WSR 17-03-002
PERMANENT RULES
DEPARTMENT OF AGRICULTURE

[Filed January 4, 2017, 1:56 p.m., effective February 4, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: This rule-making order amends chapter 16-403 WAC by:

1. Reorganizing the language to more logically parallel the applicable United States Department of Agriculture grades and standards that are adopted by reference;
2. Addressing several newer apple varieties that have entered the market; and
3. Modifying the language to make it more clear and readable.

Citation of Existing Rules Affected by this Order: Repealing WAC 16-403-140, 16-403-141, 16-403-142, 16-403-143, 16-403-155, 16-403-175, 16-403-205, 16-403-225, 16-403-230, 16-403-235, 16-403-240, 16-403-245, 16-403-250, 16-403-260, 16-403-265, 16-403-270, 16-403-275, 16-403-285, 16-403-290 and 16-403-295; and amending WAC 16-403-190, 16-403-195, 16-403-200, 16-403-215, 16-403-220, and 16-403-280.

Statutory Authority for Adoption: RCW 15.17.030, [15.17.]050, and [15.17.]060.

Other Authority: Chapter 34.05 RCW.

Adopted under notice filed as WSR 16-22-058 on October 31, 2016.

Changes Other than Editing from Proposed to Adopted Version: Only editing changes were made to WAC 16-403-014.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 21, Amended 6, Repealed 20.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 21, Amended 6, Repealed 20.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.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: January 4, 2017.

Derek I. Sandison
Director

NEW SECTION

WAC 16-403-004 Purpose. The purpose of this chapter is to provide for the fair and orderly marketing of fresh apples in the state of Washington by establishing uniform grades and standards and by providing for the inspection of these products.

NEW SECTION

WAC 16-403-014 Definitions. "Aggregate" means the gathering together of separate areas into one mass for the purpose of comparison to determine the extent affected.

"Clean" means that the apples are free from excessive dirt, dust, spray residue and other foreign material.

"Diameter" means, when measuring for minimum size, the greatest dimension of the apple measured at right angles to a line from stem to blossom end. When measuring for maximum size, diameter means the smallest dimension of the apple determined by passing the apple through a round opening in any position.

"Fairly tight" means that the apples are the proper size for molds or cell compartments in which they are packed and the molds or cells are filled in such a way that no more than a slight movement of apples within the molds or cells is possible.

"Fairly well filled" means that the net weight of the apples in containers ranging from 2,100 to 2,900 cubic inches capacity is not less than thirty-seven pounds for Jonathan, McIntosh, and Golden Delicious varieties and not less than forty pounds for all other varieties.

"Fairly well formed" means that the apple may be slightly abnormal in shape but not to an extent which detracts materially from its appearance.

"Firmness terms." The following four terms are used for describing different stages of firmness of apples:

• "Hard" means apples with a tenacious flesh and starchy flavor.

• "Firm" means apples with a tenacious flesh but which are becoming crisp with a slightly starchy flavor, except the Delicious variety.

• "Firm ripe" means apples with crisp flesh except that the flesh of the Rome Beauty or similar varieties may be slightly mealy.

• "Ripe" means apples with mealy flesh and soon to become soft for the variety.

"Fruit weight" means, when measuring for minimum weight as a designation of fruit size, the individual apple must meet the minimum weight designation as marked on the container or package.

"Mature" means that the apples have reached the stage of development which will ensure the proper completion of the ripening process. Before a mature apple becomes overripe it will show varying degrees of firmness, depending upon the stage of the ripening process.

"Overripe" means apples which have progressed beyond the stage of ripe, with flesh very mealy or soft, and past commercial utility.

"Principal display panel" means the end or side panels, exclusive of tops and bottoms of a container for which all required markings must be placed together to comply with this regulation.

"Well formed" means having the normal shape characteristic of the variety, except that the shape may be slightly irregular provided it does not more than slightly detract from the appearance of the apple.

"Worm hole" means a puncture or hole caused by an insect that is one-eighth inch or more in depth.

"WSDA" means the Washington state department of agriculture and its director.

NEW SECTION

WAC 16-403-024 Adoption of Washington state standards for grades of apples. Washington state standards apple grades for extra fancy and fancy, except the Fuji variety, must be equivalent to or better than the U.S. standards for U.S. extra fancy and U.S. fancy grades of apples, 7 C.F.R. Sec. 51.300 et seq., in effect as of December 19, 2002. Apples meeting the foregoing grades may be marked either with the proper Washington or U.S. grade, or both. In no case may the Washington grade and condition requirements be interpreted as less than the standards required by the applicable U.S. standards for grades for the comparable Washington grade and variety.

NEW SECTION

WAC 16-403-034 General standards for Washington grades. General standards for Washington grades shall apply to apples of one variety (except when more than one variety is printed on the container) which must meet the following standards in addition to standards specific to each Washington grade:

(1) The apples must be mature but not overripe, clean, fairly well formed, and free from decay, internal browning, internal breakdown, brown surface discoloration, scab, freezing injury, visible water core, broken skins, and bruises, except those which are slight and incidental to proper handling and packing; and

(2) The apples must be free from damage by invisible water core after January 31st of the year following the year of production except for the Washington C grade.

(3) Invisible water core is not a quality factor of the Fuji variety at any time of the year.

(4) Apples of the red, partial red or blushed varieties must meet the color requirements specified for the variety in WAC 16-403-064.

NEW SECTION

WAC 16-403-044 Washington extra fancy grade standards for red, partial red or blushed variety apples. In addition to meeting the general standards under WAC 16-403-034, Washington extra fancy grade red, partial red, or blushed variety apples must be free from injury as specified in WAC 16-403-164(1) and 16-403-174(1) and damage as specified in WAC 16-403-164(2) and 16-403-174(2).

NEW SECTION

WAC 16-403-054 Washington fancy grade standards for red, partial red or blushed variety apples. In addition to meeting the general standards under WAC 16-403-034, Washington fancy grade red, partial red, or blushed variety apples must also be free from damage as specified in WAC 16-403-164(2) and 16-403-174(2).

NEW SECTION

WAC 16-403-064 Color requirements. (1) Faded brown stripes may not be considered as color.

(2) The color requirements for any variety may not be less than those required under the United States standards for the varieties and the respective variety grades of apples under 7 C.F.R. Sec. 51.305 (effective December 19, 2002), which color standards are incorporated by reference.

(3) Solid red varieties: The color percentage requirement stated below refers to the area of the surface which must be covered with a good shade of solid red characteristic of the variety. However, an apple having color of a lighter shade of solid red or striped red than that considered as a good shade of red characteristic of the variety may be admitted to a grade provided it has sufficient additional area covered so that the apple has as good an appearance as one with the minimum percentage of good red characteristic of the variety required for the grade, subject to the limitations set forth below.

Color shade percentages for solid red varieties.

Variety	Extra Fancy Good Shade Percent	Extra Fancy Lighter Shade Percent	Fancy Good Shade Percent	Fancy Lighter Shade Percent
Beacon	33 1/3	33 1/3	15	15
Empire	50	66	33	40
Idared	66	66	40	40
Spartan	50	66	33	40
Jonathan	50	66	33	40
Melrose	66	66	40	40
Red Delicious	66	66	40	40
Red Rome	66	66	40	40
Spartan	66	66	40	40
Winesap	66	66	40	40
Other similar varieties	50	66	33	40
Red sport varieties	66	66	40	40

(4) Striped red varieties:

The percentage stated refers to the area of the surface in which stripes of a good shade of red characteristic of the variety predominate over stripes of lighter red, green or yellow. However, an apple having color of a lighter shade than that considered as a good shade of red characteristic of the variety may be admitted to a grade provided it has sufficient additional area covered so that the apple has as good an appearance as one with the minimum percentage of good red characteristic of the variety required for the grade, subject to the limitations set forth below.

Color requirements for striped or partial red varieties.

Variety	Extra Fancy Good Shade Percent	Extra Fancy Lighter Shade Percent	Fancy Good Shade Percent	Fancy Lighter Shade Percent
Akane	33 1/3	33 1/3	15	15
Cameo	33 1/3	33 1/3	15	15
Cortland	50	50	33	33
Delicious	50	50	25	25
Red Fuji	50	50	33	33
Red Gala	50	50	33	33
Honeycrisp	33 1/3	33 1/3	15	15
Jonamac	50	50	33	33
Liberty	33 1/3	33 1/3	15	15
Early McIntosh	33 1/3	33 1/3	15	15
McIntosh	35	50	15	33
Nittany	25	25	10	10
Rome	35	50	15	33
Rome Beauty	50	50	33	33
Starkrimson	33 1/3	33 1/3	15	15
Stayman	50	50	33	33
Tydeman Red	33 1/3	33 1/3	15	15
Winesap	50	50	25	25
York	50	50	33	33
Other similar varieties	50	50	25	25

(5) Red cheeked or blushed varieties.

(a) Blush cheek means at least ten percent of the surface has blush color characteristic of the variety.

(b) Tinge of color means the apples has any amount of the surface area of blush type color which predominates over the background color of the apple.

(c) Color requirements for red cheeked or blushed varieties:

Variety	Extra Fancy Percent	Fancy Percent
Ambrosia	Blush cheek	Tinge of color
Arlet or Swiss Gourmet	Blush cheek	Tinge of color
Braeburn	Blush cheek	Tinge of color
Envy	Blush cheek	Tinge of color
Elstar	Blush cheek	Tinge of color
Fuji	Blush cheek	Tinge of color
Gala	Blush cheek	Tinge of color
Gala Supreme	Blush cheek	Tinge of color
Royal Gala	Blush cheek	Tinge of color
Blushing Golden Delicious	Blush cheek	Tinge of color
Jazz	Blush cheek	Tinge of color
Jonagold	Blush cheek	Tinge of color
Lady Alice	Blush cheek	Tinge of color
Molleys Delicious	Blush cheek	Tinge of color
Pacific Rose	Blush cheek	Tinge of color
Pinata	Blush cheek	Tinge of color
Pomona	Blush cheek	Tinge of color
Sonata	Blush cheek	Tinge of color
Sonya	Blush cheek	Tinge of color
Swiss Gourmet or Arlet	Blush cheek	Tinge of color
Other similar varieties	Blush cheek	Tinge of color

NEW SECTION

WAC 16-403-074 Washington extra fancy standards for green or yellow varieties. Washington green or yellow variety extra fancy apples must meet the following standards in addition to meeting the general standards under WAC 16-403-034. The apples must be free from:

(1) Slightly rough and rough russeting: Provided, that russeting other than rough or bark-like russeting materially affecting the appearance of the apple may be permitted in the stem cavity or calyx basin if it cannot be seen when the apple is placed stem end and calyx end down on a flat surface.

(2) Injury as specified in WAC 16-403-164(1) and 16-403-174(1); and

(3) Damage as specified in WAC 16-403-164(2) and 16-403-174(2).

NEW SECTION

WAC 16-403-084 Washington fancy standards for green or yellow varieties. In addition to meeting the general standards under WAC 16-403-034, green or yellow variety fancy apples must be free from damage as specified in WAC 16-403-164(2) and 16-403-174(2).

NEW SECTION

WAC 16-403-094 Washington C grade standards for green or yellow varieties. The requirements for Washington C grade green or yellow variety apples include the conditions for Washington fancy grade apples under WAC 16-403-054. In addition, apples of this grade must be free from excessive damage caused by russeting as defined under the definitions of "damage by russeting," in WAC 16-403-164(2) under the following conditions:

(1) The aggregate area of an apple which is covered by smooth net-like russeting may not exceed twenty-five percent.

