WSR 23-06-051
EXPEDITED RULES
HEALTH CARE AUTHORITY
[Filed February 27, 2023, 9:33 a.m.]

Title of Rule and Other Identifying Information: WAC 182-503-0005 Washington apple health—How to apply, 182-503-0510 Washington apple health—Program summary, 182-505-0300 Hospital presumptive eligibility, 182-513-1605 Medicaid alternative care (MAC)—Eligibility, 182-513-1615 Tailored supports for older adults (TSOA)—General eligibility, 182-530-7250 Reimbursement—Miscellaneous, and 182-550-4900 Disproportionate share hospital (DSH) payments—General provisions.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Correct typographical errors.

Reasons Supporting Proposal: The agency is correcting cross-references to a repealed rule and an outdated reference to an agency program. The agency is replacing references to WAC 182-532-0720 with references to chapter 182-532 WAC because that rule was repealed under WSR 19-18-024. The agency is replacing instances of the term TAKE CHARGE with current program terminology, specifically the family planning only programs under chapter 182-532 WAC.

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: Health care authority, governmental.

Name of Agency Personnel Responsible for Drafting: Brian Jensen, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0815; Implementation and Enforcement: Paige Lewis, P.O. Box 42722, Olympia, WA 98504-2722, 360-725-0757.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: None.

This notice meets the following criteria to use the expedited adoption process for these rules:

Corrects typographical errors, makes address or name changes, or clarifies language of a rule without changing its effect.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: The proposed rules correct typographical errors and clarify language of a rule without changing its effect.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, Health Care Authority, P.O. Box 42716, Olympia, WA 98504-2716, phone 360-725-1306, fax 360-586-9272, email arc@hca.wa.gov, AND RECEIVED BY May 2, 2023.

February 27, 2023
Wendy Barcus
Rules Coordinator

OTS-4384.1

AMENDATORY SECTION (Amending WSR 22-20-052, filed 9/28/22, effective 10/29/22)

WAC 182-503-0005 Washington apple health—How to apply. (1) You may apply for Washington apple health at any time.

(2) For apple health programs for children, pregnant people, parents and caretaker relatives, and adults age 64 and under without medicare (including people who have a disability or are blind), you may apply:

(a) Online via the Washington Healthplanfinder at www.wahealthplanfinder.org;

(b) By calling the Washington Healthplanfinder customer support center and completing an application by telephone;

(c) By completing the application for health care coverage (HCA 18-001P), and mailing or faxing to Washington Healthplanfinder; or

(d) At a department of social and health services (DSHS) community services office (CSO).

(3) If you seek apple health coverage and are age 65 or older, have a disability, are blind, need assistance with medicare costs, or seek coverage of long-term services and supports, you may apply:

(a) Online via Washington Connection at www.WashingtonConnection.org;

(b) By completing the application for aged, blind, disabled/long-term care coverage (HCA 18-005) and mailing or faxing it to DSHS;

(c) By calling the DSHS customer service contact center and completing an application by telephone;

(d) In person at a local DSHS CSO or home and community services (HCS) office; or

(e) As specified in subsection (2) of this section, if you are a child, pregnant, a parent or caretaker relative, or an adult age 64 and under without medicare.

(4) You may receive help filing an application.

(a) For households containing people described in subsection (2) of this section:

(i) Call the Washington Healthplanfinder customer support center number listed on the application for health care coverage form (HCA 18-001P); or

(ii) Contact a navigator, health care authority volunteer assistor, or broker.

(b) For people described in subsection (3) of this section who are not applying with a household containing people described in subsection (2) of this section:

(i) Call or visit a local DSHS CSO or HCS office; or

(ii) Call the DSHS community services customer service contact center number listed on the medicaid application form.

(5) To apply for tailored supports for older adults (TSOA), see WAC 182-513-1625.

(6) You must apply directly with the service provider for the following programs:

(a) The breast and cervical cancer treatment program under WAC 182-505-0120;

(b) The ((~~TAKE CHARGE~~)) family planning only programs under chapter 182-532 WAC; and

(c) The kidney disease program under chapter 182-540 WAC.

(7) For the confidential pregnant minor program under WAC 182-505-0117 and for minors living independently, you must complete a separate application directly with us (the medicaid agency).

More information on how to give us an application may be found at the agency's website: www.hca.wa.gov/free-or-low-cost-health-care (search for "teen").

(8) As the primary applicant or head of household, you may start an application for apple health by providing your:

(a) Full name;

(b) Date of birth;

(c) Physical address, and mailing addresses (if different); and

(d) Signature.

(9) To complete an application for apple health, you must also give us all of the other information requested on the application.

(10) You may have an authorized representative apply on your behalf as described in WAC 182-503-0130.

(11) We help you with your application or renewal for apple health in a manner that is accessible to you. We provide equal access (EA) services as described in WAC 182-503-0120 if you:

(a) Ask for EA services, you apply for or receive long-term services and supports, or we determine that you would benefit from EA services; or

(b) Have limited-English proficiency as described in WAC 182-503-0110.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-20-052, § 182-503-0005, filed 9/28/22, effective 10/29/22; WSR 18-11-071, § 182-503-0005, filed 5/15/18, effective 6/15/18; WSR 17-15-061, § 182-503-0005, filed 7/13/17, effective 8/13/17. Statutory Authority: RCW 41.05.021, 41.05.160, Public Law 111-148, 42 C.F.R. § 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-16-052, § 182-503-0005, filed 7/29/14, effective 8/29/14.]

AMENDATORY SECTION (Amending WSR 17-12-019, filed 5/30/17, effective 7/1/17)

WAC 182-503-0510 Washington apple health—Program summary. (1) The agency categorizes Washington apple health programs into three groups based on the income methodology used to determine eligibility:

(a) Those that use a modified adjusted gross income (MAGI)-based methodology described in WAC 182-509-0300, called MAGI-based apple health programs;

(b) Those that use an income methodology other than MAGI, called non-MAGI-based apple health programs, which include:

(i) Supplemental security income (SSI)-related apple health programs;

(ii) Temporary assistance for needy families (TANF)-related apple health programs; and

(iii) Other apple health programs not based on MAGI, SSI, or TANF methodologies.

(c) Those that provide coverage based on a specific status or entitlement in federal rule and not on countable income, called deemed eligible apple health programs.

(2) MAGI-based apple health programs include the following:

(a) Apple health parent and caretaker relative program described in WAC 182-505-0240;

(b) MAGI-based apple health adult medical program described in WAC 182-505-0250, for which the scope of coverage is called the alternative benefits plan (ABP) described in WAC 182-500-0010;

(c) Apple health for pregnant women program described in WAC 182-505-0115;

(d) Apple health for kids program described in WAC 182-505-0210 (3)(a);

(e) Premium-based apple health for kids described in WAC 182-505-0215;

(f) Apple health long-term care for children and adults described in chapter 182-514 WAC; and

(g) Apple health alien emergency medical program described in WAC 182-507-0110 through 182-507-0125 when the person is eligible based on criteria for a MAGI-based apple health program.

(3) Non-MAGI-based apple health programs include the following:

(a) SSI-related programs which use the income methodologies of the SSI program (except where the agency has adopted more liberal rules than SSI) described in chapter 182-512 WAC to determine eligibility:

(i) Apple health for workers with disabilities (HWD) described in chapter 182-511 WAC;

(ii) Apple health SSI-related programs described in chapters 182-512 and 182-519 WAC;

(iii) Apple health long-term care and hospice programs described in chapters 182-513 and 182-515 WAC;

(iv) Apple health medicare savings programs described in chapter 182-517 WAC; and

(v) Apple health alien emergency medical (AEM) programs described in WAC 182-507-0110 and 182-507-0125 when the person meets the age, blindness or disability criteria specified in WAC 182-512-0050.

(b) TANF-related programs which use the income methodologies based on the TANF cash program described in WAC 388-450-0170 to determine eligibility, with variations as specified in WAC 182-509-0001(5) and program specific rules:

(i) Refugee medical assistance (RMA) program described in WAC 182-507-0130; and

(ii) Apple health medically needy (MN) coverage for pregnant women and children who do not meet SSI-related criteria.

(c) Other programs:

(i) Breast and cervical cancer program described in WAC 182-505-0120;

(ii) ((~~TAKE CHARGE~~)) Family planning only programs described in chapter 182-532 WAC ((~~182-532-0720~~));

(iii) Medical care services described in WAC 182-508-0005;

(iv) Apple health for pregnant minors described in WAC 182-505-0117;

(v) Kidney disease program described in chapter 182-540 WAC; and

(vi) Tailored supports for older adults described in WAC 182-513-1610.

(4) Deemed eligible apple health programs include:

(a) Apple health SSI medical program described in chapter 182-510 WAC, or a person who meets the medicaid eligibility criteria in 1619b of the Social Security Act;

(b) Newborn medical program described in WAC 182-505-0210(2);

(c) Foster care program described in WAC 182-505-0211;
(d) Medical extension program described in WAC 182-523-0100; and
(e) Family planning extension described in WAC 182-505-0115(5).

