Visit our web site at www.wsgc.wa.gov about

seven days before the meeting, select "November Commission meeting" to confirm the hearing date, location, and start time.

Date of Intended Adoption: November 15, 2018.

Submit Written Comments to: Rules Coordinator, P.O. Box 42400, Olympia, WA 98504-2400, email rules. coordinator@wsgc.wa.gov, fax 360-486-3624, by November 7, 2018.

Assistance for Persons with Disabilities: Contact Julie Anderson, phone 360-486-3453, TTY 360-486-3637, email julie.anderson@wsgc.wa.gov, by November 13, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency received a petition from a card room licensee asking for a change to the soft count procedures to allow a card room to have two people, instead of the currently required three people, to conduct a soft count if licensees opt to use an automated bill counter. These rules will incorporate the petitioner's request and, in addition, establish new soft count procedures based on a house-banked card room's gross gambling receipts in their previous license year.

Reasons Supporting Proposal: Currently, all forty-six house-banked card rooms must use a three member soft count team. With the proposed rules, soft count requirements provide additional flexibility for house-banked card rooms with gross gambling receipts less than $15 million annually.

Staff looked at the soft count team requirements in ten states. Six states require a three-member soft count team; the other four allowed two member teams. The rule changes align with the soft count requirements of other states and our tribal facilities while meeting the petitioner's needs.

Statutory Authority for Adoption: RCW 9.46.070.

Statute Being Implemented: RCW 9.46.070.

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

Name of Proponent: Stacey Hess, Great American Gaming, public.

Name of Agency Personnel Responsible for Drafting and Enforcement: Tina Griffin, Assistant Director, 4565 7th Avenue S.E., Lacey, WA 98503, 360-486-3546; and Implementation: David Trujillo, Director, 4565 7th Avenue S.E., Lacey, WA 98503, 360-486-3512.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The Washington state gambling commission is not an agency that is statutorily required to prepare a cost-benefit analysis under RCW 34.05.328.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The petition is expected to reduce costs for house-banked card rooms making less than $15 million annually because of a reduction of paid staff in the count room. Testimony from the agency's public hearing set the possible cost savings at about $1,000 per month for smaller house-banked card rooms. Rules for house-banked card rooms making more than $15 million annually are not changed and no new costs for these operators.

September 19, 2018

Brian J. Considine
Legal and Legislative Manager

AMENDATORY SECTION (Amending WSR 07-09-033, filed 4/10/07, effective 1/1/08)

WAC 230-15-610 Preparing to conduct a count. (1) House-banked card game licensees must assign licensed employees to conduct the count. ((~~The count team must be made up of three or more licensed employees.~~)) The count team must not include anyone who works in the surveillance department or whose duties included preparing, approving, or reviewing records used in ((~~that~~)) the specific count process. (((~~(2)~~))) Count team requirements are based on the licensee's card room gross gambling receipts in their previous fiscal year:

Card Room Gross Gambling Receipts	Minimum Count Team Requirements
Less than $5 million.	Two person count team.
$5 million to $15 million.	Three person count team or two person count team if a currency counter is used as outlined in this chapter.
More than $15 million.	Three person count team.
A new house-banked card room whose financial statements have not yet been submitted to us.	Three person count team.

(2) Prior to using a two person count team, the licensee must receive approval from the director or their designee. The approval will be based on the licensee:

(a) Meeting the card room gross gambling receipts requirements in their previous fiscal year; and

(b) Having internal controls in place to prevent both under-reporting and misappropriation of funds; and

(c) Having demonstrated following their internal controls to prevent both under-reporting and misappropriation of funds based on their administrative history; and

(d) Having a currency counter, which complies with commission rules, and internal controls for the use of the currency counter. This applies for those licensees with card room gross gambling receipts of $5 million to $15 million.

(3) Licensees must accurately count and record the contents of drop boxes to ensure the proper accountability of all gambling chips, coin, and currency. The count must be done at least once each gambling day.