(2) The aggregate area of an apple which is covered by smooth solid russeting may not exceed ten percent except as follows:

(a) The aggregate area for Newtown, Granny Smith or similar varieties which is covered with smooth solid russeting may not exceed twenty percent; and

(b) The aggregate area of an apple which is covered with excessively rough or bark-like russeting or limb rubs may not exceed the area of a circle three-fourths inch in diameter.

(3) There is no requirement in this grade pertaining to invisible water core.

NEW SECTION

WAC 16-403-104 Combination grades and gift grade. Combination grades apply to all varieties of apples except red or partial red varieties which may only be packed in the combination extra fancy and fancy grade. Gift grade applies to a combination of apples and pears.

(1) Combination extra fancy and fancy. When extra fancy and fancy apples are packed together, the containers must be marked "Washington combination extra fancy and fancy" and must contain at least eighty percent extra fancy apples, except that Newtown variety combinations must contain at least fifty percent extra fancy apples.

(2) Combination extra fancy, fancy and C grade. When extra fancy, fancy and C grade apples are packed together, the containers must be marked "Washington combination extra fancy, fancy and C grade" and must contain at least eighty percent extra fancy apples, except that Newtown variety combinations must contain at least fifty percent extra fancy apples.

(3) Combination fancy and C grade. When fancy and C grade apples are packed together, the containers must be marked "Washington combination fancy and C grade" but must contain at least eighty percent fancy apples, except that Newtown variety combinations must contain at least fifty percent fancy apples.

(4) Gift grade. Gift grade consists of mixed varieties of apples and pears. Apples must be Washington extra fancy grade under WAC 16-403-044 and 16-403-064. Pears must be U.S. No. 1 or higher grade under WAC 16-442-020 and 16-442-030.

(a) Containers must be marked "gift grade" or with the individual variety and grade that applies to each commodity;

(b) Containers must be marked with the net contents by weight or count; and

(c) Containers must be marked with business name and address of the packer or shipper.

NEW SECTION

WAC 16-403-114 Standards, packing and labeling for culls. (1) Apples which are not graded in conformity with any of the grade standards in this chapter and which contain no more than five percent serious insect damage may be designated as "culls."

(2) Culls must be packed and labeled as specified in RCW 15.17.080.

NEW SECTION

WAC 16-403-124 Other brands and grades. The director may approve and register a private grade or brand of apple. The private grade or brand may not be lower than the second grade or classification established under chapter 15.17 RCW or under this chapter.

NEW SECTION

WAC 16-403-134 Soluble solids and shipping dates for Red Delicious, Delicious and Golden Delicious. (1) Red Delicious and Delicious varieties may not be shipped prior to October 1st of the current growing season unless they have at least eleven percent soluble solids as determined by refractometer.

(2) Golden Delicious varieties may not be shipped prior to September 20th of the current growing season unless they have at least ten and one-half percent soluble solids as determined by refractometer.

NEW SECTION

WAC 16-403-144 Firmness at time of shipping standards for Red Delicious, Delicious, Golden Delicious, Gala, and Jonagold. At time of shipment the following firmness standards must be met:

(1) Red Delicious and Delicious varieties must pressure test at least twelve pounds. However, apples failing to pressure test twelve pounds may be considered as meeting the requirements of this section when the individual apple exhibits its edible qualities and texture of flesh comparable to other apples of the same variety which pressure test twelve pounds or more.

(2) Golden Delicious variety must pressure test at least ten pounds. However, apples failing to pressure test ten pounds may be considered as meeting the requirements of this section when the individual apple exhibits edible qualities and texture of flesh comparable to other apples of the same variety which pressure test ten pounds or more.

(3) Gala and Jonagold varieties must pressure test at least eleven pounds.

NEW SECTION

WAC 16-403-154 Starch-iodine requirement for the Granny Smith variety. Granny Smith variety may not be shipped prior to October 10th unless ninety percent or more of any lot of apples meets the stage of maturity as indicated by starch-iodine rating of 1.2 using a starch-iodine rating scale from Cascade Analytical, Inc. or any equivalent rating scale applicable to the Granny Smith variety.

NEW SECTION

WAC 16-403-164 Defects—Injury, damage and serious damage. (1) "Injury" means any specific defect defined in this section, or an equally objectionable variation of any one of these defects, any other defect, or any combination of defects which more than slightly detracts from the appearance or the edible or shipping quality of the apple. The following specific defects are considered as injury:

(a) Russeting.

(i) Russeting in the stem cavity or calyx basin which cannot be seen when the apple is placed stem end or calyx end down on a flat surface is not considered in determining whether or not an apple is injured by russeting.

(ii) Smooth net-like russeting when an aggregate area of more than ten percent of the surface is covered for red, partial red and blushed varieties and five percent of the surface for green and yellow varieties, and when the color of the russeting shows no very pronounced contrast with the background color of the apple.

(iii) Lesser amounts of more conspicuous net-like russeting when the appearance is affected to a greater extent than the above amount permitted is considered injury.

(iv) Smooth solid russeting when the aggregate area in the green and yellow varieties exceeds more than one-quarter inch in diameter and in the red and partial red varieties when the aggregate area exceeds three-eighths inch in diameter is also considered as injury.

(b) Sunburn or sprayburn, when the discolored area does not blend into the normal color of the fruit.

(c) Dark brown or black limb rubs which affect an aggregate area of more than one-quarter inch in diameter for red, partial red or blushed varieties and one-eighth inch for green or yellow varieties. However, light brown limb rubs of a russet character are considered injury by russeting under definition in (a) of this subsection.

(d) Hail marks, drought spots, other similar depressions or scars:

(i) When the skin is broken, whether healed or unhealed;

(ii) When there is appreciable discoloration of the surface;

(iii) When any surface indentation exceeds one-sixteenth inch in depth;

(iv) When any surface indentation exceeds one-eighth inch in diameter; or

(v) When the aggregate affected area of such spots exceeds one-half inch in diameter for red, partial red and blushed varieties or one-quarter inch for green or yellow varieties.

(e) Disease:

(i) Cedar rust infection which affects an aggregate area of more than three-sixteenths inch in diameter.

(ii) Sooty blotch or fly speck which is thinly scattered over more than five percent of the surface, or dark, heavily concentrated areas which affect an area of more than one-quarter inch in diameter.

(iii) Red skin spots which are thinly scattered over more than one-tenth of the surface, or dark, heavily concentrated spots which affect an area of more than one-quarter inch in diameter.

(f) Insects:

(i) Any healed sting or healed stings which affect an aggregate area of more than one-eighth inch in diameter including any encircling discolored rings.

(ii) Worm holes.

(g) Stem cavity or calyx basin cracks.

(i) Which more than slightly detract from the appearance or the edible or shipping quality of the apple;

(ii) Are not well healed; or

(iii) Are well healed which exceed an aggregate length of one-eighth inch.

(2) "Damage" means any specific defect defined in this subsection or an equally objectionable variation of any one of these defects, any other defect or any combination of defects which materially detracts from the appearance or the edible or shipping quality of the apple. The following specific defects are considered damage:

(a) Russeting. Russeting in the stem cavity or calyx basin which cannot be seen when the apple is placed stem end or calyx end down on a flat surface is not considered in determining whether or not an apple is damaged by russeting: Provided, that excessively rough or bark-like russeting in the stem cavity or calyx basin are considered damage when the appearance of the apple is materially affected. The following types and amounts of russeting outside of the stem cavity or calyx basin are considered damage:

(i) Russeting which is excessively rough or rough on green and yellow varieties.

(ii) Smooth net-like russeting when an aggregate area of more than fifteen percent of the surface is covered and the color of the russeting shows no very pronounced contrast with the background color of the apple;

(iii) Smooth solid russeting when an aggregate area of more than five percent of the surface is covered and the pattern and color of the russeting shows no very pronounced contrast with the background color of the apple;

(iv) Lesser amounts of smooth net-like or smooth solid russeting when more conspicuous and the appearance is affected to a greater extent than the amount permitted in this section;

(v) Slightly rough russeting which covers an aggregate area of more than one-half inch in diameter; or

(vi) Rough russeting in the red and partial red varieties which covers an aggregate area of more than one-quarter inch in diameter.

(b) Sunburn or sprayburn which has caused blistering or cracking of the skin or when the discolored area does not blend into the normal color of the fruit unless the injury can be classed as russeting under the definition in (a) of this subsection.

(c) Limb rubs which affect an aggregate area of more than one-half inch in diameter. However, light brown limb rubs of a russet character are considered damage by russeting under the definition in (a) of this subsection.

(d) Hail marks, drought spots, other similar depressions or scars when:

(i) Any unhealed mark is present;

(ii) Any surface indentation exceeds one-eighth inch in depth;

(iii) The skin has not been broken and the aggregate affected area exceeds one-half inch in diameter; or

(iv) The skin has been broken and well healed and the aggregate area exceeds one-quarter inch in diameter.

(e) Stem cavity or calyx basin cracks which are not well healed or well healed stem cavity or calyx basin cracks which exceed an aggregate length of one-quarter inch.

(f) Disease:

(i) Scab spots which affect an aggregate area of more than one-quarter inch in diameter;

(ii) Cedar rust infection which affects an aggregate area of more than one-quarter inch in diameter;

(iii) Sooty blotch or fly speck which is thinly scattered over more than one-tenth of the surface, or dark, heavily concentrated areas which affect an area of more than one-half inch in diameter;

(iv) Red skin spots which are thinly scattered over more than one-tenth of the surface, or dark, heavily concentrated spots which affect an area of more than one-half inch in diameter;

(v) Bitter pit or Jonathan spot when one or more spots affects the surface of the apple.

(g) Insects:

(i) Any healed sting or healed stings which affect an aggregate area of more than three-sixteenths inch in diameter including any encircling discolored rings; or

(ii) Worm holes.

(3) "Serious damage" means any specific defect defined in this subsection or an equally objectionable variation of any one of these defects, any other defect, or any combination of defects which seriously detracts from the appearance or the edible or shipping quality of the apple. The following specific defects are considered as serious damage:

(a) Russeting. The following types and amounts of russeting are considered as serious damage:

(i) Smooth solid russeting, when more than one-half of the surface in the aggregate is covered, including any russeting in the stem cavity or calyx basin; or

(ii) Slightly rough, excessively rough or bark-like russeting which detracts from the appearance of the fruit to a greater extent than the amount of smooth solid russeting permitted in (a)(i) of this subsection.

(b) Sunburn or sprayburn which seriously detracts from the appearance of the fruit.

(c) Limb rubs which affect more than one-tenth of the surface in the aggregate.

(d) Hail marks, drought spots, or scars, if they materially deform or disfigure the fruit, or if such defects affect more than one-tenth of the surface in the aggregate. However; no hail marks which are unhealed are permitted and not more than an aggregate area of one-half inch is allowed for well healed hail marks where the skin has been broken.

(e) Stem or calyx cracks which are not well healed or well healed stem or calyx cracks which exceed an aggregate length of one-half inch.

(f) Visible water core which affects an area of more than one-half inch in diameter.

(g) Disease:

(i) Scab spots which affect a total area of more than three-fourths inch in diameter;

(ii) Cedar rust infection which affects a total area of more than three-fourths inch in diameter;

(iii) Sooty blotch or fly speck which affects more than one-third of the surface;

(iv) Red skin spots which affect more than one-third of the surface;

(v) Bitter pit or Jonathan spot which is thinly scattered over more than one-tenth of the surface and does not materially deform or disfigure the fruit.

(h) Insects:

(i) Healed stings which affect an aggregate area of more than one-quarter inch in diameter including any encircling discolored rings; or

(ii) Worm holes.

NEW SECTION

WAC 16-403-174 Bruises—Injury, damage and serious damage. The standard for bruises under the categories of injury, damage or serious damage is as follows:

(1) Injury consists of bruises which are not slight and incident to proper handling and packing, and which are greater than:

(a) One-eighth inch in depth;

(b) Five-eighths inch in diameter; or

(c) Any combination of lesser bruises which detract from the appearance or edible quality of the apple to an extent greater than any one bruise described in (a) or (b) of this subsection.

(2) Damage consists of bruises which are not slight and incident to proper handling and packing, and which are greater than:

(a) Three-sixteenths inch in depth;

(b) Seven-eighths inch in diameter; or

(c) Any combination of lesser bruises which detract from the appearance or edible quality of the apple to an extent greater than any one bruise described in (a) or (b) of this subsection.

(3) Serious damage consists of bruises which are not slight and incident to proper handling and packing, and which are greater than:

(a) Three-eighths inch in depth;

(b) One and one-eighth inch in diameter; or

(c) Any combination of lesser bruises which detract from the appearance or edible quality of the apple to an extent greater than any one bruise described in (a) or (b) of this subsection.

NEW SECTION

WAC 16-403-184 Invisible water core. Invisible water core will be considered as "damage" when existing around the core and extending to water core in the vascular bundles, or surrounding the vascular bundles when the affected areas surrounding three or more vascular bundles meet or coalesce, or existing in more than a slight degree outside the circular area formed by the vascular bundles: Provided, that invisible water core shall not be scored as damage against the Fuji variety of apples under any circumstances.

AMENDATORY SECTION (Amending WSR 06-12-117, filed 6/7/06, effective 7/8/06)

WAC 16-403-190 Tolerances. In order to allow for variations incident to proper grading, sizing and ((~~handling~~)) firmness in each of the foregoing grades, the following tolerances are provided as specified:

(1) Defects: Washington extra fancy, Washington fancy and Washington C grade.

Ten percent of the apples in any lot may fail to meet the requirements of the grade, but not more than ((~~one-half of this amount, or 5~~)) five percent((~~,~~)) shall be allowed for apples which are seriously damaged, including therein not more than one percent for apples affected by decay or internal breakdown.

(2) Combination grades. When applying the foregoing tolerances to combination grades, no part of any tolerance ((~~shall~~)) may be allowed to reduce, for the lot as a whole, the percent of apples of the higher grade required in the combination.

Combinations requiring ((~~80~~)) eighty percent of the higher grade for the lot shall not have ((~~not~~)) less than ((~~65~~)) sixty-five percent of the higher grade in individual samples.

Combinations requiring ((~~50~~)) fifty percent of the higher grade for the lot shall not have ((~~not~~)) less than ((~~40~~)) forty percent of the higher grade in individual samples.

(3) Size. When size is designated by the numerical count for a container, not more than ((~~5~~)) five percent of the apples in the lot may vary more than ((~~1/2~~)) one-half inch in diameter. When size is designated by minimum or maximum diameter or weight, not more than ((~~5~~)) five percent of the apples in any lot may be smaller than the designated minimum and not more than ((~~10~~)) ten percent may be larger than the designated maximum.

(4) Firmness. Not more than ten percent of the apples in any lot of Red Delicious, Delicious, Golden Delicious, Jonagold, and Gala varieties ((~~shall~~)) may fail to meet the firmness requirements as defined in WAC ((~~16-403-142~~)) 16-403-144.

AMENDATORY SECTION (Amending WSR 06-12-117, filed 6/7/06, effective 7/8/06)

WAC 16-403-195 Application of tolerances. The contents of individual samples in the lot((~~,~~)) are subject to the following limitations: Provided, that the averages for the entire lot are within the tolerances specified for the grade in WAC 16-403-190.

(1) Packages which contain more than ((~~10~~)) ten pounds((~~:~~

~~Samples shall~~)) may not have ((~~not~~)) more than one and one-half times a specified tolerance of ((~~10~~)) ten percent or more ((~~and not~~)) or more than double a tolerance of less than ((~~10~~)) ten percent, except that at least one apple which is seriously damaged by insects or affected by decay or internal breakdown may be permitted in any sample.

(2) Packages which contain ((~~10~~)) ten pounds or less((~~:~~

~~No packages~~)) may have no more than three times the tolerance specified, except that at least three defective apples may be permitted in any package: Provided, that not more than three apples or more than ((~~18~~)) eighteen percent (whichever is the larger amount) may be seriously damaged by insects or affected by decay or internal breakdown.

AMENDATORY SECTION (Amending WSR 92-15-056, filed 7/13/92, effective 8/13/92)

WAC 16-403-200 Calculation of percentages. ((~~(1)~~)) When the numerical count is marked on the container, or when containers are packed to weigh ten pounds or less, or in any container where the minimum diameter of the smallest apple does not vary more than one-half inch from the minimum diameter of the largest apple, percentages shall be calculated on the basis of count((~~.~~

~~(2) When the minimum diameter and/or minimum weight of individual apples, or minimum and maximum diameters and/or weights of individual apples are marked on a container or when the apples are jumbled in a container or in bulk~~)). In all other cases, percentages shall be calculated on the basis of weight ((~~or an equivalent basis~~)).

AMENDATORY SECTION (Amending WSR 06-12-117, filed 6/7/06, effective 7/8/06)

WAC 16-403-215 Packing requirements. Tolerances. In order to allow for variations incident to proper packing, not more than ten percent of the containers in any lot may fail to meet the following requirements:

(1) Apples tray packed or cell packed in cartons shall be arranged according to approved and recognized methods. Packs shall be at least fairly tight((~~a~~)) or fairly well filled((~~b~~)).

(2) Closed cartons containing apples not tray or cell packed shall be fairly well filled((~~b~~)) or the pack shall be sufficiently tight to prevent any appreciable movement of the apples.

(3) Apples on the shown face of any container shall be reasonably representative in size, color and quality of the contents.

((~~(4) Tolerances: In order to allow for variations incident to proper packing, not more than 10 percent of the containers in any lot may fail to meet these requirements.~~

~~a "Fairly tight" means that apples are of the proper size for molds or cell compartments in which they are packed and that molds or cells are filled in such a way that no more than slight movement of apples within molds or cells is possible.~~

~~b "Fairly well filled" means that the net weight of apples in containers ranging from 2,100 to 2,900 cubic inch capacity is not less than 38 pounds for Jonathan, McIntosh and Golden Delicious varieties and not less than 40 pounds for all other varieties.~~))

AMENDATORY SECTION (Amending WSR 06-12-117, filed 6/7/06, effective 7/8/06)

WAC 16-403-220 Marking requirements—Open or closed containers. (1) Individual destination states or countries may have specific requirements for letter heights and placement of markings.

(2) All required markings must be displayed together on the principal display panel of the containers.

(3) All required markings must be a minimum of one-quarter inch in height for a principal display panel of one hundred to four hundred square inches. Markings on consumer-type packages must be at least one-quarter inch in height.

(4) Containers must have the following markings:

(a) The ((~~containers shall bear the~~)) correct name of the variety or when more than one variety or commodity is in the container, each variety and commodity must be shown((~~,~~));

(b) The name and address of the grower, packer, or distributor((~~, and his address,~~));

(c) The grade((~~,~~));

(d) The net contents either in terms of dry measure or weight; and

(e) The numerical count or the minimum diameter of apples packed in a closed container((~~, and the net contents either in terms of dry measure or weight. The minimum weight of individual apples within the container may be stated in lieu of, in combination with, or in addition to, minimum diameter as a declaration of size. All open containers and consumer packages must bear statement of net weight or volume.~~

~~(a)~~)). All open containers and consumer packages must bear a statement of net weight or volume. Over-wrapped consumer units may be marked with count, if all specimens can be counted.

(i) When containers are marked as to number of apples in the container, each container contains the correct number of apples designated by the markings.

(ii) When the numerical count is not shown, the minimum diameter or minimum weight of individual apples shall be plainly stamped, stenciled, or otherwise marked on the container in terms of whole inches, or whole inches and not less than ((~~eight~~)) eighth inch fractions thereof or in terms of whole grams.

((~~(b)~~)) (iii) The minimum weight of individual apples within the container may only be stated in combination with the minimum diameter as a declaration of size for Red Delicious and Golden Delicious. All other varieties and sizes may only have a minimum diameter or minimum weight designated.

(iv) When used in combination with minimum diameter as a size designation, the following minimum fruit weights shall be used:

Red Delicious		Golden Delicious	
2 1/8 in. ((~~or~~)) and 65	grams	2 1/8 in. and 63	grams
2 1/4 in. ((~~or~~)) and 75	grams	2 1/4 in. and 70	grams
2 3/8 in. ((~~or~~)) and 84	grams	2 3/8 in. and 82	grams
2 1/2 in. ((~~or~~)) and 100	grams	2 1/2 in. and 95	grams
2 5/8 in. ((~~or~~)) and 115	grams	2 5/8 in. and 109	grams
2 3/4 in. ((~~or~~)) and 139	grams	2 3/4 in. and 134	grams

((~~(c)~~)) (v) The word "minimum," or its abbreviation, when following a diameter size or weight size marking, means that the apples are of the size marked or larger.

((~~(2) Over-wrapped consumer units may be marked with count, if all specimens can be counted.~~

~~(3) Any of these marks may be placed on either the end or side of the container. (California requires end markings.)~~

~~(4) When containers are marked as to number, each container shall contain the correct number of apples designated by the markings.~~

~~(5) Grade markings on consumer-type packages must be at least one-fourth inch in height.~~

~~(6)~~)) (f) Apples which were produced outside of the state of Washington and which are graded, packed, or repacked in the state of Washington, shall be correctly labeled as to the state or country of origin, e.g., "Product of Oregon," "Grown in Oregon," "Produced in Canada."

((~~Such marking shall be placed on the same end or side panel of the container as other markings related to grade, variety, net contents, and name and address of the grower, packer, or distributor, and shall be of similar print size.~~)) (g) Consumer type packages ((~~shall~~)) are not ((~~be~~)) required to bear a statement as to origin when such marking has been placed on the master shipping ((~~container.~~

~~(7) Containers shall be marked with the harvest year beginning on October 1 of each year and be applied only to apples harvested in the previous year; that this marking shall occur at the time of shipment; and be displayed on the principal display panel with letters of a minimum of one-half inch in height~~)) container's principal display panel.

NEW SECTION

WAC 16-403-224 Crop year designation. Apples from the previous year's crop that are packed and shipped on or after October 1st must be marked with the crop year on each carton or shipping container at the time of shipment. The markings must be displayed on the principal display panel with letters of a minimum of one-half inch in height.

NEW SECTION

WAC 16-403-234 Condition after storage or transit. At the shipping point all defects are considered quality factors at the time of packing: Provided, that if the apples have been in storage for more than seven days after packing, factors listed as condition in the *USDA Apples Shipping Point and Market Inspection Instructions* handbook dated March 2005 are scored as condition factors, and: Provided further, that decay, brown surface discoloration or any other deterioration which may have developed on apples after they have been in storage or transit are considered as affecting condition and not the grade.

AMENDATORY SECTION (Amending WSR 03-24-007, filed 11/20/03, effective 12/21/03)

WAC 16-403-280 Adoption of United States standards as state standards. ((~~In addition to the standards for apples prescribed in WAC 16-403-140 through 16-403-275, there are hereby adopted, as additional standards of the state of Washington for apples,~~)) Except as otherwise modified in this chapter and under this section, WSDA adopts the United States standards for grades of apples, 7 C.F.R. Part 51, Subpart "United States Standards for Grades of Apples" (effective December 19, 2002), ((~~adopted by the United States Department of Agriculture, as they~~)) as the standards apply to U.S. extra fancy, U.S. fancy, U.S. No. 1 and U.S. No. 1 hail, ((~~provided,~~)) subject to and including the following requirements.

(1) The color requirements specified for U.S. No. 1 and U.S. No. 1 hail must be a good shade of red color ((~~and the~~));

(2) The percentage of color required for U.S. No. 1 and U.S. No. 1 hail for Delicious ((~~shall~~)) must be ((~~25~~)) twenty-five percent a good shade of red color ((~~and provided further, that all the~~));

(3) The United States grades as applied to Red Delicious, Delicious, Golden Delicious, Gala, and Jonagold varieties ((~~shall~~)) must meet the firmness requirements of WAC ((~~16-403-142~~)) 16-403-144; and

(4) The United States grades as applied to the Granny Smith variety must meet the starch-iodine requirements of WAC 16-403-154.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 16-403-140	Washington state standards for apples.
WAC 16-403-141	Red Delicious, Delicious, Golden Delicious—Minimum soluble solids.
WAC 16-403-142	Red Delicious, Delicious, Golden Delicious, Gala, and Jonagold—Minimum firmness.
WAC 16-403-143	Granny Smith—Starch-iodine requirements.
WAC 16-403-155	Color requirements.
WAC 16-403-175	Green or yellow varieties—Color requirements.
WAC 16-403-205	Condition after storage or transit.
WAC 16-403-225	Other brands and grades.
WAC 16-403-230	Well formed.
WAC 16-403-235	Fairly well formed.
WAC 16-403-240	Diameter or fruit weight.
WAC 16-403-245	Mature.
WAC 16-403-250	Overripe.
WAC 16-403-260	Clean.
WAC 16-403-265	Injury.
WAC 16-403-270	Damage.
WAC 16-403-275	Serious damage.
WAC 16-403-285	Spots showing diameters in fractions of an inch.
WAC 16-403-290	Damage by invisible watercore.
WAC 16-403-295	Inspector's guide for apple bruises at shipping point and market.

WSR 17-03-004
PERMANENT RULES
PUBLIC DISCLOSURE COMMISSION

[Filed January 4, 2017, 3:11 p.m., effective February 4, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Differentiate citizen action notices referred by the attorney general or prosecuting attorney solely for investigation from complaints filed with the commission and clarify the commission's limited investigatory role when a citizen action notice is referred. Update enforcement procedural rules to make consistent with the state's model administrative procedures and recent public records case law, modernize time period calculations for requests of reconsideration of decisions. Make consistent the terms "day" and "business day" throughout chapter 390-37 WAC. Simplify and enhance the penalty schedule used for brief adjudicative proceedings by consolidating five current schedules into one and inserting penalty amounts for additional violations that may be heard in a brief adjudicative proceeding.

Citation of Existing Rules Affected by this Order: Repealing WAC 390-37-155, 390-37-160, 390-37-165, 390-37-170 and 390-37-175; and amending WAC 390-37-041, 390-37-050, 390-37-060, 390-37-100, 390-37-105, 390-37-132, 390-37-142, 390-37-144, and 390-37-150.

Statutory Authority for Adoption: RCW 42.17A.110.

Adopted under notice filed as WSR 16-22-055 on October 31, 2016.

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 1, Repealed 0.

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

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

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

Date Adopted: December 8, 2016.

Jana Y. Greer
Executive Assistant

AMENDATORY SECTION (Amending WSR 12-03-002, filed 1/4/12, effective 2/4/12)

WAC 390-37-041 ((~~Enforcement~~)) Citizen action notice procedures—Allegations submitted to the attorney general's office and/or prosecuting attorneys. (1) When a person has notified the attorney general or prosecuting attorney under RCW 42.17A.765(4) that there is reason to believe a violation of the sections of chapter 42.17A RCW enforced by the commission has occurred, and the attorney general or ((~~prosecutor~~)) prosecuting attorney forwards the ((~~complaint~~)) citizen action notice to the commission, commission staff may:

((~~(1) Initiate~~)) (a) Conduct an investigation and report the findings to the commission within time frames provided for in RCW 42.17A.765;

((~~(2) Submit a report to the commission that may include a recommendation;~~

~~(3) Schedule the matter for an adjudicative proceeding before the commission following investigation; and/or~~

~~(4)~~)) (b) Conduct an initial review and report to the commission whether the initial review indicated that a violation of chapter 42.17A RCW may have occurred;

(c) Recommend to the commission whether to recommend to the referring attorney general or prosecuting attorney to commence a civil action; and

(d) Take any other steps consistent with the agency's authority and resources.

(2)(a) A report to the commission will be made in an open public meeting. Commission staff shall provide advance notice of the meeting to the initiator and the subject of the citizen action as soon as is practicable. Any commission action to determine whether a recommendation will be made to the attorney general or prosecuting attorney will be made in an open public meeting within the time allotted by law.

(b) A report of investigation or initial review may be provided at any time to the attorney general or prosecuting attorney, at their request.

(3) When a citizen action notice is filed alleging the same or substantially similar violations alleged earlier by the same person in a complaint filed with the commission, the commission staff may continue its investigation of the complaint and may initiate an adjudicative proceeding as provided for in WAC 390-37-060.

AMENDATORY SECTION (Amending WSR 16-01-015, filed 12/4/15, effective 1/4/16)

WAC 390-37-050 Enforcement procedures—Respondent's notice of complaint. Within ten ((~~business~~)) days of receipt by the commission of a complaint which on its face appears to have merit, the commission shall notify the respondent that a complaint has been filed. The notice shall set forth the nature of the complaint and its origin (citizen complaint, commission or other) and the statutory provision alleged to have been violated. If an alternative response to the alleged violation has been issued as provided by this chapter, the notice shall also describe that response, including any conditions the respondent is required to meet.

AMENDATORY SECTION (Amending WSR 16-01-015, filed 12/4/15, effective 1/4/16)

WAC 390-37-060 Enforcement procedures—Alternative responses to noncompliance—Investigation of complaints—Initiation of adjudicative proceeding. (1) Upon receipt of a complaint, the executive director will conduct an initial review of the complaint to determine what action will be taken. An initial review is a preliminary investigation to determine whether the allegations are limited to minor or technical violations of chapter 42.17A or if there is sufficient ground indicating that a material violation of chapter 42.17A RCW may have occurred so as to warrant a formal investigation.

(a) If the executive director ((~~shall return~~)) determines that any complaint ((~~that~~)) is obviously unfounded or frivolous((~~.~~)), the executive director will inform the complainant why ((~~the complaint is returned~~)) no further investigation is warranted.

(b) The executive director may resolve any complaint that alleges minor or technical violations of chapter 42.17A by issuing a formal written warning. If the resolution is conditioned upon the respondent reaching or maintaining compliance, specific expectations and any deadlines should be clearly explained in the written warning. A respondent's failure to meet conditions may result in a complaint being reopened.

(c) The executive director may use the complaint publication process set out in WAC 390-32-030 to resolve any complaint that alleges minor or technical violations of chapter 42.17A RCW.

(d) The executive director shall initiate a formal investigation whenever an initial review of a complaint indicates that a material violation of chapter 42.17A RCW may have occurred.

(2) If the executive director determines a formal investigation will require the expenditure of substantial resources, the executive director may request review and concurrence by the commission before proceeding.

(3) The executive director shall initiate an adjudicative proceeding or provide a report to the commission whenever a formal investigation reveals facts that the executive director

has reason to believe are a material violation of chapter 42.17A RCW and do not constitute substantial compliance.

(4) The respondent and complainant shall be notified of the date of the adjudicative proceeding or a report on an enforcement matter resulting from a complaint no later than ten ((~~calendar~~)) days before that date. The notice shall contain the information required by RCW 34.05.434, the staff investigative report, and any charges to be adjudicated. The notice, whenever possible, will be delivered electronically.

((~~(5) It is the policy of the commission during the course of any investigation that all records generated or collected as a result of that investigation are exempt from public inspection and copying under RCW 42.56.240(1).~~

~~(a) The records are exempt until:~~

~~(i) A final staff investigative report is submitted; or~~

~~(ii) The executive director issues a final disposition of the complaint through an alternative response as provided in this section.~~

~~(b) Without waiving any exemptions from public disclosure that are otherwise available for pending investigations, the commission may make public:~~

~~(i) A copy of a complaint filed with or submitted to the commission, including any attachments;~~

~~(ii) A copy of the respondent's initial response to a complaint; and~~

~~(iii) Materials concerning an enforcement matter that are placed on the commission's web site with a commission meeting agenda.~~

~~(c) If a request is made for any such record that implicates the privacy of an individual as defined in RCW 42.56.050, written notice of the records request may be provided to the individual in order that such individual may request a protective order from a court under RCW 42.56.540.~~

~~(d) Certain documents provided to the commission shall be returned to candidates, campaigns, or political committees as required by RCW 42.17A.105 within seven calendar days of the commission's final action upon completion of an audit or field investigation.~~))

AMENDATORY SECTION (Amending WSR 12-03-002, filed 1/4/12, effective 2/4/12)

WAC 390-37-100 Enforcement procedures—Conduct of hearings (adjudicative proceedings). (1) An enforcement hearing (adjudicative proceeding) shall be conducted pursuant to the Administrative Procedure Act (chapter 34.05 RCW). Chapter 390-37 WAC further governs these proceedings, as supplemented by chapter 10-08 WAC. To the extent chapters 390-37 and 10-08 WAC differ, chapter 390-37 WAC controls.

(2) An adjudicative proceeding shall be heard by the commission, except for brief adjudicative proceedings which are conducted by the chair or the chair's designee.

(3) The commission shall have the authority to:

(a) Determine the order of presentation of evidence;

(b) Administer oaths and affirmations;

(c) Rule on procedural matters, objections, and motions;

(d) Rule on offers of proof and receive relevant evidence;

(e) Pursuant to RCW 34.05.449(5), close parts of a hearing to public observation or order the exclusion of witnesses upon a showing of good cause;

(f) Interrogate witnesses called by the parties in an impartial manner to develop any facts deemed necessary to fairly and adequately decide the matter;

(g) Call additional witnesses and request additional exhibits deemed necessary to complete the record and receive such evidence subject to full opportunity for cross-examination and rebuttal by all parties;

(h) Take official notice of facts pursuant to RCW 34.05.452(5);

((~~(h)~~)) (i) Regulate the course of the hearing and take any appropriate action necessary to maintain order during the hearing;

((~~(i)~~)) (j) Permit or require oral argument or briefs and determine the time limits for submission thereof;

((~~(j)~~)) (k) Issue an order of default pursuant to RCW 34.05.440;

((~~(k)~~)) (l) Take any other action necessary and authorized by any applicable statute or rule;

((~~(l)~~)) (m) Waive any requirement of these rules unless a party shows that it would be prejudiced by such a waiver; and

((~~(m)~~)) (n) The commission chair or the chair's designee may conduct the procedural aspects of the adjudicative proceeding under (a) through ((~~(l)~~)) (m) of this subsection, unless a majority of members present vote to seek a full commission decision on any particular matter.

(4) The commission may decide dispositive motions, and any other matters referred to it by the presiding officer at a prehearing conference.

(5) After an adjudicative proceeding by the commission, the commission may find that:

(a) Respondent did not violate the act, as alleged, and dismiss the case; or

(b) Respondent violated chapter 42.17A RCW, as alleged, and determine the sanction, if any, to be imposed; or

(c) Respondent is in apparent violation of chapter 42.17A RCW, its own remedies are inadequate and enter its order referring the matter to the appropriate law enforcement agency as provided in RCW 42.17A.105 and 42.17A.755.

(6) Upon the conclusion of an adjudicative proceeding, the commission:

(a) Shall set forth in writing its findings of fact, conclusions of law and decision on the merits of the case and enter an order; and

(b) Shall serve the respondent a copy of the findings of fact, conclusions of law and decision and order.

(7) The executive director is authorized to sign orders on behalf of the commission.

((~~(8) When the commission finds an apparent violation and refers the matter to an enforcement agency, the commission shall give to the respondent written notice of such finding and order of referral.~~))

AMENDATORY SECTION (Amending WSR 03-22-065, filed 11/4/03, effective 12/5/03)

WAC 390-37-105 Prehearing conference—Rule. (1) In any prehearing conference prior to an enforcement hearing (adjudicative proceeding), the chair or the chair's designee upon his/her own motion or upon request by one of the parties or their qualified representative, may direct the parties to appear at a specified time and place for a conference to consider:

(a) Identifying and simplifying issues;

(b) The necessity of amendments to the ((~~hearing notice~~)) pleadings;

(c) The possibility of obtaining stipulations, admissions of facts and of documents;

(d) Limiting the number and consolidation of the examination of witnesses; and

(e) Procedural and such other matters as may aid in the conduct of the proceeding.

(2) Prehearing conferences may be presided over by the chair or his/her designee.

(3) Prehearing conferences may be held by telephone conference call or at a time and place specified by the presiding officer.

(4) In a prehearing conference, the presiding officer may hear prehearing motions regarding preliminary matters such as motions *in limine*, discovery motions, and other similar matters. The presiding officer shall not consider dispositive motions in a prehearing conference and such motions will automatically be scheduled for consideration before the commission.

(5) Following the prehearing conference, the presiding officer shall issue an order reciting the action taken and decisions made at the conference and the date on which objections to the order are to be filed and served. If no objection to the order is timely filed with the presiding officer, the order shall control the subsequent course of the proceeding unless modified for good cause by subsequent order.

(6) When the chair or his/her designee presides over a prehearing conference, he or she is acting as a quasi-judicial body which relates to a quasi-judicial matter between named parties. Therefore, a prehearing conference is not subject to chapter 42.30 RCW, Open Public Meetings Act.

AMENDATORY SECTION (Amending WSR 03-22-065, filed 11/4/03, effective 12/5/03)

WAC 390-37-132 Enforcement hearings (adjudicative proceedings)—Depositions ((~~and interrogatories~~))—Notice. A party desiring to take the deposition of any person upon oral examination shall give reasonable notice of not less than ((~~seven calendar~~)) five business days in writing to the commission and all parties. The notice shall state the time and place for taking the deposition and the name and address of each person to be examined. On motion of a party to whom the notice is served, the commission or its hearing officer may, for cause shown, enlarge or shorten the time. If the parties so stipulate in writing, depositions may be taken at any time or place, upon any notice, and in any manner and when so taken may be used as other depositions.

AMENDATORY SECTION (Amending WSR 06-07-001, filed 3/1/06, effective 4/1/06)

WAC 390-37-136 Production of documents and use at hearing and other hearing procedures (adjudicative proceedings). (1) Unless a prehearing order states otherwise, the provisions of this rule apply to evidence and written argument (legal briefs) filed and served in hearings (adjudicative proceedings). Parties or the executive director may request a prehearing conference if provisions of this rule need to be adjusted or if the provisions are not adhered to by the parties.

(2) The parties are encouraged to exchange copies of proposed exhibits, exhibit lists and witness lists prior to the deadline specified in subsection (3)(a) of this section. The parties are encouraged to exchange documents by email. The parties are encouraged to confer and determine whether there are any objections to the evidence and whether any agreements or stipulations can be reached regarding proposed exhibits, witnesses, and legal and factual issues.

(3)(a) Unless the commission determines otherwise, when evidence is to be offered at the adjudicative proceeding or when briefs are to be submitted at the adjudicative proceeding, the party offering the evidence or brief shall file with the commission and serve on all parties a copy of proposed exhibits, exhibit lists, witness lists, and briefs with the commission via an email to the executive director or his or her designee by the date and time designated by the executive director or designee, which is typically by 1:00 p.m. Pacific Time at least eight ((~~calendar~~)) days prior to the hearing. The email shall provide the name of the party submitting the documents, the total number of pages, the software used to prepare the document, and the name, address, telephone number and email address of the person sending the email message.

(b) In the event electronic submission is not readily available to a *pro se* respondent or the evidence is not suited to email transmission, other means of providing these materials to the commission may be approved by the chair or the executive director, or their designees if requested in advance of the date and time in (a) of this subsection.

(c) On the day the parties provide these materials electronically to the commission, they shall also mail or otherwise deliver a paper (or hard copy) set of the materials to the commission.

(d) The parties shall confirm in advance with the executive director that any documents provided electronically are able to be accessed by software available at the agency. If they are not accessible, the executive director shall direct how the documents are to be submitted.

(e) The documents are considered filed when received during actual business hours at the commission office. If received after actual business hours, they will be deemed filed the next business day.

(4) Respondent's exhibits shall be numbered R-1, R-2, etc. Commission staff exhibits shall be numbered S-1, S-2, etc. Jointly submitted exhibits shall be numbered J-1, J-2, etc. If an exhibit is not jointly submitted but there is no objection to it by the responding party, the party offering the exhibit shall designate agreed-to exhibits on the party's exhibit list.

(5) Briefs shall contain the name of the respondent in the caption and the cause number. Briefs shall be no more than twenty-five pages, double-spaced, excluding attachments or exhibits.

(6) The parties shall inform the executive director of any special equipment necessary for the adjudicative proceeding at the time documents are filed with the commission.

AMENDATORY SECTION (Amending WSR 16-01-015, filed 12/4/15, effective 1/4/16)

WAC 390-37-142 Brief enforcement hearing (adjudicative proceeding)—Procedure. (1) A brief adjudicative proceeding may be presided over by the chair, or a member of the commission designated by the chair.

(2) When a violation, as described in WAC 390-37-140, is alleged, before taking action, the executive director shall send the alleged violator notice, which shall include:

(a) Alleged violation;

(b) The maximum amount of the penalty that can be imposed at the hearing, relevant penalty schedules, and the amount of any proposed fine; and

(c) Person's right to respond either in writing or in person to explain his/her view of the matter.

(3) As provided in RCW 34.05.050, a respondent who has been notified of a brief adjudicative proceeding may waive the hearing by providing the following prior to the hearing:

(a) A signed statement of understanding;

(b) Any missing required reports; and

(c) A penalty payment specified by the executive director in accordance with the penalty authority of WAC 390-37-140 and the brief enforcement hearing penalty schedules of this chapter.

(4) As used in this section, the term "statement of understanding" means a written statement signed by the respondent that:

(a) Acknowledges a violation of chapter 42.17A RCW and any relevant rules; and

(b) Expresses the respondent's understanding that the commission will not hold any adjudicative proceeding concerning the violation.

(5) At the time of the hearing if the presiding officer believes alleged violations are of such magnitude as to merit penalties greater than ((~~$1,000~~)) one thousand dollars, the presiding officer shall immediately adjourn the hearing and direct the matter be scheduled for an adjudicative proceeding by the full commission.

(6) At the time any unfavorable action is taken((~~, within ten business days~~)) the presiding officer shall serve upon each party a written statement describing the violation, the reasons for the decision, and the penalty imposed((~~, and their right to request review by the commission~~)). Within ten days, the presiding officer shall give the parties a brief written statement of the reasons for the decision and information about any internal administrative review available. The executive director is authorized to sign the decision on behalf of the presiding officer.

(7) The written decision of the presiding officer is an initial order. If no review is taken of the initial order, the initial order shall be the final order.

AMENDATORY SECTION (Amending WSR 03-22-065, filed 11/4/03, effective 12/5/03)

WAC 390-37-144 Brief adjudicative proceeding—Administrative review procedures. (1) The commission shall conduct a review of the initial order upon the written or oral request of a party if the commission receives the request within twenty-one ((~~business~~)) days after the service of the initial order. "Service" is defined as the date the order was deposited in the U.S. mail per RCW 34.05.010(19), or personally served. The party seeking review shall state the reason for the review, and identify what alleged errors are contained in the initial order.

(2) If the parties have not requested review, the commission may conduct a review of the initial order upon its own motion and without notice to the parties, but it may not take any action on review less favorable to any party than the original order without giving that party notice and an opportunity to explain that party's view of the matter.

(3) The order on review shall be in writing stating the findings made, and the reasons for the decision, and notice that reconsideration and judicial review are available. The order on review shall be entered within twenty ((~~business~~)) days after the date of the initial order or of the request for review, whichever is later.

(4) If the commission is not scheduled to meet within twenty ((~~business~~)) days after the date of the initial order or request for review and therefore cannot dispose of the request within that time period, the request is:

(a) Deemed denied under RCW 34.05.491(5) and the initial order becomes final;

(b) Considered a request for reconsideration under WAC 390-37-150; and

(c) Scheduled for consideration and disposition at the next commission meeting at which it is practicable to do so.

AMENDATORY SECTION (Amending WSR 03-22-065, filed 11/4/03, effective 12/5/03)

WAC 390-37-150 Reconsideration and judicial review of decisions. (1) For purposes of this rule, "decision" means any findings, conclusions, order, or other action by the commission which is reviewable by a court.

(2) A decision may be reconsidered only upon (a) the written request of a party thereby or (b) the motion or written request of a commissioner who voted on the prevailing side when that decision was made.

(3) Such a request for reconsideration shall be filed at the office of the public disclosure commission, or motion made, ((~~no later than twenty-one business days after~~)) within ten days of service of the decision of which reconsideration is sought. Copies of the request or motion shall be served on all parties of record at the time the request for reconsideration or motion is filed.

(4) A request or motion for reconsideration shall specify the grounds therefor. Grounds for reconsideration shall be limited to:

(a) A request for review was deemed denied in accordance with WAC 390-37-144(4);

(b) New facts or legal authorities that could not have been brought to the commission's attention with reasonable diligence. If errors of fact are alleged, the requester must identify the specific evidence in the prior proceeding on which the requester is relying. If errors of law are alleged, the requester must identify the specific citation; or

(c) Significant typographical or ministerial errors in the order.

(5) Upon being served with a decision, the respondent may treat that decision as final for the purpose of petitioning for judicial review. The commission may not reconsider any decision after being served with a petition for judicial review.

(6) When a request for reconsideration is served, or motion made, enforcement of the decision of which reconsideration is sought shall be stayed and the decision shall not be final until the commission has acted on the reconsideration.

(7) The commission is deemed to have denied request for reconsideration or motion if, within twenty ((~~business~~)) days from the date the request or motion is filed, the commission does not either (a) dispose of the request or motion, or (b) serve the parties with written notice specifying the date if will act upon the request or motion.

(8) The commission shall act on the reconsideration request or motion, at the next meeting at which it practicably may do so, by:

(a) Deciding whether to reconsider its decision; and

(b) If it decides to do so, either:

(i) Affirming its decision; or

(ii) Withdrawing or modifying the final order; or

(iii) Setting the matter for further hearing.

Provided, That before a decision may be amended other than by lowering a penalty, the respondent shall be given notice and an opportunity to be heard if, and in the same manner as, required for the original decision.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 390-37-155	Electronic filing brief enforcement hearing penalty schedule.
WAC 390-37-160	Statement of financial affairs (F-1) penalty schedule.
WAC 390-37-165	Candidate registration statement (C-1)/candidate statement of financial affairs (F-1) penalty schedule.
WAC 390-37-170	Lobbyist monthly expense report (L-2) penalty schedule.
WAC 390-37-175	Lobbyist employer report (L-3) penalty schedule.

NEW SECTION

WAC 390-37-143 Brief enforcement hearings (adjudicative proceeding)—Penalty schedule. The presiding officer may assess a penalty up to one thousand dollars upon finding a violation of chapter 42.17A RCW or Title 390 WAC.

(1) Base penalty amounts:

Violation	1st Occasion	2nd Occasion	3rd Occasion
Failure to timely file an accurate and complete statement of financial affairs (F-1):			
Filed report after hearing notice, but before enforcement hearing. Provided written explanation or appeared at hearing to explain mitigating circumstances. Did not enter into statement of understanding.	$0 - $150	$150 - $300	$300 - $600
Filed report after hearing notice, but before enforcement hearing. Did not enter into statement of understanding.	$150	$300	$600
Failed to file report by date of enforcement hearing.	$250	$500	$1,000
Candidate's failure to timely file an accurate and complete registration statement (C-1)/statement of financial affairs (F-1):			
Filed report after hearing notice, but before enforcement hearing. Provided written explanation or appeared at hearing to explain mitigating circumstances. Did not enter into statement of understanding.	$0 - $150 per report	$150 - $300 per report	$300 - $600 per report up to $1,000
Filed report after hearing notice, but before enforcement hearing. Did not enter into statement of understanding.	$150 per report	$300 per report	$600 per report up to $1,000
Failed to file report by date of enforcement hearing.	$250 per report	$500 per report	consideration by full commission
Failure to timely file an accurate and complete lobbyist monthly expense report (L-2):			
Filed report after hearing notice, but before enforcement hearing. Provided written explanation or appeared at hearing to explain mitigating circumstances. Did not enter into statement of understanding.	$0 - $150	$150 - $300	$300 - $600
Filed report after hearing notice, but before enforcement hearing. Did not enter into statement of understanding.	$150	$300	$600
Failed to file report by date of enforcement hearing.	$250	$500	$1,000
Failure to timely file an accurate and complete lobbyist employer report (L-3):			

Violation	1st Occasion	2nd Occasion	3rd Occasion
Filed report after hearing notice, but before enforcement hearing. Provided written explanation or appeared at hearing to explain mitigating circumstances. Did not enter into statement of understanding.	$0 - $150	$150 - $300	$300 - $600
Filed report after hearing notice, but before enforcement hearing. Did not enter into statement of understanding.	$150	$300	$600
Failed to file report by date of enforcement hearing.	$250	$500	$1,000
Failure to timely file accurate and complete disclosure reports:			
Political committee registration (C-1pc).	$150	$300	$600
Statement of contributions deposit (C-3).	$150	$300	$600
Summary of total contributions and expenditures (C-4).	$150	$300	$600
Independent expenditures and electioneering communications (C-6).	$150	$300	$600
Last minute contribution report (LMC).	$150	$300	$600
Out-of-state committee report (C-5).	$150	$300	$600
Annual report of major contributors (C-7).	$150	$300	$600
Failure to timely file accurate and complete reports disclosing lobbying activities:			
Lobbyist registration (L-1).	$150	$300	$600
Public agency lobbying report (L-5).	$150	$300	$600
Grass roots lobbying report (L-6).	$150	$300	$600
Failure to file electronically.	$350	$650	$1,000
Exceeding contribution limits.	$150	$300	$600
Exceeding mini reporting threshold.	$150	$300	$600
Failure to comply with political advertising sponsor identification requirements.	$150	$300	$600
Failure to include required candidate's party preference in political advertising.	$150	$300	$600
Failure to comply with other political advertising requirements, RCW 42.17A.330 through 42.17A.345.	$150	$300	$600
Use of public facilities to assist a campaign for election or promote a ballot measure.	$150	$300	$600

"Occasion" means established violation. Only violations in the last five years will be considered for the purpose of determining second and third occasions.

(2) In determining the appropriate penalty, the presiding officer may consider the nature of the violation and aggravating and mitigating factors, including:

(a) Whether the respondent is a first-time filer;

(b) The respondent's compliance history for the last five years, including whether the noncompliance was isolated or limited in nature, indicative of systematic or ongoing problems, or part of a pattern of violations by the respondent, or in the case of a political committee or other entity, part of a pattern of violations by the respondent's officers, staff, principal decision makers, consultants, or sponsoring organization;

(c) The respondent's unpaid penalties from a previous enforcement action;

(d) The impact on the public, including whether the noncompliance deprived the public of timely or accurate information during a time-sensitive period, or otherwise had a significant or material impact on the public;

(e) The amount of financial activity by the respondent during the statement period or election cycle;

(f) Whether the late or unreported activity was significant in amount or duration under the circumstances, including in proportion to the total amount of expenditures by the respondent in the campaign or statement period;

(g) Corrective action or other remedial measures initiated by respondent prior to enforcement action, or promptly taken when noncompliance brought to respondent's attention;

(h) Good faith efforts to comply, including consultation with commission staff prior to initiation of enforcement action and cooperation with commission staff during enforcement action, and a demonstrated wish to acknowledge and take responsibility for the violation;

(i) Personal emergency or illness of the respondent or member of his or her immediate family;

(j) Other emergencies such as fire, flood, or utility failure preventing filing;

(k) Sophistication of respondent or the financing, staffing, or size of the respondent's campaign or organization;

(l) Commission staff, third-party vendor, or equipment error, including technical problems at the agency preventing or delaying electronic filing.

(3) The presiding officer has authority to suspend all or a portion of an assessed penalty under the conditions to be determined by that officer including, but not limited to, payment of the nonsuspended portion of the penalty within five business days of the date of the entry of the order in that case.

(4) If, on the third occasion, a respondent has outstanding penalties or judgments, the matter will be directed to the full commission for consideration.

(5) The presiding officer may direct a matter to the full commission if the officer believes one thousand dollars would be an insufficient penalty or the matter warrants consideration by the full commission. Cases will automatically be scheduled before the full commission for an enforcement action when the respondent:

(a) Was found in violation during a previous reporting period;

(b) The violation remains in effect following any appeals; and

(c) The person has not filed the disclosure forms that were the subject of the prior violation at the time the current hearing notice is being sent.

WSR 17-03-006
PERMANENT RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 17-04—Filed January 4, 2017, 3:50 p.m., effective January 4, 2017]

Effective Date of Rule: January 4, 2017.

Other Findings Required by Other Provisions of Law as Precondition to Adoption or Effectiveness of Rule: As described in the Federal Register (Vol. 81, No. 266, Page 84431), 50 C.F.R. 660.212(a) is now amended to require any sablefish landed in the limited entry primary season sablefish fishery or the limited entry and open access daily trip limit fisheries on the west coast to be reported via electronic fish ticket. This rule making will align state rules with federal rule effective January 1, 2017, and eliminate the need for duplicative electronic and paper ticket reporting.

Purpose: The purpose of this rule making is to amend existing rules to require the submission of electronic fish tickets for any directed commercial groundfish landings as authorized under 50 C.F.R., Part 660 into Washington. These changes will conform to the federal rule effective January 1, 2017, requiring all purchases of sablefish from vessels landing into Washington, Oregon, and California to be reported using the Pacific States Marine Fisheries Commission (PSMFC) ETix system. The PSMFC ETix system will collect the same information as is currently collected on the marine fish receiving paper tickets and transmit the data to the Washington department of fish and wildlife electronically. Without these changes, existing state regulations would require deliveries from the affected fisheries to be reporting using both the ETix system and the state. Incidental landings of groundfish from commercial ocean salmon troll and pink shrimp fisheries are not affected by this rule making.

Citation of Existing Rules Affected by this Order: Amending WAC 220-69-210, 220-69-240, 220-69-246, 220-69-250, and 220-69-274.

Statutory Authority for Adoption: RCW 77.04.012, 77.04.013, 77.04.020, 77.04.055, and 77.12.047.

Other Authority: 50 C.F.R. Part 660.

Adopted under notice filed as WSR 16-22-097 on November 2, 2016.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 5, 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 5, 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: January 4, 2017.

J. W. Unsworth
Director

AMENDATORY SECTION (Amending WSR 14-02-013, filed 12/19/13, effective 1/19/14)

WAC 220-69-210 Fish receiving ticket definitions. The following definitions apply to this chapter:

(1) "Broker" means a person whose business it is to bring a seller of fish and shellfish and a purchaser of those fish and shellfish together. A broker is not required to have a wholesale fish dealer's license if the fish or shellfish only transit the state of Washington, and no storage, handling, processing, or repackaging occurs within the state.

(2) A broker who takes physical possession of fish or shellfish is an original receiver and must complete a fish receiving ticket. A broker acting strictly as an intermediary is not required to complete a fish receiving ticket for fish or shellfish that are delivered to an original receiver in the state of Washington. A broker must complete a fish receiving ticket for brokering an interstate or foreign sale from a Washington fisher who is not a holder of a direct retail endorsement, or a sale of fish or shellfish that have entered the state from another state, territory, or country, if the fish or shellfish are placed into interstate or foreign commerce without having been delivered to an original receiver in the state of Washington.

(3) "Department" means the Washington Department of Fish and Wildlife, Fish Program - Commercial Harvest Data Team, 600 Capitol Way North, Olympia, Washington 98501-1091.

(4) "Delivery" means arrival at a place or port and includes arrivals from offshore waters to waters within the

state, arrivals ashore from state or offshore waters, and arrivals within the state from interstate or foreign commerce.

(5) "Electronic fish receiving ticket" means the groundfish catch reporting system described in 50 C.F.R.((~~§ 660.113 (b)(4)(ii)~~)), Part 660 that is used to submit harvest and fishing information to the department and the National Marine Fisheries Service.

(6) "Fish" means food fish classified under WAC 220-12-010 and game fish taken by treaty fishers and sold commercially.

(7) "Fish buyer" or "buyer" means a person who receives fish or shellfish and who is required to complete a fish receiving ticket. A wholesale fish dealer or a retail seller who directly receives fish or shellfish taken by a commercial fisher, or receives fish or shellfish in interstate or foreign commerce is acting in the capacity of a buyer and is required to complete a fish receiving ticket. A buyer who is acting as an agent for a wholesale fish dealer is required to have a fish buyer's license issued by the department.

(8) "Fish receiving ticket" means a document produced by the department for commercial catch accounting purposes and includes nontreaty fish receiving tickets, such as Puget Sound salmon, troll, marine, utility, and shellfish receiving tickets; treaty Indian fish receiving tickets; and treaty Indian shellfish receiving tickets.

(9) "Fisher" means a person engaged in commercial fishing activities.

(10) "Fresh" means unprocessed and unfrozen, regardless of whether the fish or shellfish are in the round, cleaned, or packaged for retail sale.

(11) "Frozen" means completely frozen throughout. Flash frozen and surface glaze frozen fish and shellfish are unfrozen fish and shellfish.

(12) "Nontreaty" means all entities not qualified by definition as "treaty."

(13) "Original receiver" or "receiver" means the first person in possession of fish or shellfish in the state of Washington who is acting in the capacity of a buyer. A fisher who is not the holder of a direct retail endorsement and who sells fish or shellfish to anyone other than a dealer, or a fisher who delivers fish or shellfish and places the fish or shellfish into interstate or foreign commerce, is the original receiver of the fish or shellfish. A cold storage facility that holds fish or shellfish for a fisher is not an original receiver, provided that the facility does not process, package, or otherwise handle the fish or shellfish. A person transporting fish or shellfish on behalf of a fisher, and who is in possession of an accurately completed commercial food fish and shellfish transportation ticket, is not an original receiver, provided that the fish or shellfish are transported only to a cold storage facility or to a buyer.

(14) "Processed" means preparing and preserving and requires a wholesale fish dealer's license. Preserving includes treating with heat, including smoking and kippering. Cooked crab is processed. Preserving also includes freezing fish and shellfish.

(15) "Shellfish" means shellfish classified under WAC 220-12-020.

(16) "Treaty" and "treaty Indian," for purposes of fish receiving tickets only, means persons who are members of federally recognized Indian tribes who harvest fish or shellfish in Washington pursuant to an Indian treaty, whether such harvest is on or off reservation.

(17) "Wholesale fish dealer" or "dealer" means a person who, acting for commercial purposes, takes possession or ownership of fish or shellfish and sells, barters, or exchanges or attempts to sell, barter, or exchange fish or shellfish that have been landed into the state of Washington or entered the state of Washington in interstate or foreign commerce. A wholesale fish dealer must be licensed. A fisher who is not a holder of a direct retail endorsement and sells fish or shellfish to anyone other than a wholesale fish dealer is required to have a wholesale dealer's license. A retail seller who receives fish or shellfish in interstate or foreign commerce, or from a person who is not a wholesale fish dealer, is required to have a wholesale fish dealer's license.

(18) "Working day" means Monday through Friday, exclusive of a Washington state or federal holiday.

AMENDATORY SECTION (Amending WSR 16-14-046, filed 6/28/16, effective 7/29/16)

WAC 220-69-240 Duties of commercial purchasers and receivers. (1) It is unlawful for any person originally receiving or buying fresh, iced, or frozen fish or shellfish, whether or not the fish or shellfish was previously delivered in another state, territory, or country, to fail to:

(a) Be a licensed wholesale fish dealer or fish buyer; and

(b) Immediately, completely, accurately, and legibly prepare the appropriate state of Washington fish receiving ticket for each and every purchase or receipt of such commodities.

(i) The original receiver must record each delivery on a separate fish receiving ticket; and

(ii) The original receiver must prepare a fish receiving ticket for purchases of fish or shellfish from fishers who are also fish dealers if the fisher/dealer has not previously completed a fish receiving ticket and provided a copy of the fish receiving ticket or the ticket number as proof.

(2) Failure to be licensed under subsection (1) of this section is punishable under RCW 77.15.620. Failure to properly prepare a fish receiving ticket is punishable under RCW 77.15.630.

(3) It is unlawful for the original receiver to fail to initiate the completion of the fish receiving ticket upon receipt of any portion of a commercial catch. If delivery of the catch takes more than one day, the original receiver must enter the date that the delivery is completed on the fish receiving ticket as the date of delivery. If, for any reason, the delivery vessel leaves the delivery site, the original receiver must immediately enter the date the vessel leaves the delivery site on the fish receiving ticket.

(4) It is unlawful for any original receiver of shellfish to fail to record all shellfish aboard the vessel making the delivery to the original receiver. The poundage of any fish or shellfish that are unmarketable, discards, or weigh backs must be shown on the fish receiving ticket and identified as such, but a zero dollar value may be entered for those fish or shellfish.

(5) Any employee of a licensed wholesale dealer who is authorized to receive or purchase fish or shellfish for that dealer on the premises of the primary business address or any of its plant locations as declared on the license application, is authorized to initiate and sign fish receiving tickets on behalf of his or her employer. The business, firm, and/or licensed wholesale fish dealer the buyers are operating under is responsible for the accuracy and legibility of all documents initiated in its name.

(6) This section does not apply to purchases or receipts made by individuals or consumers at retail.

(7) Subsections (1) through (4) of this section do not apply to persons delivering or receiving fish taken ((~~under the Pacific Coast Groundfish Shoreside Individual Fishing Quota (IFQ) Program (50 C.F.R. § 660.140) who~~)) by the directed commercial fisheries for Pacific Coast Groundfish authorized under 50 C.F.R., Part 660 if such persons are in compliance with the provisions of WAC 220-69-250(5) and ((~~who~~)):

(a) Complete electronic fish receiving tickets prior to either processing fish or removing the fish from the delivery site; ((~~and~~))

(b) Electronically submit the electronic fish receiving tickets to the National Marine Fisheries Service and the department no later than twenty-four hours after the date the fish are received((~~.~~)); and

(c) Electronically submit any amendments made to the mandatory information required under WAC 220-69-256 after the initial submission required under (b) of this subsection.

(8) For purposes of this section;

(a) The term "completed" means that scale weights have been recorded for all delivered fish; and

(b) The term "submitted" means that all mandatory information required under WAC 220-69-256 has been entered and timelines under subsection (7)(b) of this section have been met.

(9) Forage fish and mackerel:

(a) It is unlawful for any person receiving forage fish or mackerel to fail to report the forage fish or mackerel on fish receiving tickets initiated and completed on the day the forage fish or mackerel are delivered.

(i) Herring must also be reported on herring harvest logs.

(ii) The harvested amount of forage fish or mackerel must be entered upon the fish ticket when the forage fish are off-loaded from the catcher vessel.

(iii) An estimate of herring, candlefish, anchovy, sardine or mackerel caught but not sold due to mortality must be included on the fish ticket as "loss estimate."

(b) In the coastal sardine fishery or coastal mackerel fishery, it is unlawful to purchase, per sardine or mackerel fishery vessel, more than fifteen percent cumulative weight of sardine or mackerel for the purposes of conversion into fish flour, fishmeal, fish scrap, fertilizer, fish oil, other fishery products, or by-products, for purposes other than human consumption or fishing bait during the sardine or mackerel fishery season. Sardine and mackerel purchased for these purposes must be included, by weight, on the fish ticket as "reduction."

(c) In any forage fish fishery or in the mackerel purse seine fishery, it is unlawful to purchase anchovy in excess of fifteen percent, by weight, of the total landing weight per vessel, for the purposes of conversion into fish flour, fishmeal, fish scrap, fertilizer, fish oil, or other fishery products. Anchovy purchased for these purposes must be included, by weight, on the fish ticket as "reduction."

(10) Geoduck: It is unlawful for any person receiving geoduck, whether or not the receiver holds a license as required under Title 77 RCW, to fail to accurately and legibly complete the fish receiving ticket initiated on the harvest tract immediately upon the actual delivery of geoduck from the harvesting vessel onto the shore. This fish receiving ticket must accompany the harvested geoduck from the department of natural resources harvest tract to the point of delivery.

(11) Puget Sound shrimp - Pot gear:

(a) It is unlawful for any person originally receiving or purchasing shrimp, other than ghost shrimp, harvested from Catch Area 23A, to fail to record 23A-C, 23A-E, 23A-W, or 23A-S on shellfish receiving tickets based on the location of harvest and the boundary definitions specified in WAC 220-52-051.

(b) It is unlawful for any person originally receiving or purchasing shrimp, other than ghost shrimp, harvested from Catch Area 26A, to fail to record either 26A-E or 26A-W on shellfish receiving tickets based on the location of harvest and the boundary definitions specified in WAC 220-52-051.

(c) It is unlawful for any person originally receiving or purchasing shrimp, other than ghost shrimp, harvested from Catch Area 26B, to fail to record either 26B-1 or 26B-2 on shellfish receiving tickets based on the location of harvest and the boundary definitions specified in WAC 220-52-051.

(d) It is unlawful for any person originally receiving or purchasing shrimp, other than ghost shrimp, harvested from Catch Areas 20B, 21A, and 22A, to fail to record 1A-20B, 1A-22A, 1B-20B, 1B-21A, 1B-22A, or 1C-21A on shellfish receiving tickets based on the location of harvest and the boundary definitions specified in WAC 220-52-051.

(12) Puget Sound shrimp - Trawl gear:

(a) It is unlawful for the original receiver of shrimp other than ghost shrimp taken from Puget Sound by trawl gear to fail to report to the department the previous day's purchases by 10:00 a.m. the following morning.

(b) Reports must be made by fax at 360-796-0108 or by text message or e-mail at shrimpreport@dfw.wa.gov.

(c) Reports must include, for each fish receiving ticket prepared:

(i) The buyer name, fisher name, and date of sale;

(ii) The fish receiving ticket number, including the first alphanumeric letter;

(iii) The total number of pounds caught per shrimp species; and

(iv) The Marine Fish-Shellfish Management and Catch Reporting Area where the shrimp was harvested.

(13) Puget Sound crab:

(a) It is unlawful for any wholesale dealer acting in the capacity of an original receiver of Dungeness crab taken from Puget Sound by nontreaty fishers to fail to report to the department the previous day's purchases by 10:00 a.m. the following business day.

(b) Reports must be made to the Mill Creek Regional Office by fax at 425-338-1066, or by e-mail at crabreport@dfw.wa.gov.

(c) Reports must include:

(i) The dealer's name;

(ii) The dealer's phone number;

(iii) The date of delivery of crab to the original receiver; and

(iv) The total number of pounds of crab caught by non-treaty fishers, by Crab Management Region or by Marine Fish-Shellfish Management and Catch Reporting Area.

(14) Salmon and sturgeon:

(a) During any Puget Sound fishery opening that is designated as "quick reporting required," per WAC 220-47-001:

(i) It is unlawful for any wholesale dealer acting in the capacity of an original receiver to fail to report all purchases of salmon and sturgeon made on the previous calendar day, or for a direct retail endorsement (DRE) holder to fail to report all salmon offered for retail sale on the previous calendar day.

(ii) The report must include:

(A) The dealer or DRE holder name and purchasing location;

(B) The date of purchase;

(C) Each fish receiving ticket number, including the first alphanumeric letter, used on the purchasing date; and

(D) The following catch data for each fish ticket used: The total number of days fished, gear, catch area, species, number, and total weight for each species purchased and all take home fish not purchased (wholesale dealer) or sold (DRE).

(iii) When quick reporting is required, Puget Sound reports must be submitted by 10:00 a.m. on the day after the purchase date. Submission of a report is not complete until the report arrives at the designated department location. Reports can be submitted via fax at 360-902-2949; via e-mail at psfishtickets@dfw.wa.gov; or via phone at 1-866-791-1279. In fisheries under Fraser Panel Control within Fraser Panel Area Waters (area defined under Art. XV, Annex II, Pacific Salmon Treaty 1985), other reporting requirements not listed in this subsection may be necessary under Subpart F of the International Fisheries Regulations, 50 C.F.R. Ch. III § 300.93.

(b) During any coastal troll fishery opening that is designated by rule as "quick reporting required":

(i) It is unlawful for any wholesale dealer acting in the capacity of an original receiver to fail to report all purchases of salmon and sturgeon made on the previous calendar day, or for a DRE holder to fail to report all salmon offered for retail sale on the previous calendar day.

(ii) The report must include dealer or DRE holder name and purchasing location; date of purchase; each fish receiving ticket number, including the first alphanumeric letter, used on the purchasing date; and the following catch data for each fish ticket used: Total number of days fished, gear, catch area, species, number, and total weight for each species purchased and all take home fish not purchased (wholesale dealer) or sold (DRE).

(iii) When quick reporting is required, coastal troll reports must be submitted by 10:00 a.m. on the day after the purchase date. Submission of a report is not complete until the report arrives at the designated department location. Reports can be made via fax at 360-902-2949; via e-mail at trollfishtickets@dfw.wa.gov; or via phone at 1-866-791-1279.

(c) During any Grays Harbor or Willapa Bay fishery opening that is designated by rule as "quick reporting required":

(i) It is unlawful for any wholesale dealer acting in the capacity of an original receiver to fail to report all purchases of salmon and sturgeon made on the previous calendar day, or for a DRE holder to fail to report all salmon offered for retail sale on the previous calendar day.

(ii) The report must include dealer or DRE holder name and purchasing location; date of purchase; each fish receiving ticket number, including the first alphanumeric letter, used on the purchasing date; and the following catch data for each fish ticket used:

(A) The total number of days fished;

(B) The gear used;

(C) The catch area fished; and

(D) The species, number, and total weight for each species purchased and all take home fish not purchased (wholesale dealer) or sold (DRE).

(iii) When quick reporting is required, Grays Harbor and Willapa Bay reports must be submitted by 10:00 a.m. on the day after the purchase date. Submission of a report is not complete until the report arrives at the designated department location. Reports can be made via fax at 360-249-1229; e-mail at harborfishtickets@dfw.wa.gov; or phone at 1-866-791-1280.

(d) During any Columbia River fishery opening that is designated by rule as "quick reporting required":

(i) It is unlawful for any wholesale dealer acting in the capacity of an original receiver to fail to report all purchases of salmon and sturgeon, or for a DRE holder to fail to report all salmon offered, for retail sale.

(ii) The report must include dealer or DRE holder name and purchasing location; date of purchase; each fish receiving ticket number, including the first alphanumeric letter, used on the purchasing date; and the following catch data for each fish ticket used: Total number of days fished, gear, catch area, species, number, and total weight for each species purchased and all take home fish not purchased (wholesale dealer) or sold (DRE).

(iii) When quick reporting is required, Columbia River reports must be submitted within 5, 8, 12, or 24 hours of closure of the designated fishery.

(A) The department establishes the time frame for submitting reports at the time of adoption of the quick reporting fishery. Adoption and communication of the quick reporting regulations for a given fishery occurs in conjunction with the adoption of the fishery through the Columbia River Compact.

(B) Submission of a report is not complete until the report arrives at the designated department location. Reports can be made via fax at 360-906-6776 or 360-906-6777; via e-mail at crfishtickets@dfw.wa.gov; or via phone at 1-866-791-1281.

(e) Faxing or reporting electronically in portable document format (PDF) a copy of each fish receiving ticket used, within the previously indicated time frames specified per area, satisfies the quick reporting requirement.

(15) Sea urchins and sea cucumbers:

(a) It is unlawful for any wholesale dealer acting in the capacity of an original receiver and receiving sea urchins or sea cucumbers from nontreaty fishers to fail to report to the department each day's purchases by 10:00 a.m. the following day.

(i) Wholesale dealers must report by:

(A) Fax at 360-902-2943;

(B) Toll-free telephone at 866-207-8223; or

(C) Text message or e-mail at seaurchinreport@dfw.wa.gov for sea urchins or seacucumberreport@dfw.wa.gov for sea cucumbers.

(ii) For red sea urchins, the report must specify the number of pounds received from each sea urchin district.

(iii) For green sea urchins and sea cucumbers, the report must specify the number of pounds received from each Marine Fish-Shellfish Management and Catch Reporting Area.

(iv) For sea cucumbers, the report must specify whether the landings were "whole-live" or "split-drained."

(b) It is unlawful for the original receiver of red sea urchins to fail to record on the fish receiving ticket the sea urchin district where the red sea urchins were taken and the name of the port of landing where the sea urchins were landed ashore.

(c) It is unlawful for the original receiver of sea cucumbers to fail to record on the fish receiving ticket whether the sea cucumbers were delivered "whole-live" or "split-drained."

(16) A violation of the documentation or reporting requirements in this section is punishable under RCW 77.15.630, Unlawful fish and shellfish catch accounting—Penalty.

AMENDATORY SECTION (Amending WSR 12-04-028, filed 1/26/12, effective 2/26/12)

WAC 220-69-246 Description of Washington state electronic fish receiving ticket. (1) There is hereby created a nontreaty electronic fish receiving ticket. Electronic forms are available ((~~to original receivers participating in the Pacific Coast Groundfish Shoreside Individual Fishing Quota (IFQ) Program~~)) for deliveries of fish from the directed commercial fisheries for Pacific Coast Groundfish authorized under 50 C.F.R., Part 660. The electronic form shall contain space for the following information:

(a) Fisherman: Name of licensed deliverer and department number assigned to licensed deliverer;

(b) Address: Address of licensed deliverer;

(c) Boat name: Name or Coast Guard number of landing vessel;

(d) WDFW boat registration: Washington department of fish and wildlife boat registration number;

(e) Gear: Code number or name of specific gear type used;

(f) Fisherman's signature: Signature of licensed deliverer;

(g) Date: Date of landing;

(h) Dealer: Name of dealer and department number assigned to dealer;

(i) Buyer: Name of buyer and department number assigned to buyer;

(j) Receiver's signature: Signature of original receiver;

(k) Number of days fished: Days spent catching fish;

(l) Catch area: Marine fish/shellfish management and catch reporting area code where the majority of the marine fish were caught or harvested;

(m) Species code: Department assigned species code;

(n) Individual numbers of fish species, if such fish are landed as part of an incidental catch allowance or catch ratio restriction that is expressed in numbers of fish rather than in pounds;

(o) The scale weight of all fish, to include fish with no value. However, if the department allows a species of fish to be dressed, and the fish is dressed as the department requires, such fish can be recorded in its original dressed weight and designated as dressed on the fish receiving ticket;

(p) Value of fish sold or purchased: Summary information for species, or species groups landed as described in (q) of this subsection;

(q) Description of species or species category: All species or categories of bottomfish having a vessel trip limit must be listed separately (see WAC 220-44-050), and all others must be described with the relevant category or species name issued by the department;

(r) Federal limited entry permit number granting authority for the delivery. ((~~Separate electronic fish receiving tickets are required for each federal sablefish endorsed limited entry permit number used in the delivery;~~)) The weight and value of sablefish delivered by vessels participating in the primary sablefish season authorized under 50 C.F.R., Part 660, Subpart E, Section 231 must be reported by individual sablefish limited entry permit number;

(s) All legally defined gear as defined in 50 C.F.R. 660, Subpart D, and WAC 220-44-030, aboard the vessel at the time of delivery;

(t) Total amount: Total value of landing;

(u) Take-home fish: Species, number, and pounds of fish or shellfish retained for personal use;

(v) Seized/overage: Species and pounds of fish or shellfish; and

(w) Work area for dealer's use: Used at dealer's discretion.

(2) The electronic fish receiving ticket shall be used exclusively for nontreaty deliveries of fish harvested by participants lawfully involved in the ((~~Pacific Coast Groundfish Shoreside IFQ Program described in 50 C.F.R. 660.140~~)) directed commercial fisheries for Pacific Coast Groundfish authorized under 50 C.F.R., Part 660.

AMENDATORY SECTION (Amending WSR 14-02-013, filed 12/19/13, effective 1/19/14)

WAC 220-69-250 Required information on nontreaty fish receiving tickets. (1) It is unlawful for a person required to complete a nontreaty fish receiving ticket to fail to enter the mandatory information referenced in WAC 220-69-230 (2)(a) through (m) and (p) through (y) on each nontreaty fish receiving ticket, except as provided in subsection (5) of this section.

(2) A valid license card or duplicate license card issued by the department used with an approved mechanical imprinter satisfies the requirements in WAC 220-69-230 (2)(a) through (e), except as provided in WAC 220-69-273.

(3) A valid dealer or buyer card issued by the department used with an approved mechanical imprinter satisfies the requirements in WAC 220-69-230 (2)(h) and (i).

(4) December 1 through December 30, the crab inspection certificate number is a required entry on all shellfish receiving tickets documenting landings and sale of Dungeness crab from the Pacific Ocean, Coastal Washington, Grays Harbor, Willapa Harbor, and Columbia River waters. The crab inspection certificate number must be entered legibly in the space indicated for dealer's use.

(5) A person who sells or receives deliveries of fish made ((~~under the Pacific Coast Groundfish Shoreside Individual Fishing Quota (IFQ) Program (50 C.F.R. § 660.140) may use the electronic fish ticket system described in 50 C.F.R. § 660.113 (b)(4)(ii)~~)) from the directed commercial fisheries for Pacific Coast Groundfish authorized under 50 C.F.R., Part 660 may use an electronic fish receiving ticket to enter mandatory information in lieu of completing a nontreaty fish receiving ticket, so long as:

(a) All information required under WAC 220-69-256 is entered on the electronic fish receiving ticket;

(b) Both the fisherman and original receiver sign a legible, printed copy of the original electronic fish receiving ticket, plus all amended copies declaring the document and information contained therein as being true and accurate, and submit those signed copies as prescribed in WAC 220-69-260; and

(c) A signed copy of the electronic fish receiving ticket and all amended copies are maintained by the original receiver at the original receiver's place of business for 3 years after the date of initiation.

(6) Violation of this section is a gross misdemeanor or a class C felony punishable under RCW 77.15.630, Unlawful fish and shellfish catch accounting—Penalty, depending on the circumstances of the violation.

AMENDATORY SECTION (Amending WSR 12-04-028, filed 1/26/12, effective 2/26/12)

WAC 220-69-274 Signatures. (1) It is unlawful for the deliverer or original receiver of nontreaty fish or shellfish to fail to sign the complete nontreaty fish receiving ticket to certify that all entries on the ticket are accurate and correct.

(2) It is unlawful for the deliverer of treaty fish or shellfish to fail to sign the tribal copy of the treaty Indian fish receiving ticket to certify that all entries on the ticket are accurate and correct. It is unlawful for the original receiver of treaty food fish or shellfish to fail to sign the completed treaty Indian fish receiving ticket.

(3) It is unlawful for the deliverer or original receiver of fish ((~~caught under the Pacific Coast Groundfish Shoreside Individual Fishing Quota (IFQ) Program (50 C.F.R. § 660.140)~~)) from the directed commercial fisheries for Pacific Coast Groundfish authorized under 50 C.F.R., Part 660 to fail to print and sign a copy of the completed electronic fish receiving ticket to certify that all entries on the ticket are accurate and correct.

(a) A fisher who fails to sign a fish receiving ticket is in violation of RCW 77.15.560.

(b) An original receiver who fails to sign a fish receiving ticket is in violation of RCW 77.15.630.

(4) Where the fisherman is unable to deliver the catch, an agent of the fisherman is authorized to sign the fish receiving ticket if the agent has first obtained an alternate operator's license for the fishing vessel operated by the fisherman.

(5) If the receiver receives the fish or shellfish by any method other than direct delivery, the receiver shall affix his or her signature to the fish receiving ticket, and the fish receiving ticket shall be completed and submitted without the deliverer's signature and together with the transportation ticket. The receiver shall assume complete responsibility for the correctness of all entries on the fish receiving ticket.

WSR 17-03-009
PERMANENