WSR 12-05-074
EMERGENCY RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)
[Filed February 16, 2012, 2:41 p.m., effective February 16, 2012, 2:41 p.m.]

Effective Date of Rule: Immediately.

Purpose: The text of the rules filed as WSR 12-02-044 has not changed. This filing is a response to a lawsuit that was filed in Thurston County superior court on February 1, 2012: *SEIU Healthcare 775NW v. Robin Arnold-Williams and DSHS*, alleging that the emergency rule filing process for WSR 12-02-044 did not comply with rule-making requirements. The department of social and health services disagrees with those allegations. However, this CR-103E is provided to further clarify the basis for the emergency rules.

Effective December 30, 2011, the department amended WAC 388-106-0010 by adding and amending certain definitions related to informal supports. WAC 388-106-0210 was amended to include age guidelines that were needed to implement children's personal care changes that were initially made under WSR 11-23-053. These revisions were necessitated by the Washington state supreme court's decision in *Samantha A. v. Department of Social and Health Services* and serve the public interest by providing clients a way to better understand their award of personal care service hours.

This CR-103E *cancels and supersedes WSR 12-02-044.*

Citation of Existing Rules Affected by this Order: Amending WAC 388-106-0010 and 388-106-0210.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

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

Reasons for this Finding: On February 1, 2012, the Service Employees International Union filed a lawsuit challenging the adoption of changes to WAC 388-106-0010 and 388-106-0130 by emergency rule. *SEIU Healthcare 775NW v. Robin Arnold-Williams and DSHS*, Thurston County Superior Court, Docket No. 12-2-00195-0. The emergency rule filing process complied with rule-making requirement[s] and the department disagrees with the allegations made in the lawsuit. Nevertheless, this CR-103E is provided to further clarify the basis for the emergency rules.

Clarified Reasons for Changes Originally Made under WSR 12-02-044: The department revised its assessment process to allocate personal care services for children on a more individualized basis. The emergency rules are necessary in order to comply with state law following Washington state supreme court's decision in *Samantha A. v. Department of Social and Health Services* and serve the public interest by providing clients a way to better understand their award of personal care service hours that may have been adjusted during the individualized assessment process.

The changes to WAC 388-106-0010 and 388-106-0210 are necessary to comport with emergency amendments initially filed under WSR 11-23-082 on November 16, 2011. These rule changes were filed as soon as possible. Changes to WAC 388-106-0010 could not be included in the November 16, 2011, filing because, for unrelated reasons, it had been recently subject to permanent rule making. New changes to a recently adopted permanent rule cannot be made until the office of the code reviser incorporates the new or amended rule into the Title 388 WAC web site, which can take four to eleven weeks after the permanent rule-making order is filed.

This filing supersedes the CR-103E filed as **WSR 12-02-044** on December 30, 2011.

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

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

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

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

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

Date Adopted: February 16, 2012.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 11-22-043, filed 10/27/11, effective 11/27/11)

WAC 388-106-0010 What definitions apply to this chapter? "Ability to make self understood" means how you make yourself understood to those closest to you; express or communicate requests, needs, opinions, urgent problems and social conversations, whether in speech, writing, sign language, symbols, or a combination of these including use of a communication board or keyboard:

(a) Understood: You express ideas clearly;

(b) Usually understood: You have difficulty finding the right words or finishing thoughts, resulting in delayed responses, or you require some prompting to make self understood;

(c) Sometimes understood: You have limited ability, but are able to express concrete requests regarding at least basic needs (e.g. food, drink, sleep, toilet);

(d) Rarely/never understood. At best, understanding is limited to caregiver's interpretation of client specific sounds or body language (e.g. indicated presence of pain or need to toilet.)

"Activities of daily living (ADL)" means the following:

(a) Bathing: How you take a full-body bath/shower, sponge bath, and transfer in/out of tub/shower.

(b) Bed mobility: How you move to and from a lying position, turn side to side, and position your body while in bed, in a recliner, or other type of furniture.

(c) Body care: How you perform with passive range of motion, applications of dressings and ointments or lotions to the body and pedicure to trim toenails and apply lotion to feet. In adult family homes, contracted assisted living, enhanced adult residential care, and enhanced adult residential care-specialized dementia care facilities, dressing changes using clean technique and topical ointments must be performed by a licensed nurse or through nurse delegation in accordance with chapter 246-840 WAC. Body care excludes:

(i) Foot care if you are diabetic or have poor circulation; or

(ii) Changing bandages or dressings when sterile procedures are required.

(d) Dressing: How you put on, fasten, and take off all items of clothing, including donning/removing prosthesis.

(e) Eating: How you eat and drink, regardless of skill. Eating includes any method of receiving nutrition, e.g., by mouth, tube or through a vein.

(f) Locomotion in room and immediate living environment: How you move between locations in your room and immediate living environment. If you are in a wheelchair, locomotion includes how self-sufficient you are once in your wheelchair.

(g) Locomotion outside of immediate living environment including outdoors: How you move to and return from more distant areas. If you are living in a boarding home or nursing facility (NF), this includes areas set aside for dining, activities, etc. If you are living in your own home or in an adult family home, locomotion outside immediate living environment including outdoors, includes how you move to and return from a patio or porch, backyard, to the mailbox, to see the next-door neighbor, etc.

(h) Walk in room, hallway and rest of immediate living environment: How you walk between locations in your room and immediate living environment.

(i) Medication management: Describes the amount of assistance, if any, required to receive medications, over the counter preparations or herbal supplements.

(j) Toilet use: How you use the toilet room, commode, bedpan, or urinal, transfer on/off toilet, cleanse, change pad, manage ostomy or catheter, and adjust clothes.

(k) Transfer: How you move between surfaces, i.e., to/from bed, chair, wheelchair, standing position. Transfer does not include how you move to/from the bath, toilet, or vehicle.

(l) Personal hygiene: How you maintain personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands (including nail care), and perineum (menses care). Personal hygiene does not include hygiene in baths and showers.

"Age appropriate" means the client is functioning within typical developmental milestones. Proficiency in the identified task is not expected of a child that age and a child that age would require assistance with the task with or without a functional disability.

"Aged person" means a person sixty-five years of age or older.

"Agency provider" means a licensed home care agency or a licensed home health agency having a contract to provide long-term care personal care services to you in your own home.

"Application" means a written request for medical assistance or long-term care services submitted to the department by the applicant, the applicant's authorized representative, or, if the applicant is incompetent or incapacitated, someone acting responsibly for the applicant. The applicant must submit the request on a form prescribed by the department.

"Assessment details" means a summary of information that the department entered into the CARE assessment describing your needs.

"Assessment or reassessment" means an inventory and evaluation of abilities and needs based on an in-person interview in your own home or your place of residence, using CARE.

"Assistance available" means the amount of ((~~informal support~~)) assistance available for a task if ((~~the need~~)) status is coded partially met or shared benefit due to availability of other support. The department determines the amount of the assistance available using one of four categories:

(a) Less than one-fourth of the time;

(b) One-fourth to one-half of the time;

(c) Over one-half of the time to three-fourths of the time; or

(d) Over three-fourths but not all of the time.

"Assistance with body care" means you need assistance with:

(a) Application of ointment or lotions;

(b) Trimming of toenails;

(c) Dry bandage changes; or

(d) Passive range of motion treatment.

"Assistance with medication management" means you need assistance managing your medications. You are scored as:

(a) Independent if you remember to take medications as prescribed and manage your medications without assistance.

(b) Assistance required if you need assistance from a nonlicensed provider to facilitate your self-administration of a prescribed, over the counter, or herbal medication, as defined in chapter 246-888 WAC. Assistance required includes reminding or coaching you, handing you the medication container, opening the container, using an enabler to assist you in getting the medication into your mouth, alteration of a medication for self-administration, and placing the medication in your hand. This does not include assistance with intravenous or injectable medications. You must be aware that you are taking medications.

(c) Self-directed medication assistance/administration if you are a person with a functional disability who is capable of and who chooses to self-direct your medication assistance/administration.

(d) Must be administered if you must have medications placed in your mouth or applied or instilled to your skin or mucus membrane. Administration must either be performed by a licensed professional or delegated by a registered nurse to a qualified caregiver (per chapter 246-840 WAC). Intravenous or injectable medications may never be delegated.

Administration may also be performed by a family member or unpaid caregiver if facility licensing regulations allow.

"Authorization" means an official approval of a departmental action, for example, a determination of client eligibility for service or payment for a client's long-term care services.

"Blind person" means a person determined blind as described under WAC 388-511-1105 by the division of disability determination services of the medical assistance administration.

"Categorically needy" means the status of a person who is eligible for medical care under Title XIX of the Social Security Act. See WAC 388-475-0100 and chapter 388-513 WAC.

"Child" means an individual less than eighteen years of age.

"Chronic care management" means programs that provide care management and coordination activities for medical assistance clients receiving long-term care services and supports determined to be at risk for high medical costs.

"Health action plan" means an individual plan which identifies health-related problems, interventions and goals.

"Client" means an applicant for service or a person currently receiving services from the department.

"Current" means a behavior occurred within seven days of the CARE assessment date, including the day of the assessment. Behaviors that the department designates as current must include information about:

(a) Whether the behavior is easily altered or not easily altered; and

(b) The frequency of the behavior.

"Decision making" means your ability and actual performance in making everyday decisions about tasks or activities of daily living. The department determines whether you are:

(a) Independent: Decisions about your daily routine are consistent and organized; reflecting your lifestyle, choices, culture, and values.

(b) Modified independence/difficulty in new situations: You have an organized daily routine, are able to make decisions in familiar situations, but experience some difficulty in decision making when faced with new tasks or situations.

(c) Moderately impaired/poor decisions; unaware of consequences: Your decisions are poor and you require reminders, cues and supervision in planning, organizing and correcting daily routines. You attempt to make decisions, although poorly.

(d) Severely impaired/no or few decisions: Decision making is severely impaired; you never/rarely make decisions.

"Department" means the state department of social and health services, aging and disability services administration or its designee.

"Designee" means area agency on aging.

"Developmental milestones" means a set of functional skills that most children achieve during a certain age range.

"Difficulty" means how difficult it is or would be for you to perform an instrumental activity of daily living (IADL). This is assessed as:

(a) No difficulty in performing the activity;

(b) Some difficulty in performing the activity (e.g., you need some help, are very slow, or fatigue easily); or

(c) Great difficulty in performing the activity (e.g., little or no involvement in the activity is possible).

"Disabling condition" means you have a medical condition which prevents you from self performance of personal care tasks without assistance.

"Estate recovery" means the department's process of recouping the cost of medicaid and long-term care benefit payments from the estate of the deceased client. See chapter 388-527 WAC.

"Home health agency" means a licensed:

(a) Agency or organization certified under medicare to provide comprehensive health care on a part-time or intermittent basis to a patient in the patient's place of residence and reimbursed through the use of the client's medical identification card; or

(b) Home health agency, certified or not certified under medicare, contracted and authorized to provide:

(i) Private duty nursing; or

(ii) Skilled nursing services under an approved medicaid waiver program.

"Income" means income as defined under WAC 388-500-0005.

"Individual provider" means a person employed by you to provide personal care services in your own home. See WAC 388-71-0500 through 388-71-05909.

"Disability" is described under WAC 388-511-1105.

"Informal support" means a person or resource that is available to provide assistance without home and community program funding. The person or resource providing the informal support must be age 18 or older. Examples of informal supports include but are not limited to: family members, friends, neighbors, school, childcare, after school activities, adult day health, church or community programs.

"Institution" means medical facilities, nursing facilities, and institutions for the mentally retarded. It does not include correctional institutions. See medical institutions in WAC 388-500-0005.

"Instrumental activities of daily living (IADL)" means routine activities performed around the home or in the community and includes the following:

(a) Meal preparation: How meals are prepared (e.g., planning meals, cooking, assembling ingredients, setting out food, utensils, and cleaning up after meals). NOTE: The department will not authorize this IADL to plan meals or clean up after meals. You must need assistance with actual meal preparation.

(b) Ordinary housework: How ordinary work around the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry).

(c) Essential shopping: How shopping is completed to meet your health and nutritional needs (e.g., selecting items). Shopping is limited to brief, occasional trips in the local area to shop for food, medical necessities and household items required specifically for your health, maintenance or well-being. This includes shopping with or for you.

(d) Wood supply: How wood is supplied (e.g., splitting, stacking, or carrying wood) when you use wood as the sole source of fuel for heating and/or cooking.

(e) Travel to medical services: How you travel by vehicle to a physician's office or clinic in the local area to obtain medical diagnosis or treatment-includes driving vehicle yourself, traveling as a passenger in a car, bus, or taxi.

(f) Managing finances: How bills are paid, checkbook is balanced, household expenses are managed. The department cannot pay for any assistance with managing finances.

(g) Telephone use: How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed).

"Long-term care services" means the services administered directly or through contract by the aging and disability services administration and identified in WAC 388-106-0015.

"Medicaid" is defined under WAC 388-500-0005.

"Medically necessary" is defined under WAC 388-500-0005.

"Medically needy (MN)" means the status of a person who is eligible for a federally matched medical program under Title XIX of the Social Security Act, who, but for income above the categorically needy level, would be eligible as categorically needy. Effective January 1, 1996, an AFDC-related adult is not eligible for MN.

"New Freedom consumer directed services (NFCDS)" means a mix of services and supports to meet needs identified in your assessment and identified in a New Freedom spending plan, within the limits of the individual budget, that provide you with flexibility to plan, select, and direct the purchase of goods and services to meet identified needs. Participants have a meaningful leadership role in:

(a) The design, delivery and evaluation of services and supports;

(b) Exercising control of decisions and resources, making their own decisions about health and well being;

(c) Determining how to meet their own needs;

(d) Determining how and by whom these needs should be met; and

(e) Monitoring the quality of services received.

"New Freedom consumer directed services (NFCDS) participant" means a participant who is an applicant for or currently receiving services under the NFCDS waiver.

"New Freedom spending plan (NFSP)" means the plan developed by you, as a New Freedom participant, within the limits of an individual budget, that details your choices to purchase specific NFCDS and provides required federal medicaid documentation.

"Own home" means your present or intended place of residence:

(a) In a building that you rent and the rental is not contingent upon the purchase of personal care services as defined in this section;

(b) In a building that you own;

(c) In a relative's established residence; or

(d) In the home of another where rent is not charged and residence is not contingent upon the purchase of personal care services as defined in this section.

"Past" means the behavior occurred from eight days to five years of the assessment date. For behaviors indicated as past, the department determines whether the behavior is addressed with current interventions or whether no interventions are in place.

"Personal aide" is defined in RCW 74.39.007.

"Personal care services" means physical or verbal assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL) due to your functional limitations. Assistance is evaluated with the use of assistive devices.

"Physician" is defined under WAC 388-500-0005.

"Plan of care" means assessment details and service summary generated by CARE.

"Provider or provider of service" means an institution, agency, or person:

(a) Having a signed department contract to provide long-term care client services; and

(b) Qualified and eligible to receive department payment.

"Reasonable cost" means a cost for a service or item that is consistent with the market standards for comparable services or items.

"Representative" means a person who you have chosen, or has been appointed by a court, whose primary duty is to act on your behalf to direct your service budget to meet your identified health, safety, and welfare needs.

"Residential facility" means a licensed adult family home under department contract or licensed boarding home under department contract to provide assisted living, adult residential care or enhanced adult residential care.

"Self performance for ADLs" means what you actually did in the last seven days before the assessment, not what you might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period and does not include support provided as defined in WAC 388-106-0010. Your self performance level is scored as:

(a) Independent if you received no help or oversight, or if you needed help or oversight only once or twice;

(b) Supervision if you received oversight (monitoring or standby), encouragement, or cueing three or more times;

(c) Limited assistance if you were highly involved in the activity and given physical help in guided maneuvering of limbs or other nonweight bearing assistance on three or more occasions. For bathing, limited assistance means physical help is limited to transfer only;

(d) Extensive assistance if you performed part of the activity, but on three or more occasions, you needed weight bearing support or you received full performance of the activity during part, but not all, of the activity. For bathing, extensive assistance means you needed physical help with part of the activity (other than transfer);

(e) Total dependence if you received full caregiver performance of the activity and all subtasks during the entire seven-day period from others. Total dependence means complete nonparticipation by you in all aspects of the ADL; or

(f) Activity did not occur if you or others did not perform an ADL over the last seven days before your assessment. The activity may not have occurred because:

(i) You were not able (e.g., walking, if paralyzed);

(ii) No provider was available to assist; or

(iii) You declined assistance with the task.

"Self performance for IADLs" means what you actually did in the last thirty days before the assessment, not what you might be capable of doing. Coding is based on the level of performance that occurred three or more times in the thirty-day period. Your self performance is scored as:

(a) Independent if you received no help, set-up help, or supervision;

(b) Set-up help/arrangements only if on some occasions you did your own set-up/arrangement and at other times you received help from another person;

(c) Limited assistance if on some occasions you did not need any assistance but at other times in the last thirty days you required some assistance;

(d) Extensive assistance if you were involved in performing the activity, but required cueing/supervision or partial assistance at all times;

(e) Total dependence if you needed the activity fully performed by others; or

(f) Activity did not occur if you or others did not perform the activity in the last thirty days before the assessment.

"Service summary" is CARE information which includes: Contacts (e.g. emergency contact), services the client is eligible for, number of hours or residential rates, personal care needs, the list of formal and informal providers and what tasks they will provide, a provider schedule, referral needs/information, and dates and agreement to the services.

"Shared benefit" means:

(a) A client and their paid caregiver both share in the benefit of an IADL task being performed; or

(b) Two or more clients in a multi-client household benefit from the same IADL task(s) being performed.

"SSI-related" is defined under WAC 388-475-0050.

"Status" means the amount of informal support available. The department determines whether the ADL or IADL is:

(a) Met, which means the ADL or IADL will be fully provided by an informal support;

(b) Unmet, which means an informal support will not be available to provide assistance with the identified ADL or IADL;

(c) Partially met, which means an informal support will be available to provide some assistance, but not all, with the identified ADL or IADL; ((~~or~~))

(d) Shared benefit, which means:

(i) A client and their paid caregiver both share in the benefit of an IADL task being performed; or

(ii) Two or more clients in a multi-client household benefit from the same IADL task(s) being performed.

(e) Age appropriate, which means the client is functioning within typical developmental milestones. Other options under status may be chosen if a child is not within typical developmental milestones; or

(f) Client declines, which means you do not want assistance with the task.

"Supplemental Security Income (SSI)" means the federal program as described under WAC 388-500-0005.

"Support provided" means the highest level of support provided (to you) by others in the last seven days before the assessment, even if that level of support occurred only once.

(a) No set-up or physical help provided by others;

(b) Set-up help only provided, which is the type of help characterized by providing you with articles, devices, or preparation necessary for greater self performance of the activity. (For example, set-up help includes but is not limited to giving or holding out an item or cutting food);

(c) One-person physical assist provided;

(d) Two- or more person physical assist provided; or

(e) Activity did not occur during entire seven-day period.

"You/your" means the client.

AMENDATORY SECTION (Amending WSR 05-11-082, filed 5/17/05, effective 6/17/05)

WAC 388-106-0210 Am I eligible for MPC-funded services? You are eligible for MPC-funded services when the department assesses your ((~~needs~~)) functional ability and determines that you meet all of the following criteria:

(1) You are certified as noninstitutional categorically needy, as defined in WAC 388-500-0005. Categorically needy medical institutional programs described in chapter 388-513 WAC do not meet this criteria.

(2) You are functionally eligible which means one of the following applies:

(a) You have an unmet or partially met need for assistance with at least three of the following activities of daily living, as defined in WAC 388-106-0010:

For each Activity of Daily Living, the minimum level of assistance required in:		
	Self Performance, Status or Treatment Need is:	Support Provided is:
Eating	N/A	Setup
Toileting	Supervision	N/A
Bathing	Supervision	N/A
Dressing	Supervision	N/A
Transfer	Supervision	Setup
Bed Mobility	Supervision	Setup
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Supervision	Setup
Medication Management	Assistance Required	N/A
Personal Hygiene	Supervision	N/A
Body care which includes: ■ Application of ointment or lotions; ■ Toenails trimmed; ■ Dry bandage changes; (■ = if you are over eighteen years of age or older) or Passive range of motion treatment (if you are four years of age or older).	Needs or Received/Needs Need: coded as "Yes"	N/A

Your need for assistance in any of the activities listed in subsection (a) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose of determining your functional eligibility.

; or

(b) You have an unmet or partially met need for assistance or the activity did not occur (because you were unable or no provider was available) with at least one or more of the following:

For each Activity of Daily Living, the minimum level of assistance required in		
	Self Performance, Status or Treatment Need is:	Support Provided is:
Eating	Supervision	One person physical assist
Toileting	Extensive Assistance	One person physical assist
Bathing	((~~Limited Assistance~~)) Physical Help/part of bathing	One person physical assist
Dressing	Extensive Assistance	One person physical assist
Transfer	Extensive Assistance	One person physical assist
Bed Mobility and Turning and repositioning	Limited Assistance and Need	One person physical assist
Walk in Room OR Locomotion in Room OR Locomotion Outside Immediate Living Environment	Extensive Assistance	One person physical assist
Medication Management	Assistance Required Daily	N/A
Personal Hygiene	Extensive Assistance	One person physical assist
Body care which includes: ■ Application of ointment or lotions; ■ Toenails trimmed; ■ Dry bandage changes; (■ = if you are eighteen years of age or older) or Passive range of motion treatment (if you are four years of age or older).	Needs or Received/Needs Need: coded as "Yes"	N/A
Your need for assistance in any of the activities listed in subsection (b) of this section did not occur because you were unable or no provider was available to assist you will be counted for the purpose determining your functional eligibility.		

WSR 12-06-002
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed February 23, 2012, 11:07 a.m., effective February 25, 2012]

Effective Date of Rule: February 25, 2012.

Purpose: The agency is implementing a new alternative payment methodology for federally qualified health centers (FQHCs) and rural health clinics (RHCs) for services provided on and after July 1, 2011. The agency received approval of its state plan amendment on January 11, 2012.

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

Statutory Authority for Adoption: RCW 41.05.021.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest; that state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule; and that in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012 or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this Finding: This emergency rule is necessary to continue the current emergency rule adopted under WSR 11-22-047 while the permanent rule-making process is completed. The implementation of these emergency rules was necessitated by the level of appropriations made by the legislature in 2ESHB 1087, for services provided by FQHCs and RHCs as of July 1, 2011. Delaying this adoption could jeopardize the state's ability to provide mandatory medicaid services to a significant number of medicaid clients. The agency filed a preproposal statement of inquiry (CR-101) on November 7, 2011, under WSR 11-23-017 and received the Centers for Medicare and Medicaid Services approval on the state plan amendments on January 11, 2012. The language within the rule text has changed since the last emergency filing only to reflect the approval dates of the state plan amendment. The agency is moving forward to finalize the permanent rules.

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

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 2, Repealed 0.

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

Date Adopted: February 23, 2012.

Kevin M. Sullivan
Rules Coordinator

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) The agency:

(a) Upon approval from the federal Centers for Medicare and Medicaid Services (CMS) of the agency's state plan amendment, calculates the FQHC's APM encounter rate for services provided during the period beginning April 7, 2011, and ending June 30, 2011, as described in this section.

(b) Pending approval by CMS of the state plan amendment, continued to pay FQHCs at the encounter rate described in subsection (5) of this section.

(c) For all payments made for services provided during the period beginning April 7, 2011, and ending January 11, 2012, (the date CMS approved the state plan amendment), will recoup from FQHCs any amount paid in excess of the encounter rate established in this section. The APM utilizes each FQHC's PPS rate for each calendar year and increases it by five percent.

(7) For services provided on and after July 1, 2011, each FQHC will have the choice of receiving either its PPS rate (as determined under the method described in subsection (3) of this section) or a rate determined under a revised APM. CMS approval of the state plan amendment describing this methodology occurred on January 11, 2012.

(a) For all payments made for services between July 1, 2011, and January 11, 2012, (the date CMS approved the state plan amendment), the agency will recoup from FQHCs

any amount in excess of the encounter rate established in this section.

(b) The revised APM will be as follows:

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

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

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

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

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

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

(b) There are separate visits with unrelated diagnoses.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

encounter rates. The formula used to calculate the base encounter rate is as follows:

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

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

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

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

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

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

(((~~(b) To ensure that the APM pays an amount that is at least equal to the PPS in accordance with 42 USC 1396a (bb)(6), the annual inflator used to increase the APM rates is the greater of the APM index or the MEI.~~

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

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

~~(5)~~)) (6) The agency:

(a) Upon approval from the federal Centers for Medicare and Medicaid Services (CMS) of the agency's state plan amendment, calculates the RHC's APM encounter rate for services provided during the period beginning April 7, 2011, and ending June 30, 2011, as described in this section.

(b) Pending approval by CMS of the state plan amendment, continued to pay RHCs at the encounter rate described in subsection (5) of this section.

(c) For all payments made for services provided during the period beginning April 7, 2011, and ending January 11, 2012, (the date CMS approved the state plan amendment), will recoup from RHCs any amount paid in excess of the encounter rate established in this section. The APM utilizes each RHC's PPS rate for each calendar year and increases it by five percent.

(7) For services provided on and after July 1, 2011, each RHC will have the choice of receiving either its PPS rate (as determined under the method described in subsection (3) of this section), or a rate determined under a revised APM. CMS approval of the state plan amendment describing the methodology occurred on January 11, 2012.

(a) For all payments made for services between July 1, 2011, and January 11, 2012, (the date CMS approved the state plan amendment), the agency will recoup from RHCs any amount paid in excess of the encounter rate established in this section.

(b) The revised APM will be as follows:

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

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

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

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

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

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

(b) There are separate visits with unrelated diagnoses.

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

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

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

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

(((~~10~~))) (13) For clients enrolled with ((~~a managed care organization (MCO)~~)) an MCO, the ((~~department~~)) agency pays each RHC a supplemental payment in addition to the

amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).

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

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

WSR 12-06-004
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Basic Health)

[Filed February 23, 2012, 5:30 p.m., effective February 23, 2012, 5:30 p.m.]

Effective Date of Rule: Immediately.

Purpose: This corrects an error in the rule text of the current emergency rule adopted under WSR 12-05-046. In WAC 182-22-320 (2)(a), the word "action" has been changed to "HCA notice."

Health care authority (HCA) intends to reform, align, and clarify the Basic Health processes as a result of the federal requirements contained in the section 1115 federal waiver and to align rules and processes as a portion of the implementation of chapter 15, Laws of 2011 (2E2SHB 1738, section 53), for the transition of the single state medicaid agency to the HCA.

Citation of Existing Rules Affected by this Order: Amending WAC 182-22-320.

Statutory Authority for Adoption: RCW 70.47.050.

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

Reasons for this Finding: On January 18, 2012, the HCA received confirmation from the Center for Medicare and Medicaid Services that HCA's grievance process is out of compliance with federal law. Without the immediate adoption of this rule, no viable hearing process exists to address members' grievances, thus endangering members' ability to access medical care and services. The lack of a grievance process has immobilized subsidized Basic Health operations.

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

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

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

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 1, Repealed 0.

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

Date Adopted: February 23, 2012.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending Order 10-03, filed 11/30/10, effective 12/31/10)

WAC 182-22-320 How to appeal health care authority (HCA) decisions. (1) HCA decisions regarding the following may be appealed under this section:

(a) Eligibility;
(b) Premiums;
(c) Premium adjustments or penalties;
(d) Enrollment;
(e) Suspension;
(f) Disenrollment; or
(g) Selection of managed health care system (MHCS).

(2) ((~~To appeal an HCA decision, enrollees~~)) The hearing process described in chapter 388-526 WAC applies to the **subsidized basic health program (BHP)** appeal process found in this subsection. Where conflict exists, the requirements in this chapter take precedence.

(a) To appeal an HCA decision, enrollees or applicants must send a written request for a hearing to the HCA. The written hearing request should be signed by the appealing party and must be received by the HCA within ninety calendar days of the date of the HCA notice. The request must be sent to:

Basic Health Appeals
P.O. Box 42690
Olympia, WA 98504-2690

(b) The hearing request should include:

(i) The name, mailing address, and BHP account number of the subscriber or applicant;

(ii) The name and address of the enrollee or applicant affected by the decision, if that person is not the subscriber on the account;

(iii) A copy of the HCA notice of the decision that is being appealed or, if the notice is not available, a statement of the decision being appealed;

(iv) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documentation; and

(v) If the appealing party is not an enrollee or the subscriber on the account, a signed agreement from the enrollee authorizing the appealing party to act on the enrollees behalf and authorizing the HCA to release otherwise confidential

information to the appealing party's designated representative.

(c) HCA provides at least ten days advanced notice of any change in enrollment or premiums. An enrollee may continue receiving the same benefits under the same terms and conditions as received before the change, if a hearing is requested before the effective date of the agency action. This is called continuation of benefits. Requests for continuation of benefits should be in writing. To qualify for continuation of benefits, the appealing party must continue to pay all premiums when due as required by law and request the hearing in writing before the effective date of the agency's action.

(d) All active appeals filed for which no final agency decision has been rendered will be subject to the rules in this subsection. HCA reviews all appeals to determine whether the appeal can be resolved prior to sending the appeal to the office of administrative hearings (OAH) to schedule a hearing. If the appeal can be resolved to the satisfaction of the applicant or enrollee who requested the hearing, and they choose to withdraw the appeal, HCA will send a withdrawal confirmation notice and close the appeal. If the appeal cannot be resolved in favor of the applicant or enrollee that requested the hearing or if that party chooses not to withdraw the appeal, HCA will forward the appeal to OAH so a hearing can be scheduled. The provisions of chapter 388-526 WAC only apply if the appeal is sent to OAH for a hearing.

(3) This subsection applies only to Washington health (WH) program appeals. Enrollees or applicants must send a letter of appeal to the HCA. The letter of appeal should be signed by the appealing party and must be received by the HCA within thirty calendar days of the date of the decision.

(a) The letter of appeal should include:

(((~~a~~))) (i) The name, mailing address, and ((~~BHP or~~)) WHP account number of the subscriber or applicant;

(((~~b~~))) (ii) The name and address of the WH enrollee or applicant affected by the decision, if that person is not the subscriber on the account;

(((~~c~~))) (iii) A copy of the HCA notice of the decision that is being appealed or, if the notice is not available, a statement of the decision being appealed;

(((~~d~~))) (iv) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documentation; and

(((~~e~~))) (v) If the appealing party is not an enrollee or the subscriber on the account, a signed agreement from the enrollee, authorizing the appealing party to act on his/her behalf.

(((~~3~~))) (b) When an appeal is received, the HCA will send a notice to the appealing party, confirming that the appeal has been received and indicating when a decision can be expected. If the appealing party is not an enrollee on the affected account, the notice will also be sent to the subscriber.

(((~~4~~))) (c) **Initial HCA decisions:** The HCA will conduct WH appeals according to RCW 34.05.485. The HCA appeals committee or a single presiding officer designated by the HCA will review and decide the appeal. The appealing party may request an opportunity to be present in person or by telephone to explain his or her view. If the appealing party does not request an opportunity to be present to explain, the HCA appeals committee or presiding officer will review and decide the appeal based on the information and documentation submitted.

(((~~5~~))) (i) The HCA will give priority handling to appeals regarding a loss of coverage for an enrollee with an urgent medical need that could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, provided:

(((~~a~~))) (A) The appeal is received within ten business days of the effective date of the loss of coverage; and

(((~~b~~))) (B) The enrollee has clearly stated in the letter of appeal or has otherwise notified the HCA that he or she has an urgent medical need.

(((~~6~~))) (ii) For all other appeals, the HCA will send the appealing party written notice of the initial HCA decision within sixty days of receiving the letter of appeal. If the appealing party is not an enrollee on the affected account, the notice will also be sent to the subscriber. The notice will include the reasons for the initial decision and instructions on further appeal rights.

(((~~7~~))) (d) **Review of initial HCA decision on WH appeal:** The initial HCA decision becomes the final agency decision unless the HCA receives a valid request for a review from the appealing party.

(((~~a~~))) (i) To be a valid request for review, the appealing party's request may be either verbal or in writing, but must:

(((~~i~~))) (A) Be received within thirty days of the date of the initial HCA decision.

(((~~ii~~))) (B) Include a summary of the initial HCA decision being appealed and state why the appealing party believes the decision was incorrect; and

(((~~iii~~))) (C) Provide any additional information or documentation that the appealing party would like considered in the review.

(((~~b~~))) (ii) Requests for review of an initial HCA decision regarding a disenrollment for nonpayment will be reviewed by the office of administrative hearings through a hearing conducted under chapter 34.12 RCW and RCW 34.05.488 through 34.05.494.

(((~~c~~))) (iii) All other requests for review of an initial HCA decision will be reviewed by a presiding officer designated by the HCA according to the requirements of RCW 34.05.488 through 34.05.494, with the following exception: These review decisions will be based on the record and documentation submitted, unless the presiding officer decides that an in-person or telephone hearing is needed. If an in-person or telephone hearing is needed, the presiding officer will decide whether to conduct the hearing as an informal hearing or formal adjudicative proceeding.

(((~~d~~))) (iv) The presiding officer will issue a written notice of the review decision, giving reasons for the decision, within twenty-one days of receiving the request for review, unless the presiding officer finds that additional time is needed for the decision.

(((~~8~~))) (e) Enrollees who appeal a disenrollment decision that was based on eligibility issues and not related to premium payments may remain enrolled during the appeal process, provided:

(((~~a~~))) (i) The appeal was submitted according to the requirements of this section; and

(((~~b~~))) (ii) The enrollee:

(((~~(i)~~))) (A) Remains otherwise eligible;

(((~~(ii)~~))) (B) Continues to make all premium payments when due; and

(((~~(iii)~~))) (C) Has not demonstrated a danger or threat to the safety or property of the MHCS or health care authority or their staff, providers, patients or visitors.

~~(((9) Enrollees who appeal a disenrollment decision related to nonpayment of premium or any issue other than eligibility will remain disenrolled during the appeal process.~~

~~(10) If the appealing party disagrees with a review decision under subsection (6) of this section, the appealing party may request judicial review of the decision, as provided for in RCW 34.05.542. Request for judicial review must be filed with the court within thirty days of service of the final agency decision.~~)) (4) For both WH and the BHP, enrollees who appeal a disenrollment decision related to nonpayment of premium or any issue other than eligibility will remain disenrolled during the appeal process.

WSR 12-06-007
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 12-23—Filed February 24, 2012, 9:53 a.m., effective February 27, 2012, 8:00 a.m.]

Effective Date of Rule: February 27, 2012, 8:00 a.m.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-04000M and 220-52-04600T; and amending WAC 220-52-040 and 220-52-046.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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

Reasons for this Finding: The provisions of this rule are in conformity with agreed plans with applicable tribes, which have been entered as required by court order. The Puget Sound commercial season is structured to meet harvest allocation objectives. In order to meet harvest allocation goals, it is necessary to increase pot limits in Region 1 and Region 3-2 to the full complement of one hundred pots per license. Region 2 East and Region 2 West remain closed. There is insufficient time to adopt permanent rules.

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

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

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

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

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

Date Adopted: February 24, 2012.

Philip Anderson
Director

NEW SECTION

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

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

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

NEW SECTION

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

(1) Effective immediately until further notice, it is permissible to fish for Dungeness crab for commercial purposes in the following areas:

(a) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 20A between a line from the boat ramp at the western boundary of Birch Bay State Park to the western point of the entrance of the Birch Bay Marina and a line from the same boat ramp to Birch Point.

(b) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 22B in Fidalgo Bay south of a line projected from the red number 4 entrance buoy at Cape Sante Marina to the northern end of the eastern-most oil dock.

(c) Those waters of Marine Fish-Shellfish Management and Catch Reporting Area 22A in Deer Harbor north of a line projected from Steep Point to Pole Pass.

(2) Effective immediately until further notice, the following areas are closed to commercial crab fishing:

(a) That portion of Marine Fish-Shellfish Management and Catch Reporting Area 25A west of the 123° 7.0' longitude line projected from the new Dungeness light due south to the shore of Dungeness Bay.

(b) That portion of Marine Fish-Shellfish Management and Catch Reporting Area 23D west of a line from the eastern tip of Ediz Hook to the ITT Rayonier Dock.

(3) Effective immediately, until further notice, the following areas are closed to commercial crab fishing:

(a) Crab Management Region 2 East (Marine Fish-Shellfish Management and Catch Reporting Areas 24A, 24B, 24C, 24D, 26A-East) and Crab Management Region 2 West (Marine Fish-Shellfish Management and Catch Reporting Areas 25B, 25D and 26A West).

REPEALER

The following sections of the Washington Administrative Code are repealed effective 8:00 AM, February 27, 2012:

WAC 220-52-04000M	Commercial crab fishery—Lawful and unlawful gear, methods, and other unlawful acts. (12-18)
WAC 220-52-04600T	Puget Sound crab fishery—Seasons and areas. (12-18)

WSR 12-06-015
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 12-26—Filed February 27, 2012, 4:25 p.m., effective February 28, 2012]

Effective Date of Rule: February 28, 2012.

Purpose: Amend commercial fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-52-07300Y; and amending WAC 220-52-073.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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

Reasons for this Finding: The non-Indian share of the 2011-2012 red sea urchin harvest quota has been reached in Sea Urchin Districts 1 and 2, the combined San Juan Island urchin management area. Harvestable amounts of red and green sea urchins exist in the remaining areas described. Prohibiting all diving from licensed sea urchin harvest vessels within Sea Urchin District 3 when those vessels have red sea urchin on-board discourages the taking of red urchins from the district (currently closed to red urchin harvest) and reporting the catch to the adjacent harvest district. There is insufficient time to adopt permanent rules.

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

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

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

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

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

Date Adopted: February 27, 2012.

Philip Anderson
Director

NEW SECTION

WAC 220-52-07300Z Sea urchins Notwithstanding the provisions of WAC 220-52-073, effective February 28, 2012 until further notice, it is unlawful to take or possess sea urchins taken for commercial purposes except as provided for in this section:

(1) Green sea urchins: Sea Urchin Districts 1, 2, 3, and 4 are open seven days-per-week.

(2) Red sea urchins: Sea Urchin District 4 is open seven days-per-week.

(3) It is unlawful to dive for any purpose from a commercially licensed sea urchin fishing vessel in Sea Urchin District 3 when the vessel has red sea urchins on-board.

REPEALER

The following section of the Washington Administrative Code is repealed effective February 28, 2012:

WAC 220-52-07300Y	Sea urchins. (12-16)

WSR 12-06-016
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 12-25—Filed February 27, 2012, 4:45 p.m., effective February 27, 2012, 4:45 p.m.]

Effective Date of Rule: Immediately.

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

Citation of Existing Rules Affected by this Order: Amending WAC 220-33-040.

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

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

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

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

Reasons for this Finding: Prohibits retention of eulachon (Columbia River smelt) in Columbia River (and adjacent Washington-shore tributaries) commercial fisheries. Eulachon are listed as threatened under ESA. This rule is needed until a permanent rule is adopted. There is insufficient time to promulgate permanent regulations.

Washington and Oregon jointly regulate Columbia River fisheries under the congressionally ratified Columbia River compact. Four Indian tribes have treaty fishing rights in the Columbia River. The treaties preempt state regulations that fail to allow the tribes an opportunity to take a fair share of the available fish, and the states must manage other fisheries accordingly. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969). A federal court order sets the current parameters for sharing between treaty Indians and others. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546).

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

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

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

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

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

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

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

Date Adopted: February 27, 2012.

Philip Anderson
Director

NEW SECTION

WAC 220-33-04000K Smelt—Areas and seasons. Notwithstanding the provisions of WAC 220-33-040, effective immediately, until further notice, it is unlawful to fish for or possess Eulachon (Columbia River smelt) taken for commercial purposes in waters of the Columbia River and Washington tributaries.

WSR 12-06-017
EMERGENCY RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Disability Services Administration)

[Filed February 28, 2012, 9:12 a.m., effective March 1, 2012]

Effective Date of Rule: March 1, 2012.

Purpose: Under section 6014 of the Deficit Reduction Act of 2005 (DRA), medicaid will not pay for long-term care services for individuals whose equity interest in their home exceeds $500,000. Effective January 1, 2011, these limits are to be increased each year by the percentage increase in the consumer price index urban (CPIU). Effective January 1, 2011, the excess home equity limits is $506,000. The standard utility allowance (SUA) reference has changed effective October 1, 2011, this emergency adoption corrects the reference. Eliminating reference to general assistance and/or disability lifeline and referencing to the correct aged, blind or disabled (ABD) cash program or medical care services (MCS) program. This emergency adoption is coordinated with community services division's (CSD) emergency adoption in eliminating disability lifeline, this is to ensure that expenditures do not exceed funds appropriated under the 2011-2013 operating budget (2ESHB 1087) signed by Governor Gregoire on June 15, 2011.

Citation of Existing Rules Affected by this Order: Amending WAC 388-513-1305, 388-513-1315, 388-513-1350, 388-513-1380, 388-515-1505, 388-515-1506, 388-515-1507, 388-515-1509, 388-515-1512, and 388-515-1514.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.057, 74.09.500, and 74.09.530.

Other Authority: Deficit Reduction Act (DRA) of 2005.

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

Reasons for this Finding: Federal standard change of the excess home equity provisions effective January 1, 2011, based on the CPIU. This CR-103E continues emergency rules filed under WSR 11-22-072 while the department completes the process for permanent adoption. The initial public notice (CR-101) was filed December 29, 2010, under WSR

11-02-032. The SUA changed effective October 1, 2011. The department is coordinating with the health care authority (HCA) regarding current recodifying and emergency WACs HCA and CSD has filed which affect WAC references in chapters 388-513 and 388-515 WAC regarding changes to ABD cash, and MCS. Also, the department filed a CR-101 on January 4, 2012, under WSR 12-02-082 for consolidating the medically needy in-home (MNI) and medically needy residential (MNR) waivers into the community options program entry system (COPES) waiver. This consolidation will require the department to repeal WAC pertaining to MNI and MNR.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 10, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

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

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

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 10, Repealed 0.

Date Adopted: February 27, 2012.

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 12-07 issue of the Register.

WSR 12-06-020
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 12-24—Filed February 28, 2012, 2:46 p.m., effective February 28, 2012, 2:46 p.m.]

Effective Date of Rule: Immediately.

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

Citation of Existing Rules Affected by this Order: Repealing WAC 220-32-05100M; and amending WAC 220-32-051.

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

Other Authority: *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546); *Northwest Gillnetters Ass'n v. Sandison*, 95 Wn.2d 638, 628 P.2d 800 (1981); Washington fish and wildlife commission policies concerning Columbia River fisheries; 40 Stat. 515 (Columbia River compact).

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

Reasons for this Finding: In SMCRA 1E, 1F, 1G, and 1H, salmon that are harvested after 6:00 p.m. February 29, 2012, may not be sold. Closes the John Day Pool (1H) for sales of sturgeon effective 6:00 p.m. March 1, 2012, as catch is near the quota set for that area. Fisheries are consistent with the 2008-2017 management agreement and the associated biological opinion. Rule is consistent with action of the Columbia River compact on January 26, 2012, and February 27, 2012. Conforms state rules with tribal rules. There is insufficient time to adopt permanent regulations.

The Yakama, Warm Springs, Umatilla, and Nez Perce Indian tribes have treaty fishing rights in the Columbia River and inherent sovereign authority to regulate their fisheries. Washington and Oregon also have some authority to regulate fishing by treaty Indians in the Columbia River, authority that the states exercise jointly under the congressionally ratified Columbia River compact. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969). The tribes and the states adopt parallel regulations for treaty Indian fisheries under the supervision of the federal courts. A court order sets the current parameters. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546). Some salmon and steelhead stocks in the Columbia River are listed as threatened or endangered under the federal ESA. On May 5, 2008, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allows for some incidental take of these species in the fisheries as described in the 2008-2017 *U.S. v. Oregon* Management Agreement.

Columbia River fisheries are monitored very closely to ensure consistency with court orders and ESA guidelines. Because conditions change rapidly, the fisheries are managed almost exclusively by emergency rule. As required by court order, the Washington (WDFW) and Oregon (ODFW) departments of fish and wildlife convene public hearings and invite tribal participation when considering proposals for new emergency rules affecting treaty fishing rights. *Sohappy*, 302 F. Supp. at 912. WDFW and ODFW then adopt regulations reflecting agreements reached.

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

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

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

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

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

Date Adopted: February 28, 2012.

Philip Anderson
Director

NEW SECTION

WAC 220-32-05100N Columbia River salmon seasons above Bonneville Dam. Notwithstanding the provisions of WAC 220-32-050, WAC 220-32-051, WAC 220-32-052 and WAC 220-32-058, effective immediately until further notice, it is unlawful for a person to take or possess salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch taken for commercial purposes in Columbia River Salmon Management and Catch Reporting Areas 1F, 1G, and 1H. However, those individuals possessing treaty fishing rights under the Yakima, Warm Springs, Umatilla, and Nez Perce treaties may fish for salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch under the following provisions:

1. Open Areas: SMCRA 1F,1G, 1H:

a. Season: Immediately through 6:00 p.m. March 21, 2012, except SMCRA 1H is closed effective 6:00 p.m. March 1, 2012.

b. Gear: Gill nets, hoop nets, dip bag nets, and rod and reel with hook and line. No mesh restriction on gillnets.

c. Allowable sale: Steelhead, sturgeon, shad, carp, catfish, walleye, bass, and yellow perch. Salmon may only be sold if caught prior to 6:00 p.m. February 29, 2012. Sturgeon between 38-54 inches in fork length in the Bonneville Pool (1F) and sturgeon between 43-54 inches in fork length in The Dalles pool (1G) may be sold or retained for subsistence purposes. When the John Day pool (1H) is open, sturgeon between 43-54 inches in fork length may sold, but otherwise may only be retained for subsistence purposes. Live release of all oversize and under-size sturgeon is required. Fish caught from platforms or hook-and-line fisheries in open commercial areas and caught during open periods are allowed to be sold.

d. River mouth sanctuaries (WAC 220-32-058) remain in effect, except for the Spring Creek Hatchery sanctuary (sub-section 5) of WAC 220-32-058.

2. Open Area: SMCRA 1E. Each of the four Columbia River treaty tribes has an MOA or MOU with the Washington Department of Fish and Wildlife regarding tribal fisheries in the area just downstream of Bonneville Dam. Tribal fisheries in this area may only occur in accordance with the appropriate MOA or MOU specific to each tribe.

a. Participants: Tribal members may participate under the conditions described in the appropriate MOA or MOU specific to each tribe. Tribal members must carry an official tribal enrollment card.

b. Season: Immediately until further notice.

c. Gear: Hoop nets, dip bag nets, and rod and reel with hook-and-line, or as defined by each tribe's MOU or MOA.

d. Allowable sales: Steelhead, shad, carp, catfish, walleye, bass, and yellow perch. Salmon may only be sold if caught prior to 6:00 p.m. February 29, 2012. Sturgeon retention is prohibited; sturgeon may not be sold or retained for ceremonial or subsistence purposes. Sales may not occur on USACE property.

e. 24- hour quick reporting required for Washington wholesale dealers, WAC 220-69-240, for all areas.

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

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

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 220-32-05100M	Columbia River salmon seasons above Bonneville Dam. (12-13)

WSR 12-06-022
EMERGENCY RULES
EMPLOYMENT SECURITY DEPARTMENT

[Filed February 29, 2012, 9:44 a.m., effective February 29, 2012, 9:44 a.m.]

Effective Date of Rule: Immediately.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: RCW 50.22.010 (2)(c) and (3)(c) provide that the determination of an "on" indicator and of a "high unemployment period" are based on a "look back" at the unemployment rates for the three preceding calendar years. This provision expired on December 31, 2011, or on such subsequent date as provided by the department by rule, consistent with the purposes of the statute. The President has signed the Middle Class Tax Relief and Job Creation Act of 2012, Public Law 112-96, which extends the "three year look back" provision until December 29, 2012.

Purpose: Consistent with federal law, the rule extends until December 29, 2012, the "three year look back" calculation for determining an "on" indicator under RCW 50.22.010 (2)(c) and determining a "high unemployment period" under RCW 50.22.010 (3)(c).

Statutory Authority for Adoption: RCW 50.12.010, 50.12.040, and 50.22.010.

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

Reasons for this Finding: Determining the extended benefit period based on a three year, rather than a two year, "look back" means that the "off" indicator will not take effect in February 2012 as had been anticipated and extended benefits will be available to unemployed individuals beyond that date.

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

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

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

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

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

Date Adopted: February 28, 2012.

Paul Trause
Commissioner

NEW SECTION

WAC 192-240-901 How will the extended benefit period be determined? As provided in the federal Middle Class Tax Relief and Job Creation Action of 2012, Public Law 112-96, the use of unemployment rates for the preceding three calendar years is extended until December 29, 2012, for the following:

(1) The determination of an "on" indicator as provided in RCW 50.22.010 (2)(c); and

(2) The determination of a "high unemployment period" as provided in RCW 50.22.010 (3)(c).

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

WSR 12-06-023
EMERGENCY RULES
HEALTH CARE AUTHORITY
(Medicaid Program)

[Filed February 29, 2012, 10:14 a.m., effective February 29, 2012, 10:14 a.m.]

Effective Date of Rule: Immediately.

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

Citation of Existing Rules Affected by this Order: Repealing WAC 388-505-0110, 388-556-0500, 388-800-0020, 388-800-0025, 388-800-0030, 388-800-0035, 388-800-0048, 388-800-0110, 388-800-0115, 388-800-0130, 388-800-0135, 388-800-0140, 388-800-0145, 388-800-0150, 388-800-0155, 388-800-0160, and 388-800-0165; amending WAC 182-500-0070, 388-505-0270 and 182-538-063; and creating WAC 182-503-0520, 182-503-0532, 182-503-0555, 182-503-0560, 182-504-0030, 182-504-0040, 182-504-0100, 182-504-0125, 182-506-0020, 182-508-0001, 182-508-0005, 182-508-0010, 182-508-0015, 182-508-0020, 182-508-0030, 182-508-0035, 182-508-0040, 182-508-0050, 182-508-0060, 182-508-0070, 182-508-0080, 182-508-0090, 182-508-0100, 182-508-0110, 182-508-0120, 182-508-0130, 182-508-0150, 182-508-0160, 182-508-0220, 182-508-0230, 182-508-0305, 182-508-0310, 182-508-0315, 182-508-0320, 182-508-0375, 182-509-0005, 182-509-0015, 182-509-0025, 182-509-0030, 182-509-0035, 182-509-0045, 182-509-0055, 182-509-0065, 182-509-0080, 182-509-0085, 182-509-0095, 182-509-0100, 182-509-0110, 182-509-0135, 182-509-0155, 182-509-0165, 182-509-0175, 182-509-0200, 182-509-0205, and 182-509-0210.

Statutory Authority for Adoption: RCW 41.05.021, 74.09.035.

Other Authority: Chapter 36, Laws of 2011 (E2SHB 2082).

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

Reasons for this Finding: See Purpose statement above. This filing continues the emergency rule adopted under WSR 11-22-052 while the permanent rule process is completed. The permanent rule was proposed under WSR 11-23-164 and the public hearing was held on December 27, 2011. The agency anticipates adopting the permanent rule in March 2012.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 55, Amended 3, Repealed 17.

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

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

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

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 55, Amended 3, Repealed 17.

Date Adopted: February 29, 2012.

Kevin M. Sullivan
Rules Coordinator

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Chapter 182-503 WAC

PERSONS ELIGIBLE FOR MEDICAL ASSISTANCE

NEW SECTION

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

(1) A resident is an individual who:

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

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

(c) Entered the state with a job commitment.

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

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

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

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

(a) The individual:

(i) Plans to return to this state;

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

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

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

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

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

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

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

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

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

(9) An individual's residence is the state:

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

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

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

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

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

NEW SECTION

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

(a) A U.S. citizen;

(b) A U.S. national;

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

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

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

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

(a) A U.S. citizen;

(b) A U.S. national;

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

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

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

NEW SECTION

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

(1) Eighteen years of age or older; or

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

(a) Residing together; or

(b) Residing apart solely because a spouse is:

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

(ii) In a public or private institution;

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

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

NEW SECTION

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

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

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

Chapter 182-504 WAC

CERTIFICATION PERIODS AND CHANGE OF CIRCUMSTANCES

NEW SECTION

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

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

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

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

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

NEW SECTION

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

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

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

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

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

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

(ii) The form is signed and dated;

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION

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

(a) A change in address;

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

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

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

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

(i) Get a job or change employers;

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

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

(iv) Stop working.

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

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

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

NEW SECTION

WAC 182-504-0125 Effect of changes on medical program eligibility. (1) An individual continues to be eligible for medical assistance until the agency or the agency's designee completes a review of the individual's case record and determines the individual is ineligible for medical assistance or is eligible for another medical program. This applies to all individuals who, during a certification period, become ineligible for, or are terminated from, or request termination from:

(a) A categorically needy (CN) medicaid program;

(b) A program included in apple health for kids; or

(c) Any of the following cash grants:

(i) Temporary assistance for needy families (TANF);

(ii) Supplemental Security Income (SSI); or

(iii) Aged, blind, disabled (ABD) cash assistance. See WAC 388-434-0005 for changes reported during eligibility review.

(2) If CN medical coverage ends under one program and the individual meets all the eligibility requirements to be eligible under a different CN medical program, coverage is approved under the new program. If the individual's income exceeds the standard for CN medical coverage, the agency or the agency's designee considers eligibility under the medically needy (MN) program where appropriate.

(3) If CN medical coverage ends and the individual does not meet the eligibility requirements to be eligible under a different medical program, the redetermination process is complete and medical assistance is terminated giving advance and adequate notice with the following exception:

(a) An individual who claims to have a disability is referred to the division of disability determination services for a disability determination if that is the only basis under which the individual is potentially eligible for medical assis-

tance. Pending the outcome of the disability determination, medical eligibility is considered under the SSI-related medical program described in chapter 388-475 WAC.

(b) An individual with countable income in excess of the SSI-related CN medical standard is considered for medically needy (MN) coverage or medically needy (MN) with spend-down pending the final outcome of the disability determination.

(4) An individual who becomes ineligible for refugee cash assistance is eligible for continued refugee medical assistance through the eight-month limit, as described in WAC 388-400-0035(4).

(5) An individual who receives a TANF cash grant or family medical is eligible for a medical extension, as described under WAC 388-523-0100, when the cash grant or family medical program is terminated as a result of:

(a) An increase in earned income; or

(b) Collection of child or spousal support.

(6) Changes in income during a certification period affects eligibility for all medical programs except:

(a) Pregnant women's CN medical programs;

(b) A program included in apple health for kids, except as specified in subsection (5) of this section; or

(c) The first six months of the medical extension benefits described under chapter 388-523 WAC.

(7) A child who receives premium-based coverage under a program included in apple health for kids described in WAC 388-505-0210 and chapter 388-542 WAC must be redetermined for a nonpremium-based coverage when the family reports:

(a) Family income has decreased to less than two hundred percent federal poverty level (FPL);

(b) The child becomes pregnant;

(c) A change in family size; or

(d) The child receives SSI.

(8) An individual who receives SSI-related CN medical coverage and reports a change in earned income which exceeds the substantial gainful activity (SGA) limit set by Social Security Administration no longer meets the definition of a disabled individual as described in WAC 388-475-0050, unless the individual continues to receive a Title 2 cash benefit, e.g., SSDI, DAC, or DWB. The agency or the agency's designee redetermines eligibility for such an individual under the health care for workers with disabilities (HWD) program which waives the SGA income test. The HWD program is a premium-based program and the individual must approve the premium amount before the agency or the agency's designee can authorize ongoing CN medical benefits under this program.

Chapter 182-506 WAC

MEDICAL FINANCIAL RESPONSIBILITY

NEW SECTION

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

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

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

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

Chapter 182-508 WAC

ADULT MEDICAL AND CHEMICAL DEPENDENCY

NEW SECTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Is at least eighteen years old;

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

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

(f) Is an individual who:

(i) In August 1972, received:

(A) Old age assistance (OAA);

(B) Aid to blind (AB);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Meets the requirements of the ADATSA program as described in WAC 182-508-0320.

(8) An adult receiving MCS who resides in a county designated as a mandatory managed care plan county must enroll in a plan, pursuant to WAC 182-538-063.

NEW SECTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Is eligible for the aged, blind, disabled (ABD) program under WAC 388-400-0060.

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

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

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

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

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

(i) In a work release program; or

(ii) Outside of the institution including home detention.

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

NEW SECTION

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

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

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

"Physical impairment" means a diagnosable physical illness.

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

(a) Disabled based on Social Security Administration (SSA) disability criteria;

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

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

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

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

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

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

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

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

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

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

NEW SECTION

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

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

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

(a) Under special conditions that go beyond the employer providing reasonable accommodation, such as in a sheltered workshop the agency or the agency's designee has approved; or

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

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

(a) Applies for medical benefits;

(b) Becomes employed;

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

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

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

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

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

NEW SECTION

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

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

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

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

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

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

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

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

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

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

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

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

(a) A psychiatrist;

(b) A psychologist;

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

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

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

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

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

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

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

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

NEW SECTION

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

(1) Objective evidence for physical impairments means:

(a) Laboratory test results;

(b) Pathology reports;

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

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

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

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

(2) Objective evidence for mental impairments means:

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

(b) Explanation of how examination findings meet the clinical and diagnostic criteria of the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

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

(d) Testing results, if any, including:

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

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

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

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

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

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

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

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

(5) The agency or the agency's designee doesn't use symptoms related to substance abuse or a diagnosis of addiction or chemical dependency when determining incapacity when the only impairment supported by objective medical evidence is drug or alcohol addiction.

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

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

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

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

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

NEW SECTION

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

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

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

(3) A contracted doctor reviews the individual's medical evidence and the ratings assigned to the individual's impairment when the individual's impairment has lasted, or is expected to last, twelve months or more.

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

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

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

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

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

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

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

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

NEW SECTION

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION

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

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

(a) Psychosocial and treatment history records;

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

(c) Results of psychological tests; and

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

(2) The agency or the agency's designee excludes diagnosis and related symptoms of alcohol or substance abuse or addiction when the only impairment supported by objective medical evidence is drug or alcohol addiction.

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

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

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

(a) Short term memory impairment;

(b) Perceptual or thinking disturbances;

(c) Disorientation to time and place; or

(d) Labile, shallow, or coarse affect.

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

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

(b) Are consistent with a diagnosis of a mental impairment as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM).

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

Symptom Ratings or Condition		Severity Rating
(a)	The individual is diagnosed with a functional disorder with psychotic features;	Moderate (3)
(b)	The individual has had two or more hospitalizations for psychiatric reasons in the past two years;	
(c)	The individual has had more than six months of continuous psychiatric inpatient or residential treatment in the past two years;	

Symptom Ratings or Condition		Severity Rating	
(d)	The objective evidence and global assessment of functioning score are consistent with a significant limitation on performing work activities.		
(e)	The objective evidence and global assessment of functioning score are consistent with very significant limitations on ability to perform work activities.	Marked	(4)
(f)	The objective evidence and global assessment of functioning score are consistent with the absence of ability to perform work activities.	Severe	(5)

(7) If the individual is diagnosed with any combination of mental retardation, mental impairment with physical causes, or functional mental impairment, the agency or the agency's designee assigns a severity rating as follows:

Condition		Severity Rating	
(a)	Two or more disorders with moderate severity (3) ratings; or	Marked	(4)
(b)	One or more disorders rated moderate severity (3), and one rated marked severity (4).		
(c)	Two or more disorders rated marked severity (4).	Severe	(5)

(8) The agency or the agency's designee denies incapacity when the individual hasn't been diagnosed with a significant physical impairment and the individual's overall mental severity rating is one or two;

(9) The agency or the agency's designee approves incapacity when the individual has an overall mental severity rating of severe (5).

NEW SECTION

WAC 182-508-0060 PEP Step III—Determining the severity of physical impairments. The agency or the agency's designee must decide if the individual's physical impairment is serious enough to limit the individual's ability to be gainfully employed. "Severity of a physical impairment" means the degree that an impairment restricts the individual from performing basic work-related activities (see WAC 182-508-0015). Severity ratings range from one to five, with five being the most severe. The agency or the agency's designee will assign severity ratings according to the table in WAC 182-508-0035.

(1) The agency or the agency's designee assigns to each physical impairment a severity rating that is supported by medical evidence.

(2) If the individual's physical impairment is rated two, and there is no mental impairment or a mental impairment that is rated one, the agency or the agency's designee denies incapacity.

(3) If the individual's physical impairment is consistent with a severity rating of five, the agency or the agency's designee approves incapacity.

NEW SECTION

WAC 182-508-0070 PEP Step IV—Determining the severity of multiple impairments. (1) If an individual has more than one impairment, the agency or the agency's designee decides the overall severity rating by deciding if the individual's impairments have a combined effect on their ability to be gainfully employed. Each diagnosis is grouped by affected organ or function into one of thirteen "body systems." The thirteen body systems consist of:

(a) Musculo-skeletal;
(b) Special senses and speech;
(c) Respiratory;
(d) Cardiovascular;
(e) Digestive;
(f) Genito-urinary;
(g) Hemic and lymphatic;
(h) Skin;
(i) Endocrine and obesity;
(j) Neurological;
(k) Mental disorders;
(l) Neoplastic; and
(m) Immune systems.

(2) The agency or the agency's designee follows these rules when there are multiple impairments:

(a) The agency or the agency's designee groups each diagnosis by body system.

(b) When an individual has two or more diagnosed impairments that limit work activities, the agency or the agency's designee assigns an overall severity rating as follows:

Client Condition		Severity Rating
(i)	All impairments are in the same body system, are rated two and there is no cumulative effect on basic work activities.	2
(ii)	All impairments are in the same body system, are rated two and there is a cumulative effect on basic work activities.	3
(iii)	All impairments are in different body systems, are rated two and there is a cumulative effect on basic work activities.	
(iv)	Two or more impairments are in different body systems and are rated three.	4

Client Condition		Severity Rating
(v)	Two or more impairments are in different body systems; one is rated three and one is rated four.	
(vi)	Two or more impairments in different body systems are rated four.	5

(c) The agency or the agency's designee denies incapacity when the overall severity rating is two.

(d) The agency or the agency's designee approves incapacity when the overall severity rating is five.

NEW SECTION

WAC 182-508-0080 PEP Step V—Determining level of function of mentally impaired individuals in a work environment. If an individual has a mental impairment, the agency or the agency's designee evaluates the individual's cognitive and social functioning in a work setting. "Functioning" means an individual's ability to perform typical tasks that would be required in a routine job setting and the individual's ability to interact effectively while working.

(1) The agency or the agency's designee evaluates cognitive and social functioning by assessing the individual's ability to:

(a) Understand, remember, and persist in tasks by following simple instructions of one or two steps.

(b) Understand, remember, and persist in tasks by following complex instructions of three or more steps.

(c) Learn new tasks.

(d) Perform routine tasks without undue supervision.

(e) Be aware of normal hazards and take appropriate precautions.

(f) Communicate and perform effectively in a work setting with public contact.

(g) Communicate and perform effectively in a work setting with limited public contact.

(h) Maintain appropriate behavior in a work setting.

(2) The agency or the agency's designee approves incapacity when it has objective medical evidence, including a mental status exam (MSE) per WAC 182-508-0050, that demonstrates the individual is:

(a) At least moderately impaired in their ability to understand, remember, and persist in tasks following simple instructions, and at least moderately limited in their ability to:

(i) Learn new tasks;

(ii) Be aware of normal hazards and take appropriate precautions; and

(iii) Perform routine tasks without undue supervision; or

(b) At least moderately impaired in the ability to understand, remember, and persist in task following complex instructions; and

(c) Markedly impaired in the ability to learn new tasks, be aware of normal hazards and take appropriate precautions, and perform routine tasks without undue supervision.

(3) The agency or the agency's designee approves incapacity when the individual is moderately (rated three) impaired in their ability to:

(a) Communicate and perform effectively in a work setting with public contact;

(b) Communicate and perform effectively in a work setting with limited public contact; and

(c) Markedly (rated four) impaired in their ability to maintain appropriate behavior in a work setting.

NEW SECTION

WAC 182-508-0090 PEP Step VI—Determining level of function of physically impaired individuals in a work environment. In Step VI of the PEP, the agency or the agency's designee reviews the medical evidence provided and determines how an individual's physical impairment prevents that individual from working. This determination is then used in Steps VII and VIII of the PEP to determine the individual's ability to perform either work they have done in the past or other work.

(1) **"Exertion level"** means having strength, flexibility, and mobility to lift, carry, stand or walk as needed to fulfill job duties in the following work levels. For this section, "occasionally" means less than one third of the time and "frequently" means one third to two thirds of the time.

The following table is used to determine an individual's exertion level. Included in this table is a strength factor, which is an individual's ability to perform physical activities, as defined in Appendix C of the *Dictionary of Occupational Titles* (DOT), Revised Edition, published by the U.S. Department of Labor as posted on the Occupational Information Network (O.*NET).

If an individual is able to:		Then the individual is assigned this exertion level
(a)	Lift no more than two pounds or unable to stand or walk.	Severely limited
(b)	Lift ten pounds maximum and frequently lift or carry lightweight articles. Walking or standing only for brief periods.	Sedentary
(c)	Lift twenty pounds maximum and frequently lift or carry objects weighing up to ten pounds. Walk six out of eight hours per day or stand during a significant portion of the workday. Sitting and using pushing or pulling arm or leg movements most of the day.	Light
(d)	Lift fifty pounds maximum and frequently lift or carry up to twenty-five pounds.	Medium
(e)	Lift one hundred pounds maximum and frequently lift or carry up to fifty pounds.	Heavy

(2) **"Exertionally related limitation"** means a restriction in mobility, agility or flexibility in the following twelve activities: Balancing, bending, climbing, crawling, crouching, handling, kneeling, pulling, pushing, reaching, sitting, and stooping. If an individual has exertionally related limitations, then the agency or the agency's designee considers them in determining the individual's ability to work.

(3) **"Functional physical capacity"** means the degree of strength, agility, flexibility, and mobility an individual can apply to work-related activities. The agency or the agency's designee considers the effect of the physical impairment on the ability to perform work-related activities when the physical impairment is assigned an overall severity rating of three or four. The agency or the agency's designee determines functional physical capacity based on the individual's exertional, exertionally related and nonexertional limitations. All limitations must be substantiated by the medical evidence and directly related to the diagnosed impairment(s).

(4) **"Nonexertional physical limitation"** means a restriction on work activities that does not affect strength, mobility, agility, or flexibility. Examples are:

(a) Environmental restrictions which could include, among other things, an individual's inability to work in an area where they would be exposed to chemicals; and

(b) Workplace restrictions, such as impaired hearing or speech, which would limit the types of work environments an individual could work in.

NEW SECTION

WAC 182-508-0100 PEP Step VII—Evaluating a client's capacity to perform relevant past work. If the individual's overall severity rating is moderate (three) or marked (four) at this stage of the PEP and the agency or the agency's designee has not approved or denied the individual's application, then the agency or the agency's designee will decide if the individual can do the same or similar work as they have done in the past. The agency or the agency's designee looks at the individual's current physical and/or mental limitations from cognitive, social, and vocational factors to make this decision. Vocational factors are education, relevant work history, and age.

(1) The agency or the agency's designee evaluates education in terms of formal schooling or other training that would enable the individual to meet job requirements. Education is classified as:

If the individual:		Then the individual's education level is
(a)	Can't read or write a simple communication, such as two sentences or a list of items.	Illiterate
(b)	Has no formal schooling or vocational training beyond the eleventh grade; or	Limited education
(c)	Has participated in special education in basic academic classes of reading, writing, or mathematics in high school.	
(d)	Has received a high school diploma or general equivalency degree (GED); or	High school and above level of education
(e)	Has received skills training and was awarded a certificate, degree or license.	

(2) The agency or the agency's designee evaluates the individual's work experience to determine if they have relevant past work. "Relevant past work" means work that:

(a) Is defined as gainful employment per WAC 182-508-0015;

(b) Has been performed in the past five years; and

(c) The individual performed long enough to acquire the knowledge and skills to continue performing the job. The individual must meet the specific vocational preparation level as defined in Appendix C of the *Dictionary of Occupational Titles*.

(3) For each relevant past work situation that the individual had, the agency or the agency's designee determines:

(a) The exertion or skill requirements of the job; and

(b) Current cognitive, social, or nonexertion factors that significantly limit the individual's ability to perform past work.

(4) After considering vocational factors, the agency or the agency's designee denies incapacity when the individual has:

(a) The physical and mental ability to perform past work, and there is no significant cognitive, social or exertion limitation that would prevent the individual from performing past work; or

(b) Recently acquired specific work skills through completion of schooling or training, for jobs within the individual's current physical or mental capacities.

(5) The agency or the agency's designee approves incapacity when the individual is fifty-five years of age or older and doesn't have the physical or mental ability to perform past work.

NEW SECTION

WAC 182-508-0110 PEP Step VIII—Evaluating a client's capacity to perform other work. If the individual decides they cannot do work that they've done before, then the agency or the agency's designee decides if the individual can do any other work.

(1) The agency or the agency's designee approves incapacity if the individual has a physical impairment and meets the vocational factors below:

Highest Work Level Assigned by the Practitioner	Age	Education Level	Other Vocational Factors
Sedentary	Any age	Any level	Does not apply
Light	50 and older	Any level	Does not apply
Light	35 and older	Illiterate or LEP	Does not apply
Light	18 and older	Limited Education	Does not have any past work
Medium	50 and older	Limited Education	Does not have any past work

(2) The agency or the agency's designee approves incapacity when the individual has a moderate (three) or marked (four) mental health impairment and the agency or the agency's designee has objective medical evidence, including a mental status exam (MSE) per WAC 182-508-0050, that demonstrates social or cognitive factors described in WAC 182-508-0080, interfere with working as follows:

Social Limitation	Age
(a) Moderately impaired (rated three) in the individual's ability to: (i) Communicate and perform effectively in a work setting with limited public contact; and (ii) Maintain appropriate behavior in a work setting.	50 years and older
(b) The individual has a severe (five) impairment in their ability to: (i) Communicate and perform effectively in a work setting with public contact; or (ii) Communicate and perform effectively in a work setting with limited public contact.	Any age
(c) A mental disorder of marked severity (rated four): (i) One or more severe (rated five) mental impairment symptoms; and (ii) Moderately impaired (rated three) in the ability to communicate and perform effectively in a work setting with public or limited public contact.	Any age

(3) The agency or the agency's designee approves incapacity when the individual has both mental and physical impairments and the agency or the agency's designee has objective medical evidence, including a mental status exam (MSE) per WAC 182-508-0050, that demonstrate social or cognitive factors, as described in WAC 182-508-0080 interfere with working as follows:

Age	Education	Other Restrictions
Any age	Any level	(a) The individual is moderately impaired in their ability to communicate and perform effectively in a work setting with limited public contact; and (b) The individual is markedly impaired in their ability to communicate and perform effectively in a work setting with public contact.
50 or older	Limited education	(c) Restricted to medium work level or less.
Any age	Limited education	(d) Restricted to light work level.

(4) The agency or the agency's designee denies incapacity if the agency or the agency's designee decides the individual doesn't meet the criteria listed above.

NEW SECTION

WAC 182-508-0120 Deciding how long a client is incapacitated. The agency or the agency's designee decides how long an individual is incapacitated, up to the maximum period set by WAC 182-508-0160, using medical evidence on the expected length of time needed to heal or recover from the incapacitating disorder(s).

NEW SECTION

WAC 182-508-0130 Medical care services—Limited coverage. (1) The agency covers only the medically necessary services within the applicable program limitations listed in WAC 182-501-0060.

(2) The agency does not cover medical services received outside the state of Washington unless the medical services are provided in a border city listed in WAC 182-501-0175.

NEW SECTION

WAC 182-508-0150 Enrollment cap for medical care services (MCS). (1) Enrollment in medical care services (MCS) coverage is subject to available funds.

(2) The agency may limit enrollment into MCS coverage by implementing an enrollment cap and waiting list.

(3) If an individual is denied MCS coverage due to an enrollment cap:

(a) The individual is added to the MCS waiting list based on the date the individual applied.

(b) Applicants with the oldest application date will be the first to receive an opportunity for enrollment when MCS coverage is available.

(4) An individual is exempted from the enrollment cap and wait list rules when:

(a) MCS was terminated due to agency error;

(b) The individual is in the thirty-day reconsideration period for incapacity reviews under WAC 182-508-0160(4); or

(c) The individual is being terminated from a CN medical program and was receiving and eligible for CN coverage prior to the date a wait list was implemented and the following conditions are met:

(i) The individual met financial and program eligibility criteria for MCS at the time their CN coverage ended; and

(ii) The individual met the incapacity criteria for MCS at the time their CN coverage ended.

(d) The individual applied for medical coverage and an eligibility decision was not completed prior to the enrollment cap effective date.

(5) If the individual is sent an offer for MCS enrollment, the individual must submit a completed application no later than the last day of the month following the month of enrollment offer. The individual must reapply within this time period and subsequently be determined eligible before MCS coverage can begin. The individual must reapply and requalify even if the individual was previously determined eligible for MCS.

(6) The individual is removed from the MCS wait list if the individual:

(a) Is not a Washington resident;

(b) Is deceased;

(c) Requests removal from the wait list;

(d) Fails to submit an application after an enrollment offer is sent as described in subsection (5) of this section;

(e) Reapplies as described in subsection (5) of this section, but does not qualify for MCS; or

(f) Is found eligible for categorically or medically needy coverage.

NEW SECTION

WAC 182-508-0160 When medical care services benefits end. (1) The maximum period of eligibility for medical care services (MCS) is twelve months before the agency or the agency's designee must review incapacity. The agency or the agency's designee uses current medical evidence and the expected length of time before the individual will be capable of gainful employment to decide when MCS benefits will end.

(2) The individual's benefits stop at the end of the individual's incapacity period unless the individual provides additional medical evidence that demonstrates during the current incapacity period that there was no material improvement in the individual's impairment. No material improvement means that the individual's impairment continues to meet the progressive evaluation process criteria in WAC 182-508-0015 through 182-508-0110, excluding the requirement that the individual's impairment(s) prevent employment for ninety days.

(3) The medical evidence must meet all of the criteria defined in WAC 182-508-0030.

(4) The agency or the agency's designee uses medical evidence received after the individual's incapacity period had ended when:

(a) The delay was not due to the individual's failure to cooperate; and

(b) The agency or the agency's designee receives the evidence within thirty days of the end of the individual's incapacity period; and

(c) The evidence meets the progressive evaluation process criteria in WAC 182-508-0015 through 182-508-0110.

(5) Even if the individual's condition has not improved, the individual isn't eligible for MCS when:

(a) The agency or the agency's designee receives current medical evidence that doesn't meet the progressive evaluation process criteria in WAC 182-508-0035 through 182-508-0110; and

(b) The agency's or the agency designee's prior decision that the individual's incapacity met the requirements was incorrect because:

(i) The information the agency or the agency's designee had was incorrect or not enough to show incapacity; or

(ii) The agency or the agency's designee didn't apply the rules correctly to the information it had at that time.

NEW SECTION

WAC 182-508-0220 How alcohol or drug dependence affects an individual's eligibility for medical care services (MCS). (1) An individual who gets medical care services (MCS) must complete a chemical dependency assessment when the agency or the agency's designee has information that indicates the individual may be chemically dependent.

(2) An individual must accept an assessment referral and participate in drug or alcohol treatment if a certified chemical dependency counselor indicates a need for treatment, unless the individual meets one of the following good cause reasons:

(a) The agency or the agency's designee determines that the individual's physical or mental health impairment prevents them from participating in treatment.

(b) The outpatient chemical dependency treatment the individual needs isn't available in the county they live in.

(c) The individual needs inpatient chemical dependency treatment at a location that they can't reasonably access.

(3) If an individual refuses or fails to complete an assessment or treatment without good cause, the individual's MCS coverage will end following advance notification rules under WAC 388-458-0030.

NEW SECTION

WAC 182-508-0230 Eligibility standards for medical care services and ADATSA. Effective November 1, 2011, the eligibility standards for medical care services (MCS) and Alcohol and Drug Addiction Treatment and Support Act (ADATSA) program assistance units with obligations to pay shelter costs are:

Assistance Unit Size	Eligibility Standard
1	$339
2	$428

The eligibility standards for MCS and ADATSA assistance units with shelter provided at no cost are:

Assistance Unit Size	Eligibility Standard
1	$206
2	$261

The eligibility standards for MCS assistance units in medical institutions and group living facilities are:

Facility Type	Assistance Unit Size	Eligibility Standard
Medical institutions (includes nursing homes and hospitals)	1	41.62
Adult family homes	1	339.00
Boarding homes (includes assisted living, enhanced residential centers (EARC), and adult residential centers (ARC))	1	38.84
DDD group home	1	38.84
Mental Health adult residential treatment facilities (ARTF)	1	38.84

NEW SECTION

WAC 182-508-0305 Detoxification—Covered services. (1) The agency or the agency's designee only pays for services that are:

(a) Provided to eligible individuals as described in subsection (5) of this section;

(b) Directly related to detoxification; and

(c) Performed by a certified detoxification center or by a general hospital that has a contract with the department of social and health services to provide detoxification services.

(2) The agency limits on paying for detoxification services are:

(a) Three days for an acute alcoholic condition; or

(b) Five days for acute drug addiction.

(3) The agency only pays for detoxification services when notified within ten working days of the date detoxification began and all eligibility factors are met.

(4) To apply for detoxification services, an individual must complete an application for benefits. An interview is not required when applying for medical assistance. However, additional documentation may be needed to prove or confirm the information provided in the application form.

(5) An individual is eligible for detoxification services if the individual receives benefits under one of the following programs:

(a) Temporary assistance for needy families (TANF);

(b) Aged, blind, disabled cash assistance program (ABD);

(c) Supplemental Security Income (SSI);

(d) Medical care services program (MCS);

(e) Alcohol and Drug Addiction Treatment and Support Act (ADATSA); or

(f) A medical assistance program.

(6) An individual who is not eligible for one of the programs listed in subsection (5) of this section is eligible for the detoxification program if they meet the following criteria:

(a) Nonexempt countable income does not exceed the eligibility standards for MCS and ADATSA as described in WAC 182-508-0230; and

(b) Nonexempt countable resources do not exceed one thousand dollars.

(7) The following expenses are deducted from income when determining countable income:

(a) Mandatory expenses of employment;

(b) Support payments paid under a court order; and

(c) Payments to a wage earner specified by a court in bankruptcy proceedings, or previously contracted major household repairs, when failure to make such payments will result in garnishment of wages or loss of employment.

(8) The following resources are not counted when determining countable resources:

(a) A home;

(b) Household furnishings and personal clothing essential for daily living;

(c) Other personal property used to reduce need for assistance or for rehabilitation;

(d) A used and useful automobile; and

(e) All income and resources of a noninstitutionalized SSI beneficiary.

(9) The following resources are counted when determining countable resources:

(a) Cash and other liquid assets;

(b) Marketable securities; and

(c) Any other resource not specifically exempted that can be converted to cash.

(10) If an individual receives detoxification services, the individual will not incur a deductible as a factor of eligibility for the covered period of detoxification.

(11) Once an individual has been determined eligible for detoxification services, the individual is eligible from the date detoxification begins through the end of the month in which the detoxification is completed.

NEW SECTION

WAC 182-508-0310 ADATSA—Purpose. (1) The Alcohol and Drug Addiction Treatment and Support Act (ADATSA) is a legislative enactment providing state-funded treatment and support to chemically dependent indigent individuals.

(2) ADATSA provides eligible individuals with treatment if they are chemically dependent and would benefit from it.

NEW SECTION

WAC 182-508-0315 ADATSA—Covered services. If an individual qualifies for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) they may be eligible for:

(1) Alcohol/drug treatment services and support based on an individual assessment of alcohol/drug involvement and treatment needs in accordance with RCW 70.96A.100.

(2) Medical care services (MCS) as described under WAC 182-508-0005, 182-501-0060, and 182-501-0065.

NEW SECTION

WAC 182-508-0320 ADATSA—Eligible individuals. (1) To be eligible for the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) services, an individual must:

(a) Be eighteen years of age or older;

(b) Be a resident of Washington as defined in WAC 182-503-0520;

(c) Meet citizenship requirements as described in WAC 182-503-0532;

(d) Provide their Social Security number; and

(e) Meet the same income and resource criteria for the medical care services (MCS) program (unless subsection (2) of this section applies), or receive federal assistance under Supplemental Security Income (SSI) or temporary assistance for needy families (TANF).

(2) An individual with nonexcluded countable income higher than the MCS eligibility standard described in WAC 182-508-0230 may qualify for inpatient only residential treatment if total countable income is below the projected monthly cost of care in the treatment center based on the state daily reimbursement rate.

NEW SECTION

WAC 182-508-0375 ADATSA—Eligibility for state-funded medical care services (MCS). To be eligible for state-funded medical care services (MCS), one of the following situations must exist:

(1) The individual meets the requirements in WAC 182-508-0320 and be waiting to receive the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) services;

(2) The individual is participating in ADATSA residential or outpatient treatment; or

(3) The individual has chosen opiate dependency (methadone maintenance) chemical dependency treatment services instead of other ADATSA treatment, but only if these treatment services are from a state-approved, publicly funded opiate dependency/methadone maintenance program.

Chapter 182-509 WAC

INCOME AND RESOURCES

NEW SECTION

WAC 182-509-0005 MCS income—Ownership and availability. This section applies to medical care services (MCS) program.

(1) The agency or the agency's designee counts all available income owned or held by persons in the assistance unit under WAC 182-506-0020 to decide if the individual is eligible for benefits when:

(a) The individual gets or expects to get income in the month.

(b) The agency or the agency's designee must count the income based on rules under this chapter.

(c) The individual owns the income. The agency or the agency's designee uses state and federal laws about who owns property to decide if the individual actually owns the income. If the individual is married, the agency or the agency's designee decides if the income is separate or community income according to chapter 26.16 RCW.

(d) The individual has control over the income, which means the income is actually available to the individual. If the individual has a representative payee, protective payee, or other person who manages the individual's income, the agency or the agency's designee considers this as the individual having control over this income.

(e) The individual can use the income to meet their current needs. The agency or the agency's designee counts the gross amount of available income in the month the individual's assistance unit gets it. If the individual normally gets the income:

(i) On a specific day, the agency or the agency's designee counts it as available on that date.

(ii) Monthly or twice monthly and the pay date changes due to a reason beyond the individual's control, such as a weekend or holiday, the agency or the agency's designee counts it in the month the individual would normally get it.

(iii) Weekly or every other week and the pay date changes due to a reason beyond the individual's control, the agency or the agency's designee counts it in the month the individual would normally get it.

(2) If income is legally the individual's designee, the agency or the agency's designee considers the income as available to the individual even if it is paid to someone else for the individual.

(3) The agency or the agency's designee:

(a) May count the income of certain people who live in the individual's home, even if they are not getting or applying for benefits. Their income counts as part of the individual's income.

(b) Counts the income of ineligible, disqualified, or financially responsible people as defined in WAC 182-509-0100.

(4) If the individual has a joint bank account with someone who is not in the individual's assistance unit (AU), the agency or the agency's designee counts any money deposited into that account as the individual's income unless:

(a) The individual can show that all or part of the funds belong **only** to the other account holder and are held or used **only** for the benefit of that holder; or

(b) Social Security Administration (SSA) used that money to determine the other account holder's eligibility for SSI benefits.

(5) Potential income is income the individual may be able to get that can be used to lower their need for assistance. If the agency or the agency's designee determines that the individual has a potential source of income, the individual must make a reasonable effort to make the income available in order to get MCS. The agency or the agency's designee does not count that income until the individual actually gets it.

(6) If the individual's AU includes a sponsored immigrant, the agency or the agency's designee considers the income of the immigrant's sponsor as available to the immigrant under the rules of this chapter. The agency or the agency's designee uses this income when deciding if the individual's AU is eligible for benefits and to calculate the individual's monthly benefits.

(7) The individual may give the agency or the agency's designee proof about a type of income at anytime, including when the agency or the agency's designee asks for it or if the individual disagrees with a decision the agency or the agency's designee made, about:

(a) Who owns the income;

(b) Who has legal control of the income;

(c) The amount of the income; or

(d) If the income is available.

NEW SECTION

WAC 182-509-0015 MCS income—Excluded income types. There are some types of income that do not count when determining if an individual is eligible for medical care services (MCS) coverage. Examples of income that do not count are:

(1) Bona fide loans as defined in WAC 388-470-0045, except certain student loans as specified under WAC 182-509-0035;

(2) Federal earned income tax refunds and earned income tax credit (EITC) payments for up to twelve months from the date of receipt;

(3) Federal economic stimulus payments that are excluded for federal and federally assisted state programs;

(4) Federal twenty-five dollar supplemental weekly unemployment compensation payment authorized by the American Recovery and Reinvestment Act of 2009;

(5) Title IV-E and state foster care maintenance payments if the individual chooses not to include the foster child in the assistance unit;

(6) Energy assistance payments;

(7) Educational assistance that is not counted under WAC 182-509-0035;

(8) Native American benefits and payments that are not counted under WAC 388-450-0040;

(9) Income from employment and training programs that is not counted under WAC 182-509-0045;

(10) Money withheld from a benefit to repay an overpayment from the same income source;

(11) One-time payments issued under the Department of State or Department of Justice Reception and Replacement Programs, such as voluntary agency (VOLAG) payments;

(12) Payments we are directly told to exclude as income under state or federal law; and

(13) Payments made to someone outside of the household for the benefits of the assistance unit using funds that are not owed to the household.

NEW SECTION

WAC 182-509-0025 MCS income—Unearned income. This section applies to medical care services (MCS).

(1) Unearned income is income an individual gets from a source other than employment or self-employment. Some examples of unearned income are:

(a) Railroad retirement;

(b) Unemployment compensation;

(c) Social Security benefits (including retirement benefits, disability benefits, and benefits for survivors);

(d) Time loss benefits as described in WAC 388-450-0010, such as benefits from the department of labor and industries (L&I); or

(e) Veteran Administration benefits.

(2) The agency or the agency's designee counts unearned income before any taxes are taken out.

NEW SECTION

WAC 182-509-0030 MCS income—Earned income. This section applies to medical care services (MCS).

(1) Earned income money received from working. This includes:

(a) Wages;

(b) Tips;

(c) Commissions;

(d) Profits from self-employment activities as described in WAC 182-509-0080; and

(e) One-time payments for work performed over a period of time.

(2) Income received for work performed for something other than money, such as rent, is considered earned income. The amount that is counted when determining the individual's eligibility for MCS is the amount received before any taxes are taken out (gross income).

NEW SECTION

WAC 182-509-0035 MCS income—Educational benefits. This section applies to medical care services (MCS).

(1) Educational benefits that do not count are:

(a) Educational assistance in the form of grants, loans or work study, issued from Title IV of the Higher Education Amendments (Title IV - HEA) and Bureau of Indian Affairs (BIA) education assistance programs. Examples of Title IV - HEA and BIA educational assistance include, but are not limited to:

(i) College work study (federal and state);

(ii) Pell grants; and

(iii) BIA higher education grants.

(b) Educational assistance in the form of grants, loans or work study made available under any program administered by the Department of Education (DOE) to an undergraduate student. Examples of programs administered by DOE include, but are not limited to:

(i) Christa McAuliffe Fellowship Program;

(ii) Jacob K. Javits Fellowship Program; and

(iii) Library Career Training Program.

(2) For assistance in the form of grants, loans or work study under the Carl D. Perkins Vocational and Applied Technology Education Act, P.L. 101-391:

(a) If the individual is attending school half time or more, the following expenses are subtracted:

(i) Tuition;

(ii) Fees;

(iii) Costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study;

(iv) Books;

(v) Supplies;

(vi) Transportation;

(vii) Dependent care; and

(viii) Miscellaneous personal expenses.

(b) If the individual is attending school less than half time, the following expenses are subtracted:

(i) Tuition;

(ii) Fees; and

(iii) Costs for purchase or rental of equipment, materials, or supplies required of all students in the same course of study.

(c) The MCS eligibility standard based on one person is also subtracted.

(d) Any remaining income is unearned income and budgeted using the appropriate budgeting method for the assistance unit.

(3) If the individual is participating in a work study that is not excluded in subsection (1) of this section, that work study income is counted as earned income under the following conditions:

(a) The individual is allowed the earned income work incentive deduction described in WAC 182-509-0175; and

(b) The remaining income is budgeted using the appropriate budgeting method for the assistance unit.

(4) If the individual receives Veteran's Administration Educational Assistance:

(a) All applicable attendance costs are subtracted; and

(b) The remaining unearned income is budgeted using the appropriate budgeting method for the assistance unit.

NEW SECTION

WAC 182-509-0045 MCS income—Employment and training programs. This section applies to medical care services (MCS).

(1) All payments issued under the Workforce Investment Act (WIA) are excluded.

(2) All payments issued under the National and Community Service Trust Act of 1993 are excluded. This includes payments made through the AmeriCorps program.

(3) All payments issued under Title I of the Domestic Volunteer Act of 1973, such as VISTA, AmeriCorps Vista, university year for action, and urban crime prevention program are excluded.

(4) All payments issued under Title II of the Domestic Volunteer Act of 1973 are excluded. These include:

(a) Retired senior volunteer program (RSVP);

(b) Foster grandparents program; and

(c) Senior companion program.

(5) Training allowances from vocational and rehabilitative programs are counted as earned income when:

(a) The program is recognized by federal, state, or local governments; and

(b) The allowance is not a reimbursement.

(6) When an MCS client receives training allowances, the following is allowed:

(a) The earned income incentive and work expense deduction specified under WAC 182-509-0175, when applicable; and

(b) The actual cost of uniforms or special clothing required for the course as a deduction, if enrolled in a remedial education or vocational training course.

NEW SECTION

WAC 182-509-0055 MCS income—Needs-based assistance from other agencies or organizations. (1) Needs-based assistance given to the individual by other agencies or organizations is not counted if the assistance is given for reasons other than ongoing living expenses which do not duplicate the purpose of DSHS cash assistance programs. Ongoing living expenses include the following items:

(a) Clothing;

(b) Food;

(c) Household supplies;

(d) Medical supplies (nonprescription);

(e) Personal care items;

(f) Shelter;

(g) Transportation; and

(h) Utilities (e.g., lights, cooking fuel, the cost of heating or heating fuel).

(2) **"Needs-based"** means eligibility is based on an asset test of income and resources relative to the federal poverty level (FPL). This definition excludes such incomes as retirement benefits or unemployment compensation which are not needs-based.

(3) If the needs-based assistance is countable, it is treated as unearned income under WAC 182-509-0025.

NEW SECTION

WAC 182-509-0065 MCS income—Gifts—Cash and noncash. This section applies to medical care services. A gift is an item furnished to an individual without work or cost on the individual's part.

(1) A cash gift is a gift that is furnished as money, cash, checks or any other readily negotiable form. Cash gifts totaling no more than thirty dollars per calendar quarter for each assistance unit member are disregarded as income.

(2) A noncash gift is treated as a resource.

(a) If the gift is a countable resource, its value is added to the value of the individual's existing countable resources and a determination is made on the impact to continue the individual's eligibility for MCS, per WAC 182-509-0005.

(b) If the gift is an excluded or noncountable resource, it does not affect the individual's eligibility or benefit level.

NEW SECTION

WAC 182-509-0080 MCS income—Self-employment income. This section applies to medical care services (MCS).

(1) Self-employment income is income that is earned by an individual from running a business, performing a service, selling items that are made by the individual or by reselling items to make a profit.

(2) An individual is self-employed if the individual earns income without having an employer/employee relationship with the person who pays for the goods or services. This includes, but is not limited to, when:

(a) The individual has primary control of the way they do their work; or

(b) Income is reported by the individual using IRS Schedule C, Schedule C-EZ, Schedule K-1, or Schedule SE.

(3) An individual usually is considered to have an employer/employee relationship when:

(a) The person the individual provides services for has primary control of how the individual does their work; or

(b) The individual gets an IRS form W-2 to report their income.

(4) Self-employment does not have to be a licensed business for the individual's business or activity to qualify as self-employment. Some examples of self-employment include:

(a) Childcare that requires a license under chapter 74.15 RCW;

(b) Driving a taxi cab;

(c) Farming/fishing;

(d) Odd jobs such as mowing lawns, house painting, gutter cleaning, or car care;

(e) Running a lodging for roomers and/or boarders. Roomer income includes money paid to the individual for shelter costs by someone not in your assistance unit who lives with the individual when:

(i) The individual owns or is buying their own residence; or

(ii) The individual rents all or a part of their residence and the total rent charges to all others living in the home is more than the individual's total rent.

(f) Running an adult family home;

(g) Providing services such as a massage therapist or a professional escort;

(h) Retainer fees to reserve a bed for a foster child;

(i) Selling items that are home-made or items that are supplied to the individual;

(j) Selling or donating biological products such as providing blood or reproductive material for profit;

(k) Working as an independent contractor; and

(l) Running a business or trade either as a sole proprietorship or in a partnership.

(5) If the individual is an employee of a company or person who does the activities listed in subsection (2) of this section as a part of their job, the agency or the agency's designee does not count the work that is performed by the individual as self-employment.

(6) Self-employment income is counted as earned income as described in WAC 182-509-0030 except as described in subsection (7) of this section.

(7) There are special rules about renting or leasing out property or real estate that is owned by the individual. If the individual does not spend at least twenty hours per week managing the property, the income is counted as unearned income.

NEW SECTION

WAC 182-509-0085 MCS income—Self-employment income—Calculation of countable income. This section applies to medical care services (MCS). The agency or the agency's designee decides how much of an individual's self-employment income to count by:

(1) Counting actual income in the month of application. This is done by:

(a) Adding together the individual's gross self-employment income and any profit the individual made from selling their business property or equipment;

(b) Subtracting the individual's business expenses as described in subsection (2) of this section; and

(c) Dividing the remaining amount of self-employment income by the number of months over which the income will be averaged.

(2) Subtracting one hundred dollars as a business expense even if the individual's costs are less than this. If the individual's costs are more than one hundred dollars, the agency or the agency's designee may subtract the individual's actual costs if the individual provides proof of their expenses. The following expenses are never allowed:

(a) Federal, state, and local income taxes;

(b) Money set aside for retirement purposes;

(c) Personal work-related expenses (such as travel to and from work);

(d) Net losses from previous periods;

(e) Depreciation; or

(f) Any amount that is more than the payment the individual gets from a boarder for lodging and meals.

(3) If the individual has worked at their business for less than a year, figuring the individual's gross self-employment income by averaging:

(a) The income over the period of time the business has been in operation; and

(b) The monthly amount is estimated to be the amount the individual will get for the coming year.

(4) If the individual's self-employment expenses are more than their self-employment income, not using this "loss" to reduce income from other self-employment businesses or other sources of income to the assistance unit.

NEW SECTION

WAC 182-509-0095 MCS income—Allocating income—General. This section applies to medical care services (MCS).

(1) Allocation is the process of determining how much of a financially responsible person's income is considered available to meet the needs of legal dependents within or outside of an assistance unit (AU).

(2) **"In-bound allocation"** means income possessed by a financially responsible person outside the AU which is considered available to meet the needs of legal dependents in the AU.

(3) **"Out-bound allocation"** means income possessed by a financially responsible AU member which is set aside to meet the needs of a legal dependent outside the AU.

NEW SECTION

WAC 182-509-0100 MCS income—Allocating income—Definitions. The following definitions apply to the allocation rules for medical care services (MCS):

(1) **"Dependent"** means a person who:

(a) Is or could be claimed for federal income tax purposes by the financially responsible person; or

(b) The financially responsible person is legally obligated to support.

(2) **"Financially responsible person"** means a parent, stepparent, adoptive parent, spouse or caretaker relative.

(3) **"Ineligible assistance unit member"** means a person who is:

(a) Ineligible for MCS due to the citizenship/alien status requirements in WAC 182-503-0532;

(b) Ineligible to receive MCS under WAC 182-503-0560 for fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime; or

(c) Ineligible to receive MCS under WAC 182-503-0560 for violating a condition of probation or parole which was imposed under federal or state law as determined by an administrative body or court of competent jurisdiction.

NEW SECTION

WAC 182-509-0110 MCS income—Allocating income to legal dependents. This section applies to medical care services (MCS).

(1) The income of an individual is reduced by the following:

(a) The MCS earned income work incentive deduction as specified in WAC 182-509-0175; and

(b) An amount not to exceed the ordered amount paid for court or administratively ordered current or back support for legal dependents living outside the home.

(2) When an individual resides in a medical institution, alcohol or drug treatment center, boarding home, or adult family home and has income, the individual retains an amount equal to:

(a) The eligibility standard amount for the nonapplying spouse living in the home; and

(b) The standard of assistance or personal needs allowance the individual is eligible for based upon their living arrangement.

(3) An individual with countable income remaining after the allocation in subsection (2)(a) and (b) of this section is not eligible for medical care services (MCS).

NEW SECTION

WAC 182-509-0135 MCS income—Allocating income of an ineligible spouse to a medical care services (MCS) client. This section applies to medical care services (MCS). When an individual is married and lives with the nonapplying spouse, the following income is available to the individual:

(1) The remainder of the individual's wages, retirement benefits or separate property after reducing the income by:

(a) The MCS earned income work incentive deduction as specified in WAC 182-509-0175; and

(b) An amount not to exceed the ordered amount paid for court or administratively ordered current or back support for legal dependents living outside the home.

(2) The remainder of the nonapplying spouse's wages, retirement benefits and separate property after reducing the income by:

(a) An amount not to exceed the ordered amount paid for court or administratively ordered current or back support for legal dependents living outside the home, when the order is a separate order from the applying individual's order; and

(b) The one-person eligibility standard amount as specified under WAC 182-508-0230 which includes ineligible assistance unit members.

(3) One-half of all other community income, as provided in WAC 182-509-0005.

NEW SECTION

WAC 182-509-0155 MCS income—Exemption from sponsor deeming for medical care services (MCS). This section applies to medical care services (MCS).

(1) An individual who meets any of the following conditions is permanently exempt from deeming and none of a sponsor's income or resources are counted when determining eligibility for MCS:

(a) The Immigration and Nationality Act (INA) does not require the individual to have a sponsor. Immigrants who are not required to have a sponsor include those with the following status with United States Citizenship and Immigration Services (USCIS):

(i) Refugee;

(ii) Parolee;

(iii) Asylee;

(iv) Cuban/Haitian entrant; or

(v) Special immigrant from Iraq or Afghanistan.

(b) The sponsor is an organization or group as opposed to an individual;

(c) The individual does not meet the alien status requirements to be eligible for benefits under WAC 182-503-0532;

(d) The individual has worked or can get credit for forty qualifying quarters of work under Title II of the Social Security Act. If the individual worked during a quarter in which

they received TANF, Basic Food, SSI, CHIP, or nonemergency medicaid benefits, a quarter of work is not counted towards the forty quarters. A quarter of work by the following people is also counted toward the forty qualifying quarters:

(i) The individual;

(ii) The individual's parents for the time they worked before the individual turned eighteen years old (including the time they worked before the individual was born); and

(iii) The individual's spouse if still married or if the spouse is deceased.

(e) The individual becomes a United States (U.S.) citizen;

(f) The individual's sponsor is dead; or

(g) If USCIS or a court decides that the individual, their child, or their parent was a victim of domestic violence from the sponsor and:

(i) The individual no longer lives with the sponsor; and

(ii) Leaving the sponsor caused the need for benefits.

(2) While the individual is in the same assistance unit (AU) as their sponsor, they are exempt from the deeming process. An individual is also exempt from the deeming process if:

(a) The sponsor signed the affidavit of support more than five years ago;

(b) The sponsor becomes permanently incapacitated; or

(c) The individual is a qualified alien according to WAC 388-424-0001 and:

(i) Is on active duty with the U.S. armed forces or the individual is the spouse or unmarried dependent child of someone on active duty;

(ii) Is an honorably discharged veteran of the U.S. armed forces or the individual is the spouse or unmarried dependent child of an honorably discharged veteran;

(iii) Was employed by an agency of the U.S. government or served in the armed forces of an allied country during a military conflict between the U.S. and a military opponent; or

(iv) Is a victim of domestic violence and the individual has petitioned for legal status under the Violence Against Women Act.

(3) If the individual, their child, or their parent was a victim of domestic violence, the individual is exempt from the deeming process for twelve months if:

(a) The individual no longer lives with the person who committed the violence; and

(b) Leaving this person caused the need for benefits.

(4) If the AU has income at or below one hundred thirty percent of the federal poverty level (FPL), the individual is exempt from the deeming process for twelve months. This is called the "indigence exemption." For this rule, the following is counted as income to the AU:

(a) Earned and unearned income the AU receives from any source; and

(b) Any noncash items of value such as free rent, commodities, goods, or services that are received from an individual or organization.

(5) If the individual chooses to use the indigence exemption, and is eligible for a state program, this information is not reported to the United States Attorney General.

(6) If the individual chooses not to use the indigence exemption:

(a) The individual could be found ineligible for benefits for not verifying the income and resources of the sponsor; or

(b) The individual will be subject to regular deeming rules under this section.

NEW SECTION

WAC 182-509-0165 MCS income—Income calculation. This section applies to medical care services (MCS).

(1) Countable income is all income that is available to the assistance unit (AU) after the following is subtracted:

(a) Excluded or disregarded income under WAC 182-509-0015;

(b) The earned income work incentive deduction under WAC 182-509-0175;

(c) Income that is allocated to someone outside of the AU under WAC 182-509-0110 through 182-509-0135.

(2) Countable income includes all income that must be counted because it is deemed or allocated from financially responsible persons who are not members of the AU under WAC 182-509-0110 through 182-509-0165.

(3) Countable income is compared to the eligibility standards under WAC 182-508-0230.

(4) If countable income available to the AU is equal to or greater than the eligibility standard, the individual is not eligible for medical care services (MCS).

NEW SECTION

WAC 182-509-0175 MCS income—Earned income work incentive deduction. This section applies to medical care services (MCS).

(1) When determining eligibility for MCS, the agency or the agency's designee allows an earned income work incentive deduction of fifty percent of an individual's gross earned income.

(2) This deduction is used to reduce countable income before comparing the income to the eligibility standard for the program.

NEW SECTION

WAC 182-509-0200 MCS resources—How resources affect eligibility for medical care services (MCS). This section applies to medical care services (MCS).

(1) The following definitions apply to this chapter:

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

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

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

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

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

(iii) Received as a gift or inheritance.

(2) A resource is counted towards the resource limit described in subsection (6) of this section when:

(a) It is a resource that must be counted under WAC 182-509-0205;

(b) The individual owns the resource. Ownership means:

(i) The individual's name is on the title to the property; or

(ii) The individual has property that doesn't have a title; and

(c) The individual has control over the resource, which means the resource is actually available to the individual; and

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

(3) The individual must try to make their resources available even if it will take more than twenty days to do so, unless:

(a) There is a legal barrier; or

(b) A court must be petitioned to release part or all of a resource.

(4) Resources are counted as of the date of application for MCS coverage.

(5) If total countable resources are over the resource limit in subsection (6) of this section, the individual is not eligible for MCS.

(6) Countable resources must be below the standards listed below based on the equity value of all countable resources.

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

(b) Recipients can have an additional three thousand dollars in a savings account.

(7) If the individual owns a countable resource with someone who is not included in the assistance unit (AU), only the portion of the resource that is owned by the individual is counted. If ownership of the funds cannot be determined, an equal portion of the resource is presumed to be owned by the individual and all other joint owners.

(8) It is assumed an individual has control of community property and is legally able to sell the property or convert it to cash unless evidence is provided to show the individual does not have control of the property.

(9) An item may not be considered separate property if the individual used both separate and community funds to buy or improve it.

(10) The resources of victims of family violence are not counted when:

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

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

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

(11) An individual may provide proof about a resource anytime, including when asked for proof by the agency or the agency's designee, or if the individual disagrees with a decision made about:

(a) Who owns a resource;

(b) Who has legal control of the resource;

(c) The value of a resource;

(d) The availability of a resource; or

(e) The portion of a property owned by the individual or another person(s).

(12) Resources of certain people who live in the home with the individual are countable, even if they are not getting assistance. Resources that count toward the resource limit in subsection (6) of this section include the resources of ineligible or financially responsible people as defined in WAC 182-509-0100.

NEW SECTION

WAC 182-509-0205 MCS resources—How resources count toward the resource limits for medical care services (MCS). This section applies to medical care services (MCS).

(1) The following resources count toward the resource limit described in WAC 182-509-0200:

(a) Liquid resources not specifically excluded in subsection (2) of this section. These are resources that are easily changed into cash. Some examples of liquid resources are:

(i) Cash on hand;

(ii) Money in checking or savings accounts;

(iii) Money market accounts or certificates of deposit (CDs) less any withdrawal penalty;

(iv) Available retirement funds or pension benefits, less any withdrawal penalty;

(v) Stocks, bonds, annuities, or mutual funds less any early withdrawal penalty;

(vi) Available trusts or trust accounts;

(vii) Lump sum payments as described in chapter 388-455 WAC; or

(viii) Any funds retained beyond the month of receipt from conversion of federally protected rights or extraction of exempt resources by members of a federally recognized tribe that are in the form of countable resources.

(b) The cash surrender value (CSV) of whole life insurance policies.

(c) The CSV over fifteen hundred dollars of revocable burial insurance policies or funeral agreements.

(d) Funds withdrawn from an individual development account (IDA) if they were removed for a purpose other than those specified in RCW 74.08A.220.

(e) Any real property like a home, land, or buildings not specifically excluded in subsection (3) of this section.

(f) The equity value of vehicles as described in WAC 182-509-0210.

(g) Personal property that is not:

(i) A household good;

(ii) Needed for self-employment; or

(iii) Of "great sentimental value," due to personal attachment or hobby interest.

(h) Resources of a sponsor as described in WAC 388-470-0060.

(i) Sales contracts.

(2) The following types of liquid resources are not counted toward the resource limit described in WAC 182-509-0200 when determining eligibility for MCS:

(a) Bona fide loans, including student loans;

(b) Basic food benefits;

(c) Income tax refunds for twelve months from the date of receipt;

(d) Earned income tax credit (EITC) in the month received and for up to twelve months;

(e) Advance earned income tax credit payments;

(f) Federal economic stimulus payments that are excluded for federal and federally assisted state programs;

(g) Individual development accounts (IDAs) established under RCW 74.08A.220;

(h) Retroactive cash benefits or TANF/SFA benefits resulting from a court order modifying a decision of the department;

(i) Underpayments received under chapter 388-410 WAC;

(j) Educational benefits that are excluded as income under WAC 182-509-0035;

(k) The income and resources of an SSI recipient;

(l) A bank account jointly owned with an SSI recipient if SSA already counted the money for SSI purposes;

(m) Foster care payments provided under Title IV-E and/or state foster care maintenance payments;

(n) Adoption support payments;

(o) Self-employment accounts receivable that the individual has billed to the customer but has been unable to collect;

(p) Resources specifically excluded by federal law; and

(q) Receipts from exercising federally protected rights or extracted exempt resources (fishing, shell fishing, timber sales, etc.) during the month of receipt for a member of a federally recognized tribe.

(3) The following types of real property are not counted when determining eligibility for MCS coverage:

(a) A home where the individual, their spouse, or their dependents live, including the surrounding property;

(b) A house the individual does not live in but plans to return to, and the individual is out of the home because of:

(i) Employment;

(ii) Training for future employment;

(iii) Illness; or

(iv) Natural disaster or casualty.

(c) Property that:

(i) The individual is making a good faith effort to sell;

(ii) The individual intends to build a home on, if they do not already own a home;

(iii) Produces income consistent with its fair market value (FMV), even if used only on a seasonal basis; or

(iv) A household member needs for employment or self-employment. Property excluded under this section and used by a self-employed farmer or fisher retains its exclusion for one year after the household member stops farming or fishing.

(d) Indian lands held jointly with the tribe, or land that can be sold only with the approval of the Bureau of Indian Affairs.

(4) If the individual deposits excluded liquid resources into a bank account with countable liquid resources, the excluded liquid resources are not counted for six months from the date of deposit.

(5) If the individual sells their home, the individual has ninety days to reinvest the proceeds from the sale of a home into an exempt resource.

(a) If the individual does not reinvest within ninety days, the agency or the agency's designee will determine whether there is good cause to allow more time. Some examples of good cause are:

(i) Closing on a new home is taking longer than anticipated;

(ii) The individual is unable to find a new home that is affordable;

(iii) Someone in the household is receiving emergent medical care; or

(iv) The individual has children or dependents that are in school and moving would require them to change schools.

(b) If good cause is determined, more time will be allowed based on the individual's circumstances.

(c) If good cause is not determined, the money received from the sale of the home is considered a countable resource.

NEW SECTION

WAC 182-509-0210 MCS resources—How vehicles count toward the resource limit for medical care services (MCS). This rule applies to medical care services (MCS).

(1) A vehicle is any device for carrying persons and objects by land, water, or air.

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

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

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

WAC 182-538-063 ((~~GAU~~)) MCS clients residing in a designated mandatory managed care plan county. (1) In Laws of 2007, chapter 522, section 209 (13) and (14), the legislature authorized the department to provide coverage of certain medical and mental health benefits to clients who:

(a) ((~~Receive~~)) Are eligible for medical care services (MCS) under ((~~the general assistance unemployable (GAU) program~~)) WAC 182-508-0005; and

(b) Reside in a county designated by the ((~~department~~)) agency as a mandatory managed care plan county.

(2) The only sections of chapter ((~~388-538~~)) 182-538 WAC that apply to ((~~GAU~~)) MCS clients described in this section are incorporated by reference into this section.

(3) ((~~GAU~~)) MCS clients who reside in a county designated by the department as a mandatory managed care plan county must enroll in a managed care plan as required by WAC ((~~388-505-0110(7)~~)) 182-508-0001 to receive ((~~department paid~~)) agency-paid medical care. ((~~A GAU~~)) An MCS client enrolled in an MCO plan under this section is defined as ((~~a GAU~~)) an MCS enrollee.

(4) ((~~GAU~~)) MCS clients are exempt from mandatory enrollment in managed care if they are American Indian or Alaska Native (AI/AN) and meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally recognized tribal members and their descendants.

(5) The ((~~department~~)) agency exempts ((~~a GAU~~)) an MCS client from mandatory enrollment in managed care:

(a) If the ((~~GAU~~)) MCS client resides in a county that is not designated by the ((~~department~~)) agency as a mandatory MCO plan county; or

(b) In accordance with WAC ((~~388-538-130~~)) 182-538-130(3).

(6) The ((~~department~~)) agency ends ((~~a GAU~~)) an MCS enrollee's enrollment in managed care in accordance with WAC ((~~388-538-130~~)) 182-538-130(4).

(7) On a case-by-case basis, the ((~~department~~)) agency may grant ((~~a GAU~~)) an MCS client's request for exemption from managed care or ((~~a GAU~~)) an MCS enrollee's request to end enrollment when, in the ((~~department's~~)) agency's judgment:

(a) The client or enrollee has a documented and verifiable medical condition; and

(b) Enrollment in managed care could cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(8) The ((~~department~~)) agency enrolls ((~~GAU~~)) MCS clients in managed care effective on the earliest possible date, given the requirements of the enrollment system. The ((~~department~~)) agency does not enroll clients in managed care on a retroactive basis.

(9) Managed care organizations (MCOs) that contract with the ((~~department~~)) agency to provide services to ((~~GAU~~)) MCS clients must meet the qualifications and requirements in WAC ((~~388-538-067~~)) 182-538-067 and ((~~388-538-095~~)) 182-538-095 (3)(a), (b), (c), and (d).

(10) The ((~~department~~)) agency pays MCOs capitated premiums for ((~~GAU~~)) MCS enrollees based on legislative allocations for the ((~~GAU~~)) MCS program.

(11) ((~~GAU~~)) MCS enrollees are eligible for the scope of care as described in WAC ((~~388-501-0060~~)) 182-501-0060 for medical care services (MCS) programs.

(a) ((~~A GAU~~)) An MCS enrollee is entitled to timely access to medically necessary services as defined in WAC ((~~388-500-0005~~)) 182-500-0070;

(b) MCOs cover the services included in the managed care contract for ((~~GAU~~)) MCS enrollees. MCOs may, at their discretion, cover services not required under the MCO's contract for ((~~GAU~~)) MCS enrollees;

(c) The ((~~department~~)) agency pays providers on a fee-for-service basis for the medically necessary, covered medical care services not covered under the MCO's contract for ((~~GAU~~)) MCS enrollees;

(d) ((~~A GAU~~)) An MCS enrollee may obtain:

(i) Emergency services in accordance with WAC ((~~388-538-100~~)) 182-538-100; and

(ii) Mental health services in accordance with this section.

(12) The ((~~department~~)) agency does not pay providers on a fee-for-service basis for services covered under the MCO's contract for ((~~GAU~~)) MCS enrollees, even if the MCO has not paid for the service, regardless of the reason. The MCO is solely responsible for payment of MCO-contracted healthcare services that are:

(a) Provided by an MCO-contracted provider; or

(b) Authorized by the MCO and provided by nonparticipating providers.

(13) The following services are not covered for ((~~GAU~~)) MCS enrollees unless the MCO chooses to cover these services at no additional cost to the ((~~department~~)) agency:

(a) Services that are not medically necessary;

(b) Services not included in the medical care services scope of care, unless otherwise specified in this section;

(c) Services, other than a screening exam as described in WAC ((~~388-538-100~~)) 182-538-100(3), received in a hospital emergency department for nonemergency medical conditions; and

(d) Services received from a nonparticipating provider requiring prior authorization from the MCO that were not authorized by the MCO.

(14) A provider may bill ((~~a GAU~~)) an MCS enrollee for noncovered services described in subsection (12) of this section, if the requirements of WAC ((~~388-502-0160~~)) 182-502-0160 and ((~~388-538-095~~)) 182-538-095(5) are met.

(15) Mental health services and care coordination are available to ((~~GAU~~)) MCS enrollees on a limited basis, subject to available funding from the legislature and an appropriate delivery system.

(16) A care coordinator (a person employed by the MCO or one of the MCO's subcontractors) provides care coordination to ((~~a GAU~~)) an MCS enrollee in order to improve access to mental health services. Care coordination may include brief, evidenced-based mental health services.

(17) To ensure ((~~a GAU~~)) an MCS enrollee receives appropriate mental health services and care coordination, the ((~~department~~)) agency requires the enrollee to complete at least one of the following assessments:

(a) A physical evaluation;

(b) A psychological evaluation;

(c) A mental health assessment completed through the client's local community mental health agency (CMHA) and/or other mental health agencies;

(d) A brief evaluation completed through the appropriate care coordinator located at a participating community health center (CHC);

(e) An evaluation by the client's primary care provider (PCP); or

(f) An evaluation completed by medical staff during an emergency room visit.

(18) ((~~A GAU~~)) An MCS enrollee who is screened positive for a mental health condition after completing one or more of the assessments described in subsection (17) of this section may receive one of the following levels of care:

(a) **Level 1.** Care provided by a care coordinator when it is determined that the ((~~GAU~~)) MCS enrollee does not require Level 2 services. The care coordinator will provide the following, as determined appropriate and available:

(i) Evidenced-based behavioral health services and care coordination to facilitate receipt of other needed services.

(ii) Coordination with the PCP to provide medication management.

(iii) Referrals to other services as needed.

(iv) Coordination with consulting psychiatrist as necessary.

(b) **Level 2.** Care provided by a contracted provider when it is determined that the ((~~GAU~~)) MCS enrollee requires services beyond Level 1 services. A care coordinator

refers the ((~~GAU~~)) MCS enrollee to the appropriate provider for services:

(i) A regional support network (RSN) contracted provider; or

(ii) A contractor-designated entity.

(19) Billing and reporting requirements and payment amounts for mental health services and care coordination provided to ((~~GAU~~)) MCS enrollees are described in the contract between the MCO and the ((~~department~~)) agency.

(20) The total amount the ((~~department~~)) agency pays in any biennium for services provided pursuant to this section cannot exceed the amount appropriated by the legislature for that biennium. The ((~~department~~)) agency has the authority to take whatever actions necessary to ensure the ((~~department~~)) agency stays within the appropriation.

(21) Nothing in this section shall be construed as creating a legal entitlement to any ((~~GAU~~)) MCS client for the receipt of any medical or mental health service by or through the ((~~department~~)) agency.

(22) An MCO may refer enrollees to the ((~~department's~~)) agency's patient review and coordination (PRC) program according to WAC ((~~388-501-0135~~)) 182-501-0135.

(23) The grievance and appeal process found in WAC ((~~388-538-110~~)) 182-538-110 applies to ((~~GAU~~)) MCS enrollees described in this section.

(24) The hearing process found in chapter ((~~388-02~~)) 182-526 WAC and WAC ((~~388-538-112~~)) 182-538-112 applies to ((~~GAU~~)) MCS enrollees described in this section.

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

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

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

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

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

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

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

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

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

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

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-556-0500	Medical care services under state-administered cash programs.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-505-0110	Medical assistance coverage for adults not covered under family medical programs.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 388-800-0020	What detoxification services will the department pay for?
WAC 388-800-0025	What information does the department use to decide if I am eligible for the detoxification program?
WAC 388-800-0030	Who is eligible for detoxification services?
WAC 388-800-0035	How long am I eligible to receive detoxification services?
WAC 388-800-0048	Who is eligible for ADATSA?
WAC 388-800-0110	What cash benefits am I eligible for through ADATSA if I am in residential treatment?
WAC 388-800-0115	What cash benefits can I receive through ADATSA if I am in outpatient treatment?
WAC 388-800-0130	What are ADATSA shelter services?
WAC 388-800-0135	When am I eligible for ADATSA shelter services?
WAC 388-800-0140	What incapacity criteria must I meet to be eligible for ADATSA shelter services?
WAC 388-800-0145	How does the department review my eligibility for ADATSA shelter services?

WAC 388-800-0150	Who is my protective payee?
WAC 388-800-0155	What are the responsibilities of my protective payee?
WAC 388-800-0160	What are the responsibilities of an intensive protective payee?
WAC 388-800-0165	What happens if my relationship with my protective payee ends?

WSR 12-06-029
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 12-22—Filed March 1, 2012, 1:13 p.m., effective March 16, 2012]

Effective Date of Rule: March 16, 2012.

Purpose: Amend recreational fishing rules.

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

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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

Reasons for this Finding: This emergency rule is needed to increase the steelhead spawning closure by two weeks to further protect wild steelhead. There is insufficient time to adopt permanent rules.

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

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

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

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

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

Date Adopted: March 1, 2012.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 232-28-61900E Exceptions to statewide rules—South Fork Toutle River. Notwithstanding the provisions of WAC 232-28-619, effective March 16, through June 2, 2012, it is unlawful to fish in waters of the South Fork Toutle River from the mouth to the 4100 Road Bridge.

REPEALER

The following section of the Washington Administrative Code is repealed effective June 3, 2012:

WAC 232-28-61900E	Exceptions to statewide rules—South Fork Toutle River.

WSR 12-06-033
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 12-29—Filed March 2, 2012, 11:14 a.m., effective March 2, 2012, 11:14 a.m.]

Effective Date of Rule: Immediately.

Purpose: Amend recreational fishing rules.

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

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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

Reasons for this Finding: This emergency rule is needed to increase the steelhead spawning closure by two weeks to further protect wild steelhead. There is insufficient time to adopt permanent rules.

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

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

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

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

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

Date Adopted: March 2, 2012.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 232-28-61900F Exceptions to statewide rules—South Fork Toutle River. Notwithstanding the provisions of WAC 232-28-619, effective March 16, through June 1, 2012, it is unlawful to fish in waters of the South Fork Toutle River from the mouth to the 4100 Road Bridge.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 232-28-61900E	Exceptions to statewide rules—South Fork Toutle River. (12-22)

The following section of the Washington Administrative Code is repealed effective June 2, 2012:

WAC 232-28-61900F	Exceptions to statewide rules—South Fork Toutle River.

WSR 12-06-041
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 12-27—Filed March 2, 2012, 2:33 p.m., effective March 5, 2012, 6:00 p.m.]

Effective Date of Rule: March 5, 2012, 6:00 p.m.

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

Citation of Existing Rules Affected by this Order: Repealing WAC 220-32-05100N; and amending WAC 220-32-051.

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

Other Authority: *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546); *Northwest Gillnetters Ass'n v. Sandison*, 95 Wn.2d 638, 628 P.2d 800 (1981); Washington fish and wildlife commission policies concerning Columbia River fisheries; 40 Stat. 515 (Columbia River compact).

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

Reasons for this Finding: Closes Bonneville Pool (1F) for sales of sturgeon effective 6:00 p.m. March 5, 2012, as catch is near the quota set for that area. Fisheries are consistent with the 2008-2017 management agreement and the associated biological opinion. Rule is consistent with action of the Columbia River compact on January 26, 2012, and March 1, 2012. Conforms state rules with tribal rules. There is insufficient time to adopt permanent regulations.

The Yakama, Warm Springs, Umatilla, and Nez Perce Indian tribes have treaty fishing rights in the Columbia River and inherent sovereign authority to regulate their fisheries. Washington and Oregon also have some authority to regulate fishing by treaty Indians in the Columbia River, authority that the states exercise jointly under the congressionally ratified Columbia River compact. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969). The tribes and the states adopt parallel regulations for treaty Indian fisheries under the supervision of the federal courts. A court order sets the current parameters. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546). Some salmon and steelhead stocks in the Columbia River are listed as threatened or endangered under the federal ESA. On May 5, 2008, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allows for some incidental take of these species in the fisheries as described in the 2008-2017 *U.S. v. Oregon* Management Agreement.

Columbia River fisheries are monitored very closely to ensure consistency with court orders and ESA guidelines. Because conditions change rapidly, the fisheries are managed almost exclusively by emergency rule. As required by court order, the Washington (WDFW) and Oregon (ODFW) departments of fish and wildlife convene public hearings and invite tribal participation when considering proposals for new emergency rules affecting treaty fishing rights. *Sohappy*, 302 F. Supp. at 912. WDFW and ODFW then adopt regulations reflecting agreements reached.

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

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

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

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

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

Date Adopted: March 2, 2012.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-32-05100P Columbia River salmon seasons above Bonneville Dam. Notwithstanding the provisions of WAC 220-32-050, WAC 220-32-051, WAC 220-32-052 and WAC 220-32-058, effective immediately until further notice, it is unlawful for a person to take or possess salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch taken for commercial purposes in Columbia River Salmon Management and Catch Reporting Areas 1F, 1G, and 1H. However, those individuals possessing treaty fishing rights under the Yakima, Warm Springs, Umatilla, and Nez Perce treaties may fish for salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch under the following provisions:

1. Open Areas: SMCRA 1G:

a. Season: Immediately through 6:00 p.m. March 21, 2012.

b. Gear: Gill nets, hoop nets, dip bag nets, and rod and reel with hook and line. No mesh restriction on gillnets.

c. Allowable sale: Steelhead, sturgeon, shad, carp, catfish, walleye, bass, and yellow perch and sturgeon between 43-54 inches in fork length in The Dalles pool (1G) may be sold or retained for subsistence purposes. Sturgeon between 38-54 inches in fork length in the Bonneville Pool (1F) and between 43-54 inches in fork length in the John Day pool (1H) may only be retained for subsistence purposes. Live release of all oversize and under-size sturgeon is required. Fish caught from platforms or hook-and-line fisheries in open commercial areas and caught during open periods are allowed to be sold.

d. River mouth sanctuaries (WAC 220-32-058) remain in effect, except for the Spring Creek Hatchery sanctuary (sub-section 5) of WAC 220-32-058.

2. Open Area: SMCRA 1E. Each of the four Columbia River treaty tribes has an MOA or MOU with the Washington Department of Fish and Wildlife regarding tribal fisheries in the area just downstream of Bonneville Dam. Tribal fisheries in this area may only occur in accordance with the appropriate MOA or MOU specific to each tribe.

a. Participants: Tribal members may participate under the conditions described in the appropriate MOA or MOU specific to each tribe. Tribal members must carry an official tribal enrollment card.

b. Season: Immediately until further notice.

c. Gear: Hoop nets, dip bag nets, and rod and reel with hook-and-line, or as defined by each tribe's MOU or MOA.

d. Allowable sales: Steelhead, shad, carp, catfish, walleye, bass, and yellow perch. Sturgeon retention is prohibited; sturgeon may not be sold or retained for ceremonial or subsistence purposes. Sales may not occur on USACE property.

e. 24-hour quick reporting required for Washington wholesale dealers, WAC 220-69-240, for all areas.

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

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

REPEALER

The following section of the Washington Administrative Code is repealed effective 6:00 p.m. March 5, 2012:

WAC 220-32-05100N	Columbia River salmon seasons above Bonneville Dam. (12-24)

WSR 12-06-058
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 12-30—Filed March 5, 2012, 2:50 p.m., effective March 5, 2012, 2:50 p.m.]

Effective Date of Rule: Immediately.

Purpose: Amend recreational fishing rules.

Citation of Existing Rules Affected by this Order: Repealing WAC 220-56-35000R; and amending WAC 220-56-350.

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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

Reasons for this Finding: Shifting the season timing of these two adjacent beaches allows sport harvesters a continuous opportunity from March through April. There is insufficient time to adopt permanent rules.

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

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

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

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

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

Date Adopted: March 5, 2012.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-56-35000R Clams other than razor clams—Areas and seasons. Notwithstanding the provisions of WAC 220-56-350, effective immediately until further

notice, it is unlawful to take, dig for and possess clams, cockles, and mussels taken for personal use from the following public tidelands except during the open periods specified herein:

(1) Point Whitney Tidelands (excluding Lagoon): Open immediately through March 31, 2012.

(2) Point Whitney Lagoon: Open April 1 through April 30, 2012.

REPEALER

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

WAC 220-56-35000R	Clams other than razor clams—Areas and seasons.

WSR 12-06-062
EMERGENCY RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 12-34—Filed March 5, 2012, 3:59 p.m., effective March 5, 2012, 6:00 p.m.]

Effective Date of Rule: March 5, 2012, 6:00 p.m.

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

Citation of Existing Rules Affected by this Order: Repealing WAC 220-32-05100P; and amending WAC 220-32-051.

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

Other Authority: *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546); *Northwest Gillnetters Ass'n v. Sandison*, 95 Wn.2d 638, 628 P.2d 800 (1981); Washington fish and wildlife commission policies concerning Columbia River fisheries; 40 Stat. 515 (Columbia River compact).

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

Reasons for this Finding: Extends the season in Bonneville Pool (1F) for sales of sturgeon until 12:00 p.m., March 6, 2012. Safety concerns surrounding poor weather conditions triggered an emergency eighteen hour extension to allow fisherman [fishermen] time to remove gear from the water without undue risk. Fisheries are consistent with the 2008-2017 management agreement and the associated biological opinion. Rule is consistent with action of the Columbia River compact on January 26, 2012, and March 1, 2012. Conforms state rules with tribal rules. There is insufficient time to adopt permanent regulations.

The Yakama, Warm Springs, Umatilla, and Nez Perce Indian tribes have treaty fishing rights in the Columbia River and inherent sovereign authority to regulate their fisheries. Washington and Oregon also have some authority to regulate fishing by treaty Indians in the Columbia River, authority that the states exercise jointly under the congressionally ratified Columbia River compact. *Sohappy v. Smith*, 302 F. Supp. 899 (D. Or. 1969). The tribes and the states adopt parallel regulations for treaty Indian fisheries under the supervision of the federal courts. A court order sets the current parameters. *United States v. Oregon*, Civil No. 68-513-KI (D. Or.), Order Adopting 2008-2017 *United States v. Oregon* Management Agreement (Aug. 12, 2008) (Doc. No. 2546). Some salmon and steelhead stocks in the Columbia River are listed as threatened or endangered under the federal ESA. On May 5, 2008, the National Marine Fisheries Service issued a biological opinion under 16 U.S.C. § 1536 that allows for some incidental take of these species in the fisheries as described in the 2008-2017 *U.S. v. Oregon* Management Agreement.

Columbia River fisheries are monitored very closely to ensure consistency with court orders and ESA guidelines. Because conditions change rapidly, the fisheries are managed almost exclusively by emergency rule. As required by court order, the Washington (WDFW) and Oregon (ODFW) departments of fish and wildlife convene public hearings and invite tribal participation when considering proposals for new emergency rules affecting treaty fishing rights. *Sohappy*, 302 F. Supp. at 912. WDFW and ODFW then adopt regulations reflecting agreements reached.

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

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

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

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

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

Date Adopted: March 5, 2012.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-32-05100Q Columbia River salmon seasons above Bonneville Dam. Notwithstanding the provisions of WAC 220-32-050, WAC 220-32-051, WAC 220-32-052 and WAC 220-32-058, effective immediately until further notice, it is unlawful for a person to take or possess salmon, steelhead, sturgeon, shad, carp, catfish, walleye,

bass, or yellow perch taken for commercial purposes in Columbia River Salmon Management and Catch Reporting Areas 1F, 1G, and 1H. However, those individuals possessing treaty fishing rights under the Yakima, Warm Springs, Umatilla, and Nez Perce treaties may fish for salmon, steelhead, sturgeon, shad, carp, catfish, walleye, bass, or yellow perch under the following provisions:

1. Open Areas: SMCRA 1F, 1G:

a. Season: Immediately through 6:00 p.m. March 21, 2012, EXCEPT SMCRA 1F closes at 12:00 PM (noon) March 6, 2012.

b. Gear:Gill nets, hoop nets, dip bag nets, and rod and reel with hook and line. No mesh restriction on gillnets.

c. Allowable sale: Steelhead, sturgeon, shad, carp, catfish, walleye, bass, and yellow perch and sturgeon between 43-54 inches in fork length in The Dalles pool (1G) may be sold or retained for subsistence purposes. Sturgeon between 38-54 inches in fork length in the Bonneville Pool (1F) may be sold if caught prior to 12:00 PM (noon) March 6, 2012, otherwise may only be kept for subsistence. Sturgeon between 43-54 inches in fork length in the John Day pool (1H) may only be retained for subsistence purposes. Live release of all oversize and under-size sturgeon is required. Fish caught from platforms or hook-and-line fisheries in open commercial areas and caught during open periods are allowed to be sold.

d. River mouth sanctuaries (WAC 220-32-058) remain in effect, except for the Spring Creek Hatchery sanctuary (sub-section 5) of WAC 220-32-058.

2. Open Area: SMCRA 1E. Each of the four Columbia River treaty tribes has an MOA or MOU with the Washington Department of Fish and Wildlife regarding tribal fisheries in the area just downstream of Bonneville Dam. Tribal fisheries in this area may only occur in accordance with the appropriate MOA or MOU specific to each tribe.

a. Participants: Tribal members may participate under the conditions described in the appropriate MOA or MOU specific to each tribe. Tribal members must carry an official tribal enrollment card.

b. Season: Immediately until further notice.

c. Gear: Hoop nets, dip bag nets, and rod and reel with hook-and-line, or as defined by each tribe's MOU or MOA.

d. Allowable sales: Steelhead, shad, carp, catfish, walleye, bass, and yellow perch. Sturgeon retention is prohibited; sturgeon may not be sold or retained for ceremonial or subsistence purposes. Sales may not occur on USACE property.

e. 24-hour quick reporting required for Washington wholesale dealers, WAC 220-69-240, for all areas.

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

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

REPEALER

The following section of the Washington Administrative Code is repealed effective 6:01 p.m. March 5, 2012:

WAC 220-32-05100P	Columbia River salmon seasons above Bonneville Dam. (12-27)

WSR 12-06-075

EMERGENCY RULES

DEPARTMENT OF FISH AND WILDLIFE

[Order 12-32—Filed March 7, 2012, 9:02 a.m., effective March 10, 2012, 12:01 a.m.]

Effective Date of Rule: March 10, 2012, 12:01 a.m.

Purpose: Amend recreational fishing rules.

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

Statutory Authority for Adoption: RCW 77.12.047 and 77.04.020.

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

Reasons for this Finding: Survey results show that adequate clams are available for harvest in Razor Clam Areas 1, 2 and those portions of Razor Clam Area 3 opened for harvest. Washington department of health has certified clams from these beaches to be safe for human consumption. There is insufficient time to adopt permanent rules.

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

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

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

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

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

Date Adopted: March 7, 2012.

Joe Stohr
for Philip Anderson
Director

NEW SECTION

WAC 220-56-36000C Razor clams—Areas and seasons. Notwithstanding the provisions of WAC 220-56-360, it is unlawful to dig for or possess razor clams taken for personal use from any beach in Razor Clam Areas 1, 2, or 3, except as provided for in this section:

1. Effective 12:01 a.m. March 10 through 11:59 a.m. March 11, 2012, razor clam digging is allowed in Razor Clam Area 1. Digging is allowed from 12:01 a.m. to 11:59 a.m. each day only.

2. Effective 12:01 a.m. March 10 through 11:59 a.m. March 11, 2012, razor clam digging is allowed in Razor Clam Area 2. Digging is allowed from 12:01 a.m. to 11:59 a.m. each day only.

3. Effective 12:01 a.m. January March 10 through 11:59 a.m. March 11, 2012, razor clam digging is allowed in that portion Razor Clam Area 3 that is between the Grays Harbor North Jetty and the southern boundary of the Quinault Indian Nation (Grays Harbor County). Digging is allowed from 12:01 a.m. to 11:59 a.m. each day only.

4. It is unlawful to dig for razor clams at any time in Long Beach, Twin Harbors Beach or Copalis Beach Clam sanctuaries defined in WAC 220-56-372.

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

REPEALER

The following section of the Washington Administrative Code is repealed effective 12:01 p.m. March 11, 2012:

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