(((~~(3)~~))) (4) If a cage cashier completes the opener, closer, fills, and credits portions of the master game report, the cashier sends the original master game report to the count team for completion. The cage cashier must immediately send a copy directly to the accounting department.

(((~~(4)~~))) (5) A count team member must notify the surveillance room observer that the count is about to begin. The surveillance employee must then observe the count as it occurs and make a video and audio recording of the entire count process.

(((~~(5)~~))) (6) Before opening drop boxes, the count team must lock the door to the count room. Licensees must permit no person to enter or leave the count room, except for a normal work break or an emergency, until the count team has completed the entire counting, recording, and verification process for the contents of drop boxes.

AMENDATORY SECTION (Amending WSR 07-09-033, filed 4/10/07, effective 1/1/08)

WAC 230-15-615 Conducting the count. (1) All house-banked card room licensees must have a three person count team except as set forth in subsection (2) and (3) of this section. The three person count team must conduct the count as follows:

(a) The contents of drop boxes must not be combined before the count team separately counts and records the contents of each box; and

(((~~(2)~~))) (b) As each drop box is placed on the count table, a count team member must announce the game, table number, and shift, if applicable, loudly enough to be heard by all persons present and to be recorded by the audio recording equipment; and

(((~~(3)~~))) (c) A count team member must empty the contents onto the count table; and

(((~~(4)~~))) (d) Immediately after the contents are emptied onto the count table, a count team member must display the inside of the drop box to the closed circuit television camera, and show it to at least one other count team member to confirm that all contents of the drop box have been removed. A count team member must then lock the drop box and place it in the drop box storage area; and

(((~~(5)~~))) (e) Count team member(s) must separate the contents of each drop box into separate stacks on the count table by denominations of coin, chips, and currency and by type of form, record, or document; and

(((~~(6)~~))) (f) At least two count team members must count, either manually or mechanically, each denomination of coin, chips, and currency separately and independently. Count team members must place individual bills and coins of the same denomination on the count table in full view of the closed circuit television cameras, and at least one other count team member must observe and confirm the accuracy of the count orally or in writing; and

(((~~(7)~~))) (g) As the contents of each drop box are counted, a member of the count team must record the total amount of coin, chips, and currency counted (the drop) on the master games report; and

(((~~(8)~~))) (h) If a cage cashier has recorded the opener, closer, fill slips, and credit slips on the master game report before the count, a count team member must compare the series numbers and totals recorded on the master game report to the fill slips, credit slips, and table inventory slips removed from the drop boxes, confirm the accuracy of the totals, and must record, by game and shift, the totals we require on the master game report. Otherwise, the count team must complete all required information on the master game report; and

(((~~(9)~~))) (i) The accounting department may complete the win/loss portions of the master game report independently from the count team if this is properly documented in the approved internal controls.

(2) The two person count team for licensees with card game gross gambling receipts of less than $5 million in their previous fiscal year must conduct the count as follows:

(a) The contents of drop boxes must not be combined before the count team separately counts and records the contents of each box; and

(b) As each drop box is placed on the count table, a count team member must announce the game, table number, and shift, if applicable, loudly enough to be heard by all persons present and to be recorded by the audio recording equipment; and

(c) A count team member must empty the contents onto the count table; and

(d) Immediately after the contents are emptied onto the count table, a count team member must display the inside of the drop box to the closed circuit television camera, and show it to at least one other count team member to confirm that all contents of the drop box have been removed. A count team member must then lock the drop box and place it in the drop box storage area; and

(e) A count team member must separate the contents of each drop box into separate stacks on the count table by denominations of coin, chips, and currency and by type of form, record, or document; and

(f) One count team member must count, either manually or mechanically, each denomination of coin, chips, and currency separately and independently. The count team member must place individual bills and coins of the same denomination on the count table in full view of the closed circuit television cameras, and the other count team member must observe and confirm the accuracy of the count orally or in writing; and

(g) As the contents of each drop box are counted, a member of the count team must record the total amount of coin, chips, and currency counted (the drop) on the master games report; and

(h) As the count is occurring, a surveillance employee must record in the surveillance log the total chip and currency count of each drop box and the announcement by the count team of the combined dollar count of all drop boxes; and

(i) If a cage cashier has recorded the opener, closer, fill slips, and credit slips on the master game report before the count, a count team member must compare the series numbers and totals recorded on the master game report to the fill slips, credit slips, and table inventory slips removed from the drop boxes, confirm the accuracy of the totals, and must record, by game and shift, the totals we require on the master game report. Otherwise, the count team must complete all required information on the master game report; and

(j) The accounting department may complete the win/loss portions of the master game report independently from the count team if this is properly documented in the approved internal controls.

(3) The two person count team for licensees with card game gross gambling receipts between $5 million and $15 million in their previous fiscal year and use a currency counter must conduct the count as follows:

(a) The currency counter to be used must meet the following requirements:

(i) Automatically provides two separate counts of the funds at different stages in the count process. If the separate counts are not in agreement during the count process and the discrepancy cannot be resolved immediately, the count must be suspended until a third count team member is present to manually complete the count as set forth in subsection (1) of this section until the currency counter is fixed; and

(ii) Displays the total bill count and total dollar amount for each drop box on a screen, which must be recorded by surveillance.

(b) Immediately prior to the count, the count team must verify the accuracy of the currency counter with previously counted currency for each denomination actually counted by the currency counter to ensure the counter is functioning properly. The test results must be recorded on the table games count documentation and signed by the two count team members performing the test; and

(c) The currency counter's display showing the total bill count and total dollar amount of each drop box must be recorded by surveillance during the count; and

(d) The contents of drop boxes must not be combined before the count team separately counts and records the contents of each box; and

(e) As each drop box is placed on the count table, a count team member must announce the game, table number, and shift, if applicable, loudly enough to be heard by all persons present and be recorded by the audio recording equipment; and

(f) A count team member must empty the contents onto the count table; and

(g) Immediately after the contents are emptied onto the count table, a count team member must display the inside of the drop box to the closed circuit television camera, and show it to the other count team member to confirm that all contents of the drop box have been removed. A count team member must then lock the drop box and place it in the drop box storage area; and

(h) Count team member(s) must combine all currency into one stack and separate the contents of each drop box into separate stacks on the count table by denomination of coin and chips, by type of form, record, or document; and

(i) Count team members must place all of the currency from a drop box into the currency counter which will perform an aggregate count by denomination of all of the currency collected from the drop box; and

(j) One count team member must count each denomination of coin and chips separately and independently. Count team members must place coins of the same denomination on the count table in full view of the closed circuit television cameras, and the other count team member must observe and confirm the accuracy of the count orally or in writing; and

(k) As the contents of each drop box are counted, a member of the count team must record the total amount of coin, chips, and currency counted (the drop) on the master games report; and

(l) As the count is occurring, a surveillance employee must record in the surveillance log the currency counter accuracy information in (a) of this subsection, currency verification amount, total bill and dollar count of each drop box and the announcement by the count team of the combined dollar count of all drop boxes; and

(m) If a cage cashier has recorded the opener, closer, fill slips, and credit slips on the master game report before the count, a count team member must compare the series numbers and totals recorded on the master game report to the fill slips, credit slips, and table inventory slips removed from the drop boxes, confirm the accuracy of the totals, and must record, by game and shift, the totals we require on the master game report. Otherwise, the count team must complete all required information on the master game report; and

(n) The accounting department may complete the win/loss portions of the master game report independently from the count team if this is properly documented in the approved internal controls.

WSR 18-19-106
PROPOSED RULES
CLARK COLLEGE
[Filed September 19, 2018, 11:55 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-16-021.

Title of Rule and Other Identifying Information: Replace chapter 132N-153 WAC, First amendment activities for Community College District 14, with new WAC.

Hearing Location(s): On November 14, 2018, at 5:00 p.m., at Clark College, Gaiser Hall, Room 213, 1933 Ft. Vancouver Way, Vancouver, WA 98663.

Date of Intended Adoption: November 14, 2018.

Submit Written Comments to: Bob Williamson, Vice President of Administrative Services, Clark College, Baird Hall 161, 1933 Ft. Vancouver Way, Vancouver WA 98663, email bwilliamson@clark.edu, fax 360-992-2884, by November 7, 2018.

Assistance for Persons with Disabilities: Contact Megan Jasurda, phone 360-992-2065, fax 360-992-2879, TTY video phone 360-991-0901, email mjasurda@clark.edu, by November 7, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed new rule replaces existing chapter 132N-153 WAC with new language regarding time, place and manner of first amendment activities.

Reasons Supporting Proposal: The state attorney general's Vancouver office drafted and recommended a new model administrative code to clarify regulations regarding time, place and manner of first amendment activities on Clark College property.

Statutory Authority for Adoption: RCW 28B.50.140.

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

Name of Proponent: Clark College, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Bob Williamson, Clark College, Baird Hall 161, 1933 Ft. Vancouver Way, Vancouver, WA 98663, 360-992-2123.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Costs associated with implementing and enforcing the proposed rule are already accounted for in the college's budget.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. No impact on small businesses if proposed code is adopted.

September 19, 2018
Bob Williamson
Vice President of
Administrative Services

AMENDATORY SECTION (Amending WSR 12-19-020, filed 9/7/12, effective 10/8/12)

WAC 132N-153-010 Title. WAC 132N-153-010 through ((~~132N-153-090~~)) 132N-153-150 shall be known as use of Community College District 14 facilities by college groups and noncollege groups for first amendment activities.

NEW SECTION

WAC 132N-153-100 Definitions. (1) "College groups" means individuals or groups who are currently enrolled students or current employees of the college, or guests of the college who are sponsored by a recognized student organization, employee organization, or the administration of the college.

(2) "College facilities" includes all buildings, structures, grounds, office space, and parking lots.

(3) "Expressive activity" includes, but is not necessarily limited to, informational picketing, petition circulation, the distribution of informational leaflets or pamphlets, speechmaking, demonstrations, rallies, appearances of speakers in outdoor areas, protests, meetings to display group feelings or sentiments and/or other types of assemblies to share information, perspective or viewpoints.

(4) "Noncollege groups" means individuals, or combinations of individuals, who are not currently enrolled students or current employees of the college and who are not officially affiliated or associated with, or invited guests of a recognized student organization, recognized employee group, or the administration of the college.

NEW SECTION

WAC 132N-153-110 Statement of purpose. Clark Community College District 14 is an educational institution provided and maintained by the people of the state of Washington. College facilities are reserved primarily for educational use including, but not limited to, instruction, research, public assembly of college groups, student activities and other activities directly related to the educational mission of the college. The public character of the college does not grant to individuals an unlimited license to engage in activity which limits, interferes with, or otherwise disrupts the normal activities to which the college's facilities and grounds are dedicated. Accordingly, the college designates the common areas of the college as a limited public forum dedicated to the use of college groups, subject to the time, place, and manner limitations and restrictions set forth in this policy. Groups or individuals who are invited or permitted to engage in first amendment activities at the college do not represent an endorsement by Clark College or the board of trustees.

The purpose of the time, place and manner regulations set forth in this procedure is to establish procedures and reasonable controls for the use of college facilities. It is intended to balance the college's responsibility to fulfill its mission as a state educational institution of Washington with the interests of college groups seeking to assemble in common areas of the campus for expressive activity. The college recognizes that college groups should be accorded the opportunity to utilize the facilities and grounds of the college to the fullest extent possible. The college has designated certain facilities as public use areas open to noncollege groups as set forth herein.

NEW SECTION

WAC 132N-153-120 Use of facilities. (1) Subject to the regulations and requirements of this policy, groups may use the college's limited forums for expressive activities between the hours of 7:00 a.m. and 10:00 p.m.

(2) Groups are encouraged to notify the college safety and security department no later than twenty-four hours in advance of an event. However, unscheduled events are permitted so long as the event does not materially disrupt any other function occurring at the facility.

(3) All sites used for expressive activity should be cleaned up and left in their original condition and may be subject to inspection by a representative of the college after the event. Reasonable charges may be assessed against the sponsoring organization for the costs of extraordinary cleanup or for the repair of damaged property.

(4) All fire, safety, sanitation or special regulations specified for the event are to be obeyed. The college cannot and will not provide utility connections or hook-ups for purposes of expressive activity conducted pursuant to this policy.

(5) The event must not be conducted in such a manner to obstruct vehicular, bicycle, pedestrian, or other traffic or otherwise interfere with ingress or egress to the college, or to college buildings or facilities, or to college activities or events.

(6) The event must not create safety hazards or pose unreasonable safety risks to college students, employees or invitees to the college.

(7) The event must not substantially and materially interfere with educational activities inside or outside any college building or otherwise prevent the college from fulfilling its mission and achieving its primary purpose of providing an education to its students.

(8) The event must not materially infringe on the rights and privileges of college students, employees or invitees to the college.

(9) There shall be no overnight camping on college facilities or grounds. Camping is defined to include sleeping, carrying on cooking activities, or storing personal belongings for

personal habitation, or the erection of tents or other shelters or structures used for purposes of personal habitation.

(10) College facilities may not be used for commercial sales, solicitations, advertising or promotional activities, unless:

(a) Such activities serve educational purposes of the college; and

(b) Such activities are under the sponsorship of a college department or office or officially chartered student club.

(11) The event must also be conducted in accordance with any other applicable college policies and regulations, local ordinances, and state or federal laws.

NEW SECTION

WAC 132N-153-130 Additional requirements for noncollege groups. (1) College buildings, rooms, and athletic fields may be rented by noncollege groups in accordance with the college's facilities use policy. When renting college buildings or athletic fields, an individual or organization may be required to post a bond and/or obtain insurance to protect the college against cost or other liability in accordance with the college's facility use policy. When the college grants permission to use its facilities it is with the express understanding and condition that the individual or organization assumes full responsibility for any loss or damage.

(2) Noncollege groups may otherwise use college facilities for expressive activity as identified in this procedure.

(3) The college designates the following area(s) as the sole limited public forum area(s) for use by noncollege groups for expressive activity on campus:

(a) The public use areas may be scheduled. Scheduled groups have priority of use over unscheduled groups:

(i) On the college's main campus, the limited public forum is located on the circle pad approximate to the sun dial.

(ii) A secondary location is available on the lawn area south of the Japanese garden.

(iii) The limited public forum at Clark College at the Columbia Tech Center is the circle pad west of the main entry door.

(iv) The limited public forum location at the Clark Center at WSU Vancouver will be determined by WSU Vancouver policy.

(b) Please contact the vice president of administrative services for more information.

(4) Noncollege groups that seek to engage in expressive activity on the designated public use area(s) are encouraged to provide notice to the college safety and security office no later than twenty-four hours prior to the event, along with the following information solely to ensure:

(a) The area is not otherwise scheduled; and

(b) To give the college an opportunity to assess any security needs:

(i) The name, address, and telephone number of a contact person for the individual, group, entity or organization sponsoring the event;

(ii) The date, time and requested location of the event;

(iii) The nature and purpose of the event; and

(iv) The estimated number of people expected to participate in the event.

(5) When using college buildings or athletic fields, an individual or organization may be required to post a bond and/or obtain insurance to protect the college against cost or other liability in accordance with the college's facility use policy.

(6) When the college grants permission to use its facilities it is with the express understanding and condition that the individual or organization assumes full responsibility for any loss or damage.

NEW SECTION

WAC 132N-153-140 Distribution of materials. College groups may post information on bulletin boards, kiosks and other display areas designated for that purpose, and may distribute materials throughout the open areas of campus. Noncollege groups may distribute materials only at the site designated for noncollege groups. The sponsoring organization is encouraged, but not required to include its name and address on the distributed information. Postings must be date stamped and may be displayed no longer than thirty calendar days.

NEW SECTION

WAC 132N-153-150 Trespass. (1) Noncollege groups who violate these rules, any provision of the conduct code, or whose conduct jeopardizes the health or safety of others, will be advised of the specific nature of the violation, and if they persist in the violation, will be requested by the college president or designee to leave the college property. Such a request will be deemed to withdraw the license or privilege to enter onto or remain upon any portion of the college facilities of the person or group of persons requested to leave, and subject such individuals to arrest under the criminal trespass provisions of chapter 9A.52 RCW or municipal ordinance.

(2) Members of the college community (students, faculty, and staff) who do not comply with these regulations will be reported to the appropriate college office or agency for action in accordance with established college policies.

(3) When the college revokes the license or privilege of any person to be on college property, temporarily or for a stated period of time, that person may file a request for review of the decision with the vice president of administration or designee within ten days of receipt of the trespass notice. The request must contain the reasons why the individual disagrees with the trespass notice. The trespass notice will remain in effect during the pendency of any review period. The decision of the vice president of administrative services or designee will be the final decision of the college and should be issued within five work days.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 132N-153-020 Statement of purpose.

WAC 132N-153-030 Definitions.

WAC 132N-153-040 Request for use of facilities.

WAC 132N-153-050	Additional requirements for noncollege groups.
WAC 132N-153-060	The role of the president in first amendment decisions.
WAC 132N-153-070	Criminal trespass.
WAC 132N-153-080	Posting of a bond and hold harmless statement.
WAC 132N-153-090	Disclaimer.

WSR 18-19-108
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed September 19, 2018, 11:57 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-05-022.

Title of Rule and Other Identifying Information: The department is proposing to create new sections and amend existing sections within chapter 388-112A WAC, Residential long-term care services training, these sections provide training and certification requirements for long-term care workers in residential settings, along with instructor and curricula standards.

Hearing Location(s): On November 6, 2018, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than November 7, 2018.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., November 6, 2018.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by October 23, 2018.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is amending chapter 388-112A WAC, Residential long-term care services training. The proposed rules include the following changes: WAC 388-112A-0050, 388-112A-0060, 388-112A-0070, and 388-112A-0090, contain technical corrections on identifying qualifying credential for exemption; 388-112A-0125, clarifies employment and training records that caregivers should provide and employers review prior to hire; 388-112A-0495, corrects language to be consistent with statute requirements in RCW 18.20.270; 388-112A-0590, clarifies when training may be applied to the seventy-hour long-term care worker basic training; 388-112A-0600, renumbers provisions for clarity; 388-112A-0610, 388-112A-0611, and 388-112A-0612, clarify continuing education requirements with regard to deadlines and unique employment situations where workers leave and return to long-term care settings; 388-112A-1020, clarifies training preapproval, and online requirements; and 388-112A-1240, 388-112A-1270, and 388-112A-1285, contain technical corrections to clarify instructor qualifications.

Reasons Supporting Proposal: These changes are necessary to clarify caregiver training, certification requirements, and training program requirements.

Statutory Authority for Adoption: RCW 74.39A.009, 74.39A.070, 74.39A.074, 74.39A.341, 18.20.270, 18.88B.021, 18.88B.035, 70.128.230, 71A.12.030, 70.97.080.

Statute Being Implemented: RCW 74.39A.074, 18.88B.021.

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

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting: Suemary Trobaugh, 4450 10th Avenue S.E., Lacey, WA 98503, 360-725-2516; Implementation and Enforcement: Christine Morris, 4450 10th Avenue S.E., Lacey, WA 98503, 360-725-2549.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Angel Sulivan, P.O. Box 45600, Olympia, WA 98504-5310 [98504-5600], phone 360-725-2495, fax 360-725-2646, TTY 1-800-833-6388, email suliva@dshs.wa.gov.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(5) because the department prepared an analysis under RCW 34.05.328.

Explanation of exemptions, if necessary: The proposed amendments do not impose more than minor costs on small businesses so a small business economic impact statement is not required.

September 13, 2018
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 18-20 issue of the Register.