(5) A person is eligible for categorically needy (CN) health care coverage when the household's countable income is at or below the categorically needy income level (CNIL) for the specific program.

(6) If income is above the CNIL, a person is eligible for the MN program if the person is:
(a) A child;
(b) A pregnant woman; or
(c) SSI-related (aged 65, blind or disabled).

(7) MN health care coverage is not available to parents, caretaker relatives, or adults unless they are eligible under subsection (6) of this section.

(8) A person who is eligible for the apple health MAGI-based adult program listed in subsection (2)(b) of this section is eligible for ABP health care coverage as defined in WAC 182-500-0010. Such a person may apply for more comprehensive coverage through another apple health program at any time.

(9) For the other specific program requirements a person must meet to qualify for apple health, see chapters 182-503 through 182-527 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-503-0510, filed 5/30/17, effective 7/1/17. Statutory Authority: RCW 41.05.021 and Patient Protection and Affordable Care Act (P.L. 111-148), 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-06-068, § 182-503-0510, filed 2/28/14, effective 3/31/14. WSR 12-13-056, recodified as § 182-503-0510, filed 6/15/12, effective 7/1/12. WSR 12-02-034, recodified as § 182-505-0510, filed 12/29/11, effective 1/1/12. Statutory Authority: RCW 34.05.353 (2)(d), 74.08.090, and chapters 74.09, 74.04 RCW. WSR 08-11-047, § 388-503-0510, filed 5/15/08, effective 6/15/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.530. WSR 05-07-097, § 388-503-0510, filed 3/17/05, effective 4/17/05. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. WSR 02-17-030, § 388-503-0510, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-503-0510, filed 7/31/98, effective 9/1/98.]

OTS-4385.1

AMENDATORY SECTION (Amending WSR 17-12-018, filed 5/30/17, effective 6/30/17)

WAC 182-505-0300 Hospital presumptive eligibility. (1) **Purpose.** The hospital presumptive eligibility (HPE) program provides temporary Washington apple health coverage to HPE-eligible persons who enroll through an HPE-qualified hospital.

(2) **HPE-eligible persons.** To be HPE-eligible:
(a) A person must:

(i) Be younger than age ((~~sixty-five~~)) 65; and

(ii) Meet the eligibility requirements for one or more of the following programs:

(A) Washington apple health for pregnant women (chapter 182-505 WAC);

(B) Washington apple health for kids (chapter 182-505 WAC);

(C) Washington apple health for foster care (chapter 182-505 WAC);

(D) Washington apple health for parents and caretaker relatives (chapter 182-505 WAC);

(E) Washington apple health for adults (chapter 182-505 WAC); or

(F) ((~~TAKE CHARGE for~~)) Family planning only services (chapter 182-532 WAC).

(b) A person must not:

(i) Be an apple health beneficiary;

(ii) Be a supplemental security income beneficiary; or

(iii) Have received HPE coverage within the preceding ((~~twenty-four~~)) 24 months.

(3) **HPE-qualified hospitals.** To be HPE-qualified, a hospital must:

(a) Operate in Washington state;

(b) Submit a signed core provider agreement (CPA) to the agency;

(c) Submit a signed HPE agreement to the agency;

(d) Comply with the terms of the CPA and HPE agreements;

(e) Determine HPE eligibility using only those employees who have successfully completed the agency's HPE training;

(f) Agree to provide HPE-application assistance to anyone who requests it; and

(g) Agree to be listed on the agency's website as an HPE-application assistance provider.

(4) **Limitations.**

(a) An HPE-qualified hospital must attempt to help the person complete a regular apple health application before filing an HPE application. If the person cannot indicate whether they expect to file a federal tax return or be claimed as a tax dependent, the HPE-qualified hospital may treat the person as a nonfiler under WAC 182-506-0010 (5)(c) for HPE purposes.

(b) HPE coverage begins on the earlier of:

(i) The day the HPE-qualified hospital determines the person is eligible; or

(ii) The day the HPE-qualified hospital provides a covered medical service to the person, but only if the hospital determines the person is eligible and submits the decision to the agency no later than five calendar days after the date of service.

(c) HPE coverage ends on the earlier of:

(i) The last day of the month following the month in which HPE coverage began; or

(ii) The day the agency determines the person is eligible for other apple health coverage.

(d) HPE coverage does not qualify a person for continuous eligibility under WAC 182-504-0015.

(e) If HPE coverage is based on pregnancy, the pregnant person is eligible for HPE coverage only once for that pregnancy.

(f) The HPE program covers only those services included in the programs listed in subsection (2)(e) of this section, except that pregnancy-related services are limited to ambulatory prenatal care.

(g) A child born to a person with HPE coverage is ineligible for apple health under WAC 182-505-0210(2). An HPE-qualified hospital must complete a separate HPE determination for the newborn child.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-12-018, § 182-505-0300, filed 5/30/17, effective 6/30/17. Statutory Authority: RCW 41.05.021, 41.05.160, Patient Protection and Affordable Care Act established under Public Law 111-148. WSR 15-06-039, § 182-505-0300, filed 2/26/15, effective 3/29/15.]

OTS-4391.1

AMENDATORY SECTION (Amending WSR 17-12-019, filed 5/30/17, effective 7/1/17)

WAC 182-513-1605 Medicaid alternative care (MAC)—Eligibility. (1) The person receiving care must meet the financial eligibility criteria for medicaid alternative care (MAC).

(2) To be eligible for MAC services, the person receiving care must:

(a) Be age ((~~fifty-five~~)) 55 or older;

(b) Be assessed as meeting nursing facility level of care under WAC 388-106-0355, and choose to receive services under the MAC program instead of other long-term services and supports;

(c) Meet residency requirements under WAC 182-503-0520;

(d) Live at home and not in a residential or institutional setting;

(e) Have an eligible unpaid caregiver under WAC 388-106-1905;

(f) Meet citizenship and immigration status requirements under WAC 182-503-0535 (2)(a) or (b); and

(g) Be eligible for either:

(i) A noninstitutional medicaid program, which provides categorically needy (CN) or alternative benefit plan (ABP) scope of care under WAC 182-501-0060; or

(ii) An SSI-related CN program by using spousal impoverishment protections institutionalized (SIPI) spouse rules under WAC 182-513-1660.

(3) An applicant whose eligibility is limited to one or more of the following programs is not eligible for MAC:

(a) The medically needy program under WAC 182-519-0100;

(b) The medicare savings programs under WAC 182-517-0300;

(c) The family planning program under WAC 182-505-0115;

(d) The ((~~TAKE CHARGE~~)) family planning only programs under chapter 182-532 WAC ((~~182-532-720~~));

(e) The medical care services (MCS) program under WAC 182-508-0005;

(f) The alien emergency medical (AEM) program under WAC 182-507-0110 through 182-507-0120;

(g) The state funded long-term care for noncitizens program under WAC 182-507-0125;

(h) The kidney disease program under chapter 182-540 WAC; or

(i) The tailored supports for older adults (TSOA) program under WAC 182-513-1610.

(4) The following rules do not apply to services provided under the MAC benefit:

(a) Transfer of asset penalties under WAC 182-513-1363;

(b) Excess home equity under WAC 182-513-1350; and

(c) Estate recovery under chapter 182-527 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1605, filed 5/30/17, effective 7/1/17.]

AMENDATORY SECTION (Amending WSR 17-12-019, filed 5/30/17, effective 7/1/17)

WAC 182-513-1615 Tailored supports for older adults (TSOA)—General eligibility. (1) The person receiving care must meet the financial eligibility criteria for tailored supports for older adults (TSOA).

(2) To be eligible for the TSOA program, the person receiving care must:

(a) Be age ((~~fifty-five~~)) 55 or older;

(b) Be assessed as meeting nursing facility level of care under WAC 388-106-0355;

(c) Meet residency requirements under WAC 182-503-0520;

(d) Live at home and not in a residential or institutional setting;

(e) Have an eligible unpaid caregiver under WAC 388-106-1905, or meet the criteria under WAC 388-106-1910 if the person does not have an eligible unpaid caregiver;

(f) Meet citizenship or immigration status requirements under WAC 182-503-0535. To be eligible for TSOA, a person must be a:

(i) U.S. citizen under WAC 182-503-0535 (1)(c);

(ii) U.S. national under WAC 182-503-0535 (1)(d);

(iii) Qualifying American Indian born abroad under WAC 182-503-0535 (1)(f); or

(iv) Qualified alien under WAC 182-503-0535 (1)(b) and have either met or is exempt from the five-year bar requirement for medicaid.

(g) Provide a valid Social Security number under WAC 182-503-0515;

(h) Have countable resources within specific program limits under WAC 182-513-1640; and

(i) Meet income requirements under WAC 182-513-1635.

(3) TSOA applicants who receive coverage under Washington apple health programs are not eligible for TSOA, unless their enrollment is limited to the:

(a) Medically needy program under WAC 182-519-0100;

(b) Medicare savings programs under WAC 182-517-0300;

(c) Family planning program under WAC 182-505-0115;

(d) ((~~TAKE CHARGE~~)) Family planning only programs under chapter 182-532 WAC ((~~182-532-720~~)); or

(e) Kidney disease program under chapter 182-540 WAC.

(4) A person who receives apple health coverage under a categorically needy (CN) or alternative benefit plan (ABP) program is not eligible for TSOA but may qualify for:

(a) Caregiver supports under medicaid alternative care (MAC) under WAC 182-513-1605; or

(b) Other long-term services and supports under chapter 182-513 or 182-515 WAC.

(5) The following rules do not apply to services provided under the TSOA benefit:

(a) Transfer of asset penalties under WAC 182-513-1363;

(b) Excess home equity under WAC 182-513-1350;

(c) Client financial responsibility under WAC 182-515-1509;

(d) Estate recovery under chapter 182-527 WAC;

(e) Disability requirements under WAC 182-512-0050;

(f) Requirement to do anything necessary to obtain income under WAC 182-512-0700(1); and

(g) Assignment of rights and cooperation under WAC 182-503-0540.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1615, filed 5/30/17, effective 7/1/17.]

OTS-4389.1

AMENDATORY SECTION (Amending WSR 17-07-001, filed 3/1/17, effective 4/1/17)

WAC 182-530-7250 Reimbursement—Miscellaneous. (1) The medicaid agency reimburses for covered drugs, devices, and drug-related supplies provided or administered by nonpharmacy providers under specified conditions, as follows:

(a) The agency reimburses for drugs administered or prepared and delivered for individual use by an authorized prescriber during an office visit according to specific program rules found in:

(i) Chapter 182-531 WAC, Physician-related services;

(ii) Chapter 182-532 WAC, Reproductive health/family planning only((~~/TAKE CHARGE~~)); and

(iii) Chapter 182-540 WAC, Kidney disease program and kidney center services.

(b) Providers who are purchasers of Public Health Services (PHS) discounted drugs must comply with PHS 340B program requirements and Washington medicaid requirements for 340B providers participating with medicaid. (See WAC 182-530-7900.)

(2) The agency may request providers to submit a current invoice for the actual cost of the drug, device, or drug-related supply billed. If an invoice is requested, the invoice must show the:

(a) Name of the drug, device, or drug-related supply;

(b) Drug or product manufacturer;

(c) NDC of the product or products;

(d) Drug strength;

(e) Product description;

(f) Quantity; and

(g) Cost, including any discounts or free goods associated with the invoice.

(3) The agency does not reimburse providers for the cost of vaccines obtained through the state department of health (DOH). The agency does pay physicians, advanced registered nurse practitioners (ARNP), and pharmacists a fee for administering the vaccine.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-07-001, § 182-530-7250, filed 3/1/17, effective 4/1/17; WSR 16-01-046, § 182-530-7250, filed 12/9/15, effective 1/9/16. WSR 11-14-075, recodified as § 182-530-7250, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 07-20-049, § 388-530-7250, filed 9/26/07, effective 11/1/07.]

OTS-4388.1

AMENDATORY SECTION (Amending WSR 15-01-037, filed 12/8/14, effective 1/8/15)

WAC 182-550-4900 Disproportionate share hospital (DSH) payments—General provisions. (1) As required by Section 1902 (a)(13)(A) of the Social Security Act (42 U.S.C. 1396 (a)(13)(A)) and RCW 74.09.730, the medicaid agency makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income clients with special needs. These adjustments are also known as disproportionate share hospital (DSH) payments.

(2) No hospital has a legal entitlement to any DSH payment. A hospital may receive DSH payments only if:

(a) It satisfies the requirements of 42 U.S.C. 1396r-4;

(b) It satisfies all the requirements of agency rules and policies; and

(c) The legislature appropriates sufficient funds.

(3) For purposes of eligibility for DSH payments, the following definitions apply:

(a) "Base year" means the ((~~twelve~~)) 12-month medicare cost report year that ended during the calendar year immediately preceding the year in which the state fiscal year (SFY) for which the DSH application is being made begins.

(b) "Case mix index (CMI)" means the average of diagnosis related group (DRG) weights for all of an individual hospital's DRG-paid medicaid claims during the SFY two years prior to the SFY for which the DSH application is being made.

(c) "Charity care" means necessary hospital care rendered to persons unable to pay for the hospital services or unable to pay the deductibles or coinsurance amounts required by a third-party payer. The charity care amount is determined in accordance with the hospital's published charity care policy.

(d) "DSH reporting data file (DRDF)" means the information submitted by hospitals to the agency which the agency uses to verify medicaid client eligibility and applicable inpatient days.

(e) "Hospital-specific DSH cap" means the maximum amount of DSH payments a hospital may receive from the agency during a SFY. If a hospital does not qualify for DSH, the agency will not calculate the hospital-specific DSH cap and the hospital will not receive DSH payments.

(f) "Inpatient medicaid days" means inpatient days attributed to clients eligible for Title XIX medicaid programs. Excluded from this count are inpatient days attributed to clients eligible for state administered programs, medicare Part A, Title XXI, the refugee program and the ((~~TAKE CHARGE~~)) family planning only programs.

(g) "Low income utilization rate (LIUR)" means the sum of the following two percentages used to determine whether a hospital is DSH-eligible:

(i) The ratio of payments received by the hospital for patient services provided to clients under medicaid (including managed care), plus cash subsidies received by the hospital from state and local governments for patient services, divided by total payments received by the hospital from all patient categories; plus

(ii) The ratio of inpatient charity care charges less inpatient cash subsidies received by the hospital from state and local governments, less contractual allowances and discounts, divided by total charges for inpatient services.

(h) "Medicaid inpatient utilization rate (MIPUR)" means the calculation (expressed as a percentage) used to determine whether a hospital is DSH-eligible. The numerator of which is the hospital's number of inpatient days attributable to clients who (for such days) were eligible for medical assistance during the base year (regardless of whether such clients received medical assistance on a fee-for-service basis or through a managed care entity), and the denominator of which is the total number of the hospital's inpatient days in that period. "Inpatient days" include each day in which a person (including a newborn) is an inpatient in the hospital, whether or not the person is in a specialized ward and whether or not the person remains in the hospital for lack of suitable placement elsewhere.

(i) "Medicare cost report year" means the ((~~twelve~~)) 12-month period included in the annual cost report a medicare-certified hospital or institutional provider is required by law to submit to its fiscal intermediary.

(j) "Nonrural hospital" means a hospital that:

(i) Is not participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 182-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC 182-550-2600 (2)(d);

(iii) Is not a small rural hospital as defined in (n) of this subsection; and

(iv) Is located in the state of Washington or in a designated bordering city. For DSH purposes, the agency considers as nonrural any hospital located in a designated bordering city.

(k) "Obstetric services" means routine, nonemergency obstetric services and the delivery of babies.

(l) "Service year" means the one year period used to measure the costs and associated charges for hospital services. The service year may refer to a hospital's fiscal year or medicare cost report year, or to a state fiscal year.

(m) "Statewide disproportionate share hospital (DSH) cap" means the maximum amount per SFY that the state can distribute in DSH payments to all qualifying hospitals during a SFY.

(n) "Small rural hospital" means a hospital that:

(i) Is not participating in the "full cost" public hospital certified public expenditure (CPE) payment program as described in WAC 182-550-4650;

(ii) Is not designated as an "institution for mental diseases (IMD)" as defined in WAC 182-550-2600 (2)(d);

(iii) Has fewer than ((~~seventy-five~~)) 75 acute beds;

(iv) Is located in the state of Washington; and

(v) Is located in a city or town with a nonstudent population of no more than ((~~seventeen thousand eight hundred six~~)) 17,806 in calendar year 2008, as determined by population data reported by the Washington state office of financial management population of cities, towns and counties used for the allocation of state revenues. This nonstudent population is used for SFY 2010, which begins July 1, 2009. For each subsequent SFY, the nonstudent population is increased by two percent.

(o) "Uninsured patient" means a person without creditable coverage as defined in 45 C.F.R. 146.113. (An "insured patient," for DSH program purposes, is a person with creditable coverage, even if the insurer did not pay the full charges for the service.) To determine whether a service provided to an uninsured patient may be included for DSH application and calculation purposes, the agency considers only services that would have been covered and paid through the agency's fee-for-service process.

(4) To be considered for a DSH payment for each SFY, a hospital must meet the criteria in this section:

(a) DSH application requirements.

(i) Only a hospital located in the state of Washington or in a designated bordering city is eligible to apply for and receive DSH payments. An institution for mental disease (IMD) owned and operated by the state of Washington is exempt from the DSH application requirement.

(ii) A hospital that meets DSH program criteria is eligible for DSH payments in any SFY only if the agency receives the hospital's DSH application by the deadline posted on the agency's website.

(b) The DSH application review and correction period.

(i) This subsection applies only to DSH applications that meet the requirements under (a) of this subsection.

(ii) The agency reviews and may verify any information provided by the hospital on a DSH application. However, each hospital has the responsibility for ensuring its DSH application is complete and accurate.

(iii) If the agency finds that a hospital's application is incomplete or contains incorrect information, the agency will notify the hospital. The hospital must submit a new, corrected application. The agency must receive the new DSH application from the hospital by the deadline for corrected DSH applications posted on the agency's website.

(iv) If a hospital finds that its application is incomplete or contains incorrect information, it may choose to submit changes and/or corrections to the DSH application. The agency must receive the corrected, complete, and signed DSH application from the hospital by the deadline for corrected DSH applications posted on the agency's website.

(c) Official DSH application.

(i) The agency considers as official the last signed DSH application submitted by the hospital as of the deadline for corrected DSH applications. A hospital cannot change its official DSH application. Only those hospitals with an official DSH application are eligible for DSH payments.

(ii) If the agency finds that a hospital's official DSH application is incomplete or contains inaccurate information that affects the hospital's LIDSH payment(s), the hospital does not qualify for, will not receive, and cannot retain, LIDSH payment(s). Refer to WAC 182-550-5000.

(5) A hospital is a disproportionate share hospital for a specific SFY if the hospital satisfies the medicaid inpatient utilization rate (MIPUR) requirement (discussed in (a) of this subsection), and the obstetric services requirement (discussed in (b) of this subsection).

(a) The hospital must have a MIPUR of one percent or more; and

(b) Unless one of the exceptions described in (i)(A) or (B) of this subsection applies, the hospital must have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to eligible individuals.

(i) The obstetric services requirement does not apply to a hospital that:

(A) Provides inpatient services predominantly to individuals younger than age ((~~eighteen~~)) 18; or

(B) Did not offer nonemergency obstetric services to the general public as of December 22, 1987, when section 1923 of the Social Security Act was enacted.

(ii) For hospitals located in rural areas, "obstetrician" means any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(6) To determine a hospital's MIPUR, the agency uses inpatient days as follows:

(a) The total inpatient days on the official DSH application if this number is greater than the total inpatient hospital days on the medicare cost report; and

(b) The MMIS medicaid days as determined by the DSH reporting data file (DRDF) process if the Washington state medicaid days on the official DSH application do not match the eligible days on the final DRDF. If the hospital did not submit a DRDF, the agency uses paid medicaid days from MMIS.

(7) The agency administers the following DSH programs (depending on legislative budget appropriations):

(a) Low income disproportionate share hospital (LIDSH);

(b) Medical care services disproportionate share hospital (MCSDSH);

(c) Small rural disproportionate share hospital (SRDSH);

(d) Small rural indigent assistance disproportionate share hospital (SRIADSH);

(e) Nonrural indigent assistance disproportionate share hospital (NRIADSH);

(f) Public hospital disproportionate share hospital (PHDSH);

(g) Children's health program disproportionate share hospital (CHPDSH); and

(h) Sole community disproportionate share hospital (SCDSH).

(8) The agency allows a hospital to receive any one or all of the DSH payment it qualifies for, up to the individual hospital's DSH cap

(see subsection (10) of this section) and provided that total DSH payments do not exceed the statewide DSH cap. To be eligible for payment under multiple DSH programs, a hospital must meet:

(a) The basic requirements in subsection (5) of this section; and

(b) The eligibility requirements for the particular DSH payment, as discussed in the applicable DSH program WAC.

(9) For each SFY, the agency calculates DSH payments for each DSH program for eligible hospitals using data from each hospital's base year. The agency does not use base year data for MCSDSH and CHPDSH payments, which are calculated based on specific claims data.

(10) The agency's total DSH payments to a hospital for any given SFY cannot exceed the hospital-specific DSH cap for that SFY. Except for critical access hospitals (CAHs), the agency determines a hospital's DSH cap as follows. The agency:

(a) Uses the overall ratio of costs-to-charges (RCC) to determine costs for:

(i) Medicaid services, including medicaid services provided under managed care organization (MCO) plans; and

(ii) Uninsured charges; then

(b) Subtracts all payments related to the costs derived in (a) of this subsection; then

(c) Makes any adjustments required and/or authorized by federal statute or regulation.

(11) A CAH's DSH cap is based strictly on the cost to the hospital of providing services to medicaid clients served under MCO plans, and uninsured patients. To determine a CAH's DSH cap amount, the agency:

(a) Uses the overall RCC to determine costs for:

(i) Medicaid services provided under MCO plans; and

(ii) Uninsured charges; then

(b) Subtracts the total payments made by, or on behalf of, the medicaid clients serviced under MCO plans, and uninsured patients.

(12) In any given federal fiscal year, the total of the agency's DSH payments cannot exceed the statewide DSH cap as published in the federal register.

(13) If the agency's DSH payments for any given federal fiscal year exceed the statewide DSH cap, the agency will adjust DSH payments to each hospital to account for the amount overpaid. The agency makes adjustments in the following program order:

(a) PHDSH;

(b) SRIADSH;

(c) SRDSH;

(d) SCDSH;

(e) NRIADSH;

(f) MCSDSH;

(g) CHPDSH; and

(h) LIDSH.

(14) If the statewide DSH cap is exceeded, the agency will recoup DSH payments made under the various DSH programs, in the order of precedence described in subsection (13) of this section, starting with PHDSH, until the amount exceeding the statewide DSH cap is reduced to zero. See specific program regulations in the Washington Administrative Code for description of how amounts to be recouped are determined.

(15) The total amount the agency may distribute annually under a particular DSH program is capped by legislative appropriation. Any changes in payment amount to a hospital in a particular DSH program

means a redistribution of payments within that DSH program. When necessary, the agency will recoup from hospitals to make additional payments to other DSH-eligible hospitals within that DSH program.

(16) If funds in a specific DSH program need to be redistributed because of legislative, administrative, or other state action, only those hospitals eligible for that DSH program will be involved in the redistribution.

(a) If an individual hospital has been overpaid by a specified amount, the agency will recoup that overpayment amount from the hospital and redistribute it among the other eligible hospitals in the DSH program. The additional DSH payment to be given to each of the other hospitals from the recouped amount is proportional to each hospital's share of the particular DSH program.

(b) If an individual hospital has been underpaid by a specified amount, the agency will pay that hospital the additional amount owed by recouping from the other hospitals in the DSH program. The amount to be recouped from each of the other hospitals is proportional to each hospital's share of the particular DSH program.

(c) This subsection does not apply to the DSH independent audit findings and recoupment process described in WAC 182-550-4940.

(17) All information related to a hospital's DSH application is subject to audit by the agency or its designee. The agency determines the extent and timing of the audits. For example, the agency or its designee may choose to do an audit of an individual hospital's DSH application and/or supporting documentation, or audit all hospitals that qualified for a particular DSH program after payments have been distributed under that program.

(18) If a hospital's submission of incorrect information or failure to submit correct information results in DSH overpayment to that hospital, the agency will recoup the overpayment amount as allowed in RCW 74.09.220 and chapter 41.05A RCW.

(19) DSH calculations use fiscal year data, and DSH payments are distributed based on funding for a specific SFY. Therefore, unless otherwise specified, changes and clarifications to DSH program rules apply for the full SFY in which the rules are adopted.

[Statutory Authority: RCW 41.05.021 and 42 C.F.R. Part 455, Subpart F. WSR 15-01-037, § 182-550-4900, filed 12/8/14, effective 1/8/15. Statutory Authority: RCW 41.05.021 and 2013 2nd sp.s. c 4. WSR 14-08-038, § 182-550-4900, filed 3/26/14, effective 4/26/14. Statutory Authority: RCW 41.05.021. WSR 12-20-029, § 182-550-4900, filed 9/26/12, effective 10/27/12. WSR 11-14-075, recodified as § 182-550-4900, filed 6/30/11, effective 7/1/11. Statutory Authority: 2009 c 564 §§ 201 and 209, RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. WSR 10-11-032, § 388-550-4900, filed 5/11/10, effective 6/11/10. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-090, § 388-550-4900, filed 6/29/07, effective 8/1/07; WSR 06-08-046, § 388-550-4900, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-12-132, § 388-550-4900, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090, 74.04.050, and 2003 1st sp.s. c 25. WSR 04-12-044, § 388-550-4900, filed 5/28/04, effective 7/1/04. Statutory Authority: RCW 74.08.090, 74.09.500, 74.09.035(1), and 43.88.290. WSR 03-13-055, § 388-550-4900, filed 6/12/03, effective 7/13/03. Statutory Authority: RCW 74.08.090, 74.09.730 and 42 U.S.C. 1396r-4. WSR 99-14-040, § 388-550-4900, filed 6/30/99, effective 7/1/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050,

70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4900, filed 12/18/97, effective 1/18/98.]

WSR 23-06-052
EXPEDITED RULES
HEALTH CARE AUTHORITY
[Filed February 27, 2023, 9:42 a.m.]

Title of Rule and Other Identifying Information: WAC 182-508-0001 Washington apple health—Coverage options for adults not eligible under MAGI methodologies, 182-509-0001 Countable income for Washington apple health programs, 182-519-0050 Monthly income and countable resource standards for medically needy (MN), and 182-519-0100 Eligibility for the medically needy program.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Correct typographical errors.

Reasons Supporting Proposal: The agency is correcting cross-references to repealed rules that were inadvertently not corrected at the time those rules were repealed. The agency is deleting WAC 182-508-0001 (3)(d) and 182-509-0001 (2)(d) because the income limit to which they refer ceased to exist on January 1, 2020, and WAC 182-511-1060 was repealed under WSR 19-23-063. The agency is replacing references to WAC 182-513-1305 with references to WAC 182-513-1205 because the information that had been in WAC 182-513-1305 was revised and recodified in WAC 182-513-1205, and 182-513-1305 was repealed under WSR 17-03-116. The agency is replacing references to WAC 182-514-0255 with references to WAC 182-514-0263 because WAC 182-514-0255 was repealed under WSR 16-04-087. The agency is deleting WAC 182-519-0100 (1)(c) because the programs to which it refers ended in 2012 and WAC 182-515-1540 and 182-515-1550 were repealed under WSR 17-22-060.

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: Health care authority, governmental.

Name of Agency Personnel Responsible for Drafting: Brian Jensen, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0815; Implementation and Enforcement: Paige Lewis, P.O. Box 42722, Olympia, WA 98504-2722, 360-725-0757.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: None.

This notice meets the following criteria to use the expedited adoption process for these rules:

Corrects typographical errors, makes address or name changes, or clarifies language of a rule without changing its effect.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: The proposed rules correct typographical errors and clarify language of a rule without changing its effect.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, Health Care Authority, P.O. Box 42716, Olympia, WA 98504-2716, phone 360-725-1306, fax 360-586-9272, email arc@hca.wa.gov, AND RECEIVED BY May 2, 2023.

February 27, 2023
Wendy Barcus
Rules Coordinator

OTS-4386.1

AMENDATORY SECTION (Amending WSR 14-21-040, filed 10/7/14, effective 11/7/14)

WAC 182-508-0001 Washington apple health—Coverage options for adults not eligible under MAGI methodologies. (1) This chapter provides information on eligibility determinations for adults who:

(a) Need a determination of eligibility on the basis of being aged, blind, or disabled;

(b) Need a determination of eligibility based on the need for long-term institutional care or home and community-based services;

(c) Are excluded from coverage under a modified adjusted gross income (MAGI)-based program as referenced in WAC 182-503-0510 on the basis of medicare entitlement;

(d) Are not eligible for health care coverage under chapter 182-505 WAC due to citizenship or immigration requirements; or

(e) Are not eligible for health care coverage under chapter 182-505 WAC due to income which exceeds the applicable standard for coverage.

(2) The agency determines eligibility for Washington apple health (WAH) noninstitutional categorically needy (CN) coverage under chapter 182-512 WAC for an adult who is age ((~~sixty-five~~)) 65 or older, or who meets the federal blind or disabled criteria of the federal SSI program, and:

(a) Meets citizenship/immigration, residency, and Social Security number requirements as described in chapter 182-503 WAC; and

(b) Has CN countable income and resources that do not exceed the income and resource standards in WAC 182-512-0010.

(3) The agency determines eligibility for WAH health care for workers with disabilities (HWD) CN coverage for adults who meet the requirements described in WAC 182-511-1050, as follows:

(a) Are age ((~~sixteen~~)) 16 through ((~~sixty-four~~)) 64;

(b) Meet citizenship/immigration, residency, and Social Security number requirements as described in chapter 182-503 WAC;

(c) Meet the federal disability requirements described in WAC 182-511-1150; and

(d) ((~~Have net income that does not exceed the income standard described in WAC 182-511-1060; and~~

~~(e)~~)) Are employed full- or part-time (including self-employment) as described in WAC 182-511-1200.

(4) The agency determines eligibility for WAH long-term care CN coverage for adults who meet the institutional status requirements defined in WAC 182-513-1320 under the following rules:

(a) When the person receives coverage under a MAGI-based program and needs long-term care services in an institution, the agency follows rules described in chapter 182-514 WAC;

(b) When the person meets aged, blind, or disabled criteria as defined in WAC 182-512-0050 and needs long-term care services, the agency follows rules described in:

(i) Chapter 182-513 WAC, for an adult who resides in an institution; and

(ii) Chapter 182-515 WAC, for an adult who is determined eligible for WAH home and community-based waiver services.

(5) The agency determines eligibility for WAH noninstitutional CN or medically needy (MN) health care coverage for an adult who resides in an alternate living facility under rules described in WAC ((~~182-513-1305~~)) 182-513-1205.

(6) The agency determines eligibility for WAH-CN coverage under institutional rules described in chapters 182-513 and 182-515 WAC for an adult who:

(a) Has made a voluntary election of hospice services;

(b) Is not otherwise eligible for noninstitutional CN or MN health care coverage or for whom hospice is not included in the benefit service package available to the person; and

(c) Meets the aged, blind, or disabled criteria described in WAC 182-512-0050.

(7) The agency uses the following rules to determine eligibility for an adult under the WAH-MN program:

(a) Noninstitutional WAH-MN is determined under chapter 182-519 WAC for an adult with countable income that exceeds the applicable CN standard; and

(b) Non-SSI-related institutional WAH-MN long-term care coverage is determined under WAC ((~~182-514-0255 for an adult age nineteen or twenty~~)) 182-514-0263 for pregnant people and people age 20 and younger who:

(i) Meet((~~s~~)) institutional status requirements described in WAC 182-513-1320;

(ii) ((~~Does~~)) Do not meet blind or disabled criteria described in WAC 182-512-0050; and

(iii) ((~~Has~~)) Have countable income that exceeds the applicable CN standard.

(c) WAH-MN long-term care coverage is determined under WAC 182-513-1395 for an aged, blind, or disabled adult who resides in an institution and has countable income that exceeds the special income level (SIL).

(8) An adult is eligible for WAH-MN coverage when he or she:

(a) Meets citizenship/immigration, residency, and Social Security number requirements as described in WAC 182-503-0505;

(b) Has MN countable income that does not exceed the effective MN income standards in WAC 182-519-0050, or meets the excess income spenddown requirements in WAC 182-519-0110;

(c) Meets the countable resource standards in WAC 182-519-0050; and

(d) Is ((~~sixty-five~~)) 65 years of age or older or meets the blind or disabled criteria of the federal SSI program.

(9) WAH-MN coverage is available for an aged, blind, or disabled ineligible spouse of an SSI recipient. See WAC 182-519-0100 for additional information.

(10) An adult who does not meet citizenship or alien status requirements described in WAC 182-503-0535 may be eligible for the WAH alien emergency medical program as described in WAC 182-507-0110.

(11) An adult is eligible for the state-funded medical care services (MCS) program when he or she meets the requirements under WAC 182-508-0005.

(12) A person who is entitled to medicare is eligible for coverage under a medicare savings program or the state-funded buy-in program when he or she meets the requirements described in chapter 182-517 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, 457, and 45 C.F.R. § 155. WSR 14-21-040, § 182-508-0001, filed 10/7/14, effective 11/7/14. Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. WSR 12-19-051, § 182-508-0001, filed 9/13/12, effective 10/14/12.]

OTS-4387.1

AMENDATORY SECTION (Amending WSR 14-01-021, filed 12/9/13, effective 1/9/14)

WAC 182-509-0001 Countable income for Washington apple health programs. (1) For purposes of Washington apple health (WAH) program eligibility, a person's countable income is income which remains when:

(a) The income cannot be specifically excluded; and

(b) All appropriate deductions and disregards allowed by a specific program have been applied.

(2) A person's countable income may not exceed the income standard for the specific WAH program, unless the program allows for those limits to be exceeded. Specific program standards are described below:

(a) For modified adjusted gross income (MAGI)-based programs described in WAC 182-503-0510, see WAC 182-505-0100 for the applicable program standard based on a percentage of the federal poverty level (FPL);

(b) For WAH SSI-related CN coverage, see WAC 182-512-0010;

(c) For WAH MN coverage, see WAC 182-519-0050;

(d) ((~~For WAH for workers with disabilities, see WAC 182-511-1060;~~

~~(e)~~)) For WAH medicare savings programs, see WAC 182-517-0100;

((~~(f)~~)) (e) For WAH noninstitutional medical in an alternative living facility, see WAC ((~~182-513-1305~~)) 182-513-1205; and

((~~(g)~~)) (f) For WAH long-term care programs, see WAC 182-513-1315 and 182-513-1395.

(3) For the MAGI-based programs listed below, the agency or its designee determines eligibility based on the countable MAGI income of the members of the person's medical assistance unit as determined per WAC 182-506-0010:

(a) WAH for parents and caretaker relatives program as described in WAC 182-505-0240;

(b) WAH pregnancy program as described in WAC 182-505-0115;

(c) WAH for kids programs as described in WAC 182-505-0210 with the following exceptions:

(i) Newborn children born to a woman who is eligible for WAH on the date of the newborn's birth, including a retroactive eligibility determination;

(ii) Children who are receiving SSI;

(iii) Children who are in foster care or receiving subsidized adoption services.

(d) WAH MAGI-based adult medical as described in WAC 182-505-0250; and

(e) WAH MAGI-based alien emergency medical as described in WAC 182-507-0110.

(4) For the following SSI-related WAH programs, unless the state has adopted more liberal rules, income rules for the SSI program are used to determine a person's countable income:

(a) WAH noninstitutional SSI-related CN or medically needy (MN) coverage described in chapters 182-511 and 182-512 WAC;

(b) WAH institutional SSI-related CN or MN long-term care or hospice coverage described in chapters 182-513 and 182-515 WAC;

(c) WAH alien emergency medical programs based on age ((~~sixty-five~~)) 65 or older or disability described in chapter 182-507 WAC; and

(d) WAH medicare savings programs described in chapter 182-517 WAC.

(5) Anticipated nonrecurring lump sum payments received by an applicant or recipient of a WAH SSI-related medical program are counted as income in the month of receipt, subject to reporting requirements, with the exception of retroactive supplemental security income (SSI)/Social Security disability lump sum payments. See WAC 182-512-0300(4) and 182-512-0700 for more information.

(6) Countable income for the WAH refugee medical (RMA) program and WAH MN program for pregnant women and children is determined as follows:

(a) The agency or its designee allows the following deductions from a person's gross earnings:

(i) Fifty percent of gross earned income;

(ii) Actual work-related child and dependent care expenses, which are the person's responsibility; and

(iii) Court or administratively ordered current or back support paid to meet the needs of legal dependents.

(b) Only income actually contributed to an alien client from the alien's sponsor is countable unless the sponsor signs the affidavit of support I-864 or I-864A.

(c) Nonrecurring lump sum payments are counted as income in the month of receipt and as a resource if the person retains the payment after the month of receipt (resource limits do not apply to MN coverage for pregnant women and children). For RMA, nonrecurring lump sum payments are counted as income if received in the month of application and not considered if received thereafter per WAC 182-507-0130.

(7) Countable income rules for other WAH programs that are not MAGI-based or SSI-related are described in the specific program rules listed in WAC 182-503-0510 (3)(c).

(8) Some WAH programs are not based on a person's or household's countable income but are based on a specific status or entitlement in federal rule. The rules for these deemed eligible WAH programs are described in WAC 182-503-0510(4).

[Statutory Authority: RCW 41.05.021, Patient Protection and Affordable Care Act (P.L. 111-148), 42 C.F.R. §§ 431, 435, 457, and 45 C.F.R. § 155. WSR 14-01-021, § 182-509-0001, filed 12/9/13, effective 1/9/14. WSR 11-23-091, recodified as § 182-509-0001, filed 11/17/11, effective 11/21/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. WSR 08-05-018, § 388-450-0210,

filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. WSR 05-23-013, § 388-450-0210, filed 11/4/05, effective 1/1/06. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. WSR 02-17-030, § 388-450-0210, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090, 74.08A.100, and Title XIX State Plan amendment 00-008. WSR 02-03-009, § 388-450-0210, filed 1/4/02, effective 2/4/02. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-450-0210, filed 7/31/98, effective 9/1/98. Formerly WAC 388-505-0580, 388-505-0590 and 388-519-1910.]

OTS-4390.1

AMENDATORY SECTION (Amending WSR 15-17-012, filed 8/7/15, effective 9/7/15)

WAC 182-519-0050 Monthly income and countable resource standards for medically needy (MN). (1) Changes to the medically needy income level (MNIL) occur on January 1st of each calendar year when the Social Security Administration (SSA) issues a cost-of-living adjustment.

(2) Medically needy (MN) standards for people who meet institutional status requirements are in WAC 182-513-1395. The standard for a client who lives in an alternate living facility is in WAC ((~~182-513-1305~~)) 182-513-1205.

(3) The resource standards for institutional programs are in WAC 182-513-1350. The institutional standard chart is found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.

(4) Countable resource standards for the noninstitutional MN program are:

(a)	One person	$2,000
(b)	A legally married couple	$3,000
(c)	For each additional family member add	$50

(5) People who do not meet institutional status requirements use the "effective" MNIL income standard to determine eligibility for the MN program. The "effective" MNIL is the one-person federal benefit rate (FBR) established by SSA each year, or the MNIL listed below, whichever amount is higher. The FBR is the supplemental security income (SSI) payment standard. For example, in 2012, the FBR is ((~~six hundred ninety-eight dollars~~)) $698.

1	2	3	4	5	6	7	8	9	10
467	592	667	742	858	975	1125	1242	1358	1483

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-17-012, § 182-519-0050, filed 8/7/15, effective 9/7/15. Statutory Authority: RCW 41.05.021. WSR 12-20-001, § 182-519-0050, filed 9/19/12, effective 10/20/12. WSR 11-23-091, recodified as § 182-519-0050, filed 11/17/11, effective 11/21/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. WSR 08-11-098, § 388-478-0070, filed 5/20/08, effective 6/20/08. Statutory Authority: RCW 74.04.050,

74.04.057, 74.08.090, 74.09.500, 74.09.530, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5). WSR 06-06-013, § 388-478-0070, filed 2/17/06, effective 3/20/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 9902(2). WSR 05-06-090, § 388-478-0070, filed 3/1/05, effective 4/1/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 1396r-5. WSR 02-10-116, § 388-478-0070, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924 (42 U.S.C. 1396R-5). WSR 01-12-073, § 388-478-0070, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, and 74.09.575. WSR 00-10-095, § 388-478-0070, filed 5/2/00, effective 5/2/00; WSR 99-11-054, § 388-478-0070, filed 5/17/99, effective 6/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-478-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-0710, 388-507-0720, 388-511-1115, 388-518-1820, 388-518-1830, 388-518-1840 and 388-518-1850.]

AMENDATORY SECTION (Amending WSR 19-02-046, filed 12/27/18, effective 1/27/19)

WAC 182-519-0100 Eligibility for the medically needy program. (1) A person who meets the following conditions may be eligible for medically needy (MN) coverage under the special rules in chapters 182-513 and 182-515 WAC:

(a) Meets the institutional status requirements of WAC 182-513-1320; or

(b) Resides in a medical institution as described in WAC 182-513-1395((~~; or~~

~~(c) Receives waiver services under a medically needy in-home waiver (MNIW) under WAC 182-515-1550 or a medically needy residential waiver (MNRW) under WAC 182-515-1540~~)).

(2) A supplemental security income (SSI)-related person who lives in a medicaid agency-contracted alternate living facility may be eligible for MN coverage under WAC ((~~182-513-1305~~)) 182-513-1205.

(3) A person may be eligible for MN coverage under this chapter when he or she is:

(a) Not covered under subsection (1) and (2) of this section; and

(b) Eligible for categorically needy (CN) medical coverage in all other respects, except that his or her CN countable income is above the CN income standard.

(4) MN coverage may be available if the person is:

(a) A child;

(b) A pregnant woman;

(c) A refugee;

(d) An SSI-related person, including an aged, blind, or disabled person, with countable income under the CN income standard, who is an ineligible spouse of an SSI recipient; or

(e) A hospice client with countable income above the special income level (SIL).

(5) A person who is not eligible for CN medical who applies for MN coverage has the right to income deductions in addition to, or instead of, those used to calculate CN countable income. These deductions to income are applied to each month of the base period to calculate MN countable income:

(a) The agency disregards the difference between the medically needy income level (MNIL) described in WAC 182-519-0050 and the federal benefit rate (FBR) established by the Social Security Administration each year. The FBR is the one-person SSI payment standard;

(b) All health insurance premiums, except for medicare Part A through Part D premiums, expected to be paid by the person or family member during the base period or periods;

(c) Any allocations to a spouse or to dependents for an SSI-related person who is married or who has dependent children. Rules for allocating income are described in WAC 182-512-0900 through 182-512-0960;

(d) For an SSI-related person who is married and lives in the same home as his or her spouse who receives home and community-based waiver services under chapter 182-515 WAC, an income deduction equal to the MNIL, minus the nonapplying spouse's income; and

(e) A child or pregnant woman applying for MN coverage is eligible for income deductions allowed under temporary assistance for needy families (TANF) and state family assistance (SFA) rules and not under the rules for CN programs based on the federal poverty level. See WAC 182-509-0001(4) for exceptions to the TANF and SFA rules that apply to medical programs and not to the cash assistance program.

(6) The MNIL for a person who qualifies for MN coverage under subsection (1) of this section is based on rules in chapters 182-513 and 182-515 WAC.

(7) The MNIL for all other people is described in WAC 182-519-0050. If a person has countable income at or below the MNIL, the person is certified as eligible for up to ((~~twelve~~)) 12 months of MN medical coverage.

(8) If a person has countable income over the MNIL, the countable income that exceeds the agency's MNIL standards is called "excess income."

(9) A person with "excess income" is not eligible for MN coverage until the person gives the agency or its designee evidence of medical expenses incurred by that person, their spouse, or family members living in the home for whom they are financially responsible. See WAC 182-519-0110(8). An expense is incurred when:

(a) The person receives medical treatment or medical supplies, is financially liable for the medical expense, and has not paid the bill; or

(b) The person pays for the expense within the current or retroactive base period under WAC 182-519-0110.

(10) Incurred medical expenses or obligations may be used to offset any portion of countable income that is over the MNIL. This is the process of meeting "spenddown."

(11) The agency or its designee calculates the amount of a person's spenddown by multiplying the monthly excess income amount by the number of months in the certification period under WAC 182-519-0110. The qualifying medical expenses must be greater than or equal to the total calculated spenddown amount.

(12) A person who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter, a person is ineligible for MN coverage if the person's resources exceed the program standard in WAC 182-519-0050. A person who is considered for MN coverage under WAC 182-513-1395, 182-514-0250 or ((~~182-514-0255~~)) 182-514-0263 is allowed to spenddown excess resources.

(13) There is no automatic redetermination process for MN coverage. A person must apply for each eligibility period under the MN program.

(14) A person who requests a timely administrative hearing under WAC 182-518-0025(5) is not eligible for continued benefits beyond the end of the original certification date under the MN program.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-02-046, § 182-519-0100, filed 12/27/18, effective 1/27/19; WSR 15-17-012, § 182-519-0100, filed 8/7/15, effective 9/7/15. Statutory Authority: RCW 41.05.021. WSR 12-20-001, amended and recodified as § 182-519-0100, filed 9/19/12, effective 10/20/12. Statutory Authority: RCW 74.04.055, 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 C.F.R. 435.831 (3)(e) and (f). WSR 09-08-003, § 388-519-0100, filed 3/19/09, effective 4/19/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-519-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0320, 388-518-1840, 388-519-1930 and 388-522-2230.]

WSR 23-06-080
EXPEDITED RULES
DEPARTMENT OF LICENSING
[Filed March 1, 2023, 11:46 a.m.]

Title of Rule and Other Identifying Information: WAC 308-56A-460 Destroyed or wrecked vehicle—Reporting—Rebuilt, 308-56A-500 Definitions, 308-96A-260 Assignment of original registration year, and 308-94A-035 Deliver of off-road vehicle on dealer temporary permit.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The purpose of all changes is to update references to "temporary permits" to now refer to "temporary license plates." These changes are in accordance with SHB 1790, passed in 2022; temporary plates replace temporary permits as an administrative concept and throughout chapter 46.16A RCW.

Reasons Supporting Proposal: These updates are needed to maintain the relevancy of the rule. Following the effectiveness of SHB 1790, "temporary permits" are not defined or used in relevant statutes.

Statutory Authority for Adoption: RCW 46.12.600, 46.01.110, 46.16A.220.

Statute Being Implemented: RCW 46.04.5851, 46.16A.300, 46.16A.305, 46.17.400.

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: Carl Backen, 1125 Washington Street S.E., Olympia, WA 98501, 360-902-3843; Implementation and Enforcement: George Price, 1125 Washington Street S.E., Olympia, WA 98501, 360-902-0120.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: Not applicable.

This notice meets the following criteria to use the expedited adoption process for these rules:

Adopts or incorporates 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.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: References in statute to "temporary permits" were replaced with reference to "temporary license plates" with the passage of SHB 1790 in 2022. These rule amendments memorialize that change and ensure that rule is consistent with current statutory wording and framework.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Ellis Star-

rett, Department of Licensing, 1125 Washington Street S.E., Olympia, WA 98504, phone 360-902-3846, email rulescoordinator@dol.wa.gov, AND RECEIVED BY May 1, 2023.

March 1, 2023
Ellis Starrett
Rules and Policy Manager

OTS-4346.1

AMENDATORY SECTION (Amending WSR 22-10-102, filed 5/4/22, effective 7/1/22)

WAC 308-56A-460 Destroyed or wrecked vehicle—Reporting—Rebuilt. (1) **What are total loss, destroyed, salvage, and wrecked vehicles?** For the purposes of this section:

(a) A total loss vehicle is one whose destruction has been reported to the department as described in RCW 46.12.600 by an insurer (insurance companies and self-insurers as described in RCW 46.29.630);

(b) A destroyed vehicle is one whose destruction has been reported to the department as described in RCW 46.12.600 by the vehicle's owner;

(c) A salvage vehicle as defined in RCW 46.04.514;

Note: When used in this section, the terms "destroyed" and "destroyed vehicle" include total loss, destroyed, and salvage vehicles.

(d) A wrecked vehicle as defined in RCW 46.80.010(6).

Note: A vehicle may be considered destroyed or wrecked when the evidence of ownership is a salvage certificate/title, insurance company bill of sale, or wrecker bill of sale from any jurisdiction, or when the evidence of ownership indicates the vehicle may be a destroyed vehicle not reported to the department.

(2) **How are vehicles reported to the department as total loss, destroyed, salvage, or wrecked?**

(a) Insurers may report total loss vehicles to the department:

(i) Electronically through the department's online reporting system. Insurers must destroy ownership documents for a vehicle reported this way; or

(ii) By submitting the certificate of title or affidavit in lieu of title indicating the vehicle is "DESTROYED"; or

(iii) By submitting a completed total loss claim settlement form.

Note: Reports of total loss vehicles must include the insurer's name, address, and the date of loss.

(b) Registered or legal owners report a vehicle as destroyed by submitting the certificate of title or affidavit in lieu of title indicating the vehicle is "DESTROYED," and must include the registered owner's name, address, and date of loss.

(c) Licensed wreckers report wrecked vehicles as required in RCW 46.80.090.

(d) For vehicles six through 20 years old a statement whether or not the vehicle meets the market value threshold amount as defined in RCW 46.12.600 is also required.

(3) **What is the current market value threshold amount?** The current market value threshold amount is $10,430.

(4) **How is the market value threshold amount determined?** Using the current market value threshold amount described in RCW 46.12.600 each year the department will add the increased value if the increase is equal to or greater than $50.

(5) **What if the "market value threshold amount" is not provided as required?** If the market value threshold amount is not provided when required, the department would treat the report of destruction as if the market value threshold as described in RCW 46.12.600 has been met. The certificate of title will be branded according to WAC 308-56A-530.

(6) **What documentation is required to obtain a certificate of title after a vehicle is destroyed?** After a vehicle has been reported destroyed or wrecked and is rebuilt, you must submit the following documentation to the department in order to obtain a new certificate of title:

(a) Application for certificate of title as described in RCW 46.12.530;

(b) Certificate of vehicle inspection as described in WAC 308-56A-150;

(c) Bill of sale from the insurer, owner, or wrecker who reported the vehicle's destruction to the department.

(i) Bills of sale from insurers must include a representative's signature and title of office;

(ii) Bills of sale from insurers and wreckers do not need to be notarized;

(iii) Bills of sale from owners shown on department records must be notarized or certified;

(iv) A bill of sale is not required when owners shown on department records retain a destroyed vehicle and apply for a new certificate of ownership;

(v) Releases of interest from lien holder(s) or proof of payment such as a canceled check bearing a notation that it has been paid by the bank on which it was drawn or a notarized statement on a receipt from the legal owner that the debt is satisfied are required when the vehicle is retained by the registered owner(s).

(d) Odometer disclosure statement, if applicable.

(7) **What is required of a Washington licensed vehicle dealer prior to selling a destroyed or wrecked vehicle?** Except as permitted by RCW 46.70.101 (1)(b)(viii), before a dealer may sell a destroyed or wrecked vehicle under their Washington vehicle dealer license, the dealer must:

(a) Rebuild the vehicle to standards set by the state of Washington or the federal government pertaining to the construction and safety of vehicles; and

(b) Obtain a vehicle inspection by the Washington state patrol; and

(c) Apply for and receive a certificate of ownership for the vehicle, issued in the name of the vehicle dealer.

(8) **Once a destroyed or wrecked vehicle is rebuilt, do the license plates remain with the vehicle?** Whether or not the license plates remain with the vehicle depends on the circumstance:

(a) Standard issue license plates may remain with a destroyed vehicle unless they are severely damaged or the vehicle was issued a department temporary ((~~permit~~)) license plate described in WAC 308-56A-140;

(b) Replacement license plates are required for wrecked vehicles since Washington licensed wreckers are required by WAC 308-63-070 to remove them;

(c) Special license plates may remain with or be transferred to a destroyed or wrecked vehicle;

(d) Applicants may retain the current license plate number as provided for in RCW 46.16A.200, unless the vehicle was issued a de-

partment temporary ((~~permit~~)) license plate as described in WAC 308-56A-140.

(9) **Will the certificate of ownership or registration certificate indicate "WA REBUILT"?** Salvage or wrecked vehicles meeting the criteria described in WAC 308-56A-530 will be branded "WA REBUILT."

[Statutory Authority: RCW 46.12.600. WSR 22-10-102, § 308-56A-460, filed 5/4/22, effective 7/1/22; WSR 22-02-056, § 308-56A-460, filed 1/4/22, effective 2/4/22; WSR 20-19-113, § 308-56A-460, filed 9/21/20, effective 10/22/20; WSR 19-13-008, § 308-56A-460, filed 6/6/19, effective 7/7/19. Statutory Authority: RCW 46.01.110 and 46.12.600. WSR 12-20-032, § 308-56A-460, filed 9/27/12, effective 10/28/12; WSR 11-22-034, § 308-56A-460, filed 10/26/11, effective 11/26/11. Statutory Authority: RCW 46.01.110. WSR 10-19-045, § 308-56A-460, filed 9/13/10, effective 10/14/10. Statutory Authority: RCW 46.12.005 and 46.01.110. WSR 09-19-113, § 308-56A-460, filed 9/22/09, effective 10/23/09. Statutory Authority: RCW 46.01.110. WSR 04-08-080, § 308-56A-460, filed 4/6/04, effective 5/7/04; WSR 02-19-016, § 308-56A-460, filed 9/9/02, effective 10/10/02; WSR 01-20-010, § 308-56A-460, filed 9/20/01, effective 10/21/01. Statutory Authority: RCW 46.01.110 and 46.12.070. WSR 00-06-025, § 308-56A-460, filed 2/23/00, effective 3/25/00. Statutory Authority: RCW 46.01.110. WSR 92-15-024, § 308-56A-460, filed 7/6/92, effective 8/6/92. Statutory Authority: RCW 46.01.110 and 46.12.070. WSR 91-04-025, § 308-56A-460, filed 1/29/91, effective 3/1/91; Order MV 208, § 308-56A-460, filed 7/31/74.]

AMENDATORY SECTION (Amending WSR 11-23-014, filed 11/7/11, effective 12/8/11)

WAC 308-56A-500 Definitions. The following definitions apply to terms used in chapters 46.12 and 46.16A RCW and chapter 308-56A WAC:

(1) "Affidavit in lieu of title" is a written declaration confirming the certificate of title is unavailable, lost, stolen, destroyed or mutilated. The affidavit in lieu of title may be used to release interest in the vehicle. The signature of the owner completing the affidavit in lieu of title must be notarized or certified as described in WAC 308-56A-270.

(2) "Affixed" means attached.

(3) "Brands" means a permanent notation on the electric vehicle record which prints on the certificate of title and vehicle registration certificate that records a circumstance or condition involving a vehicle.

(4) "Brands incident date" is the date that a brand was first applied to a vehicle. For states/jurisdictions participating in the National Motor Vehicle Title Information System (NMVTIS), it's the date the brand was first reported. For all states or jurisdictions, it is established by using the date the current title was issued. Brands on Washington records prior to the effective date of this rule will reflect a brand incident date equal to the date the last Washington certificate of title was issued.

(5) "Certificate of title" (also referred to as "certificate of ownership" or "title") is a legal document indicating proof of ownership and will establish a fact or sustain a judgment unless contradictory evidence is produced. A certificate of title may be a document

other than a title when a title document is not issued by a jurisdiction. For example, for Canadian vehicles, the certificate of title is the registration.

(6) "Comment" means an indication on the certificate of title, vehicle title or registration application, or vehicle registration certificate that relates to tax liability, type of ownership, title transaction type or previous or current condition of the vehicle.

(7) "Commercial parking company" means any business directly engaged in providing vehicle parking upon property owned or controlled by the business and approved for public parking of vehicles.

(8) "Current license plate registration" means the current registration or one that has been expired less than one year.

(9) "Department temporary ((~~permit~~)) license plate" is a permit issued temporarily in lieu of registration and license plates when required documentation is unavailable.

(10) "Electronic/electronically filing" is a method to transmit information to the department that may include, but is not limited to, the use of the internet or facsimile.

(11) "Involuntary divestiture" means a change in vehicle ownership without the registered owner's involvement.

(12) "Impossible" as used in RCW 46.16A.200, means that there was nothing made by the manufacturer (to include, but not limited to, a bracket or the bumper of the vehicle) for the originally manufactured vehicle which would allow the license plate to be affixed to the vehicle in the manner prescribed in RCW 46.16A.200.

(13) "Joint tenancy with rights of survivorship" (JTWROS) means two or more people who own a vehicle in joint tenancy with the right to own individually if one of them dies.

(14) "Jurisdiction code" means an abbreviation used by the department that indicates state, province, district, or country.

(15) "Lien holder" means a person or entity that has a legal right or interest in another's property until a debt or duty that it secures is satisfied.

(16) "Not eligible for road use" (NEFRU) means a vehicle that does not meet Federal Motor Vehicle Safety standards, other federal or state standards for public road use as adopted, applied, and enforced by the Washington state patrol described in RCW 46.37.005.

(17) "A declaration under penalty of perjury" means a statement signed by the applicant to the effect - "I declare under penalty of perjury under the laws of the state of Washington that the information I have provided on this form is true and correct." Anyone who knowingly makes a false statement may be guilty of a crime under state law.

(18) "Personal representative" means:

(a) An individual appointed by the court; or

(b) An individual named in the last will and testament and confirmed by the court to manage the estate of a deceased person.

Personal representative may also include executor, administrator, special administrator, and guardian or limited guardian and special representative as defined in RCW 11.02.005(1).

(19) "Registered owner" means the same as described in RCW 46.04.460.

(20) "Security interest holders" means in this instance, the same as "lien holder" as defined in subsection (15) of this section.

(21) "Standard brand" is a brand found on the brands list maintained by the National Motor Vehicle Title Information System (NMVTIS) program.

(22) "Transferee" means a person to whom a vehicle is transferred, by purchase, gift, or any means other than by creation of a security interest, and any person who, as agent, signs an odometer disclosure statement for the transferee, when applicable.

(23) "Transferor" means a person who transfers ownership in a vehicle by sale, gift, or any means other than by creation of a security interest and any person who, as agent, signs an odometer disclosure statement for the transferor, when applicable.

(24) "Unique brand" means a brand issued by a state that is not participating in the National Motor Vehicle Title Information System (NMVTIS) program and does not appear on the brands list maintained by NMVTIS.

(25) "Report of sale" is a document as required by RCW 46.12.650 or electronic record transaction that protects the seller of a vehicle from certain criminal and civil liabilities arising from use of the vehicle by another person after the vehicle has been sold or a change of ownership has occurred.

(26) "Washington vehicle licensing office" means an office that is operated by the department or an agent or subagent appointed under RCW 46.01.140 for the purpose of carrying out the vehicle titling and registration provisions in Title 46 RCW.

[Statutory Authority: RCW 46.01.110. WSR 11-23-014, § 308-56A-500, filed 11/7/11, effective 12/8/11. Statutory Authority: RCW 46.12.005 and 46.01.110. WSR 09-19-113, § 308-56A-500, filed 9/22/09, effective 10/23/09. Statutory Authority: RCW 46.01.110 and 46.12.101. WSR 06-23-038, § 308-56A-500, filed 11/7/06, effective 12/8/06. Statutory Authority: RCW 46.16.010. WSR 05-23-135, § 308-56A-500, filed 11/22/05, effective 1/3/06. Statutory Authority: RCW 46.01.110. WSR 05-07-152, § 308-56A-500, filed 3/23/05, effective 5/15/05; WSR 04-08-081, § 308-56A-500, filed 4/6/04, effective 5/7/04; WSR 02-19-016, § 308-56A-500, filed 9/9/02, effective 10/10/02. Statutory Authority: RCW 65.20.110. WSR 00-13-083, § 308-56A-500, filed 6/20/00, effective 7/21/00; WSR 00-06-004, § 308-56A-500, filed 2/18/00, effective 3/20/00; WSR 90-11-091, § 308-56A-500, filed 5/18/90, effective 6/18/90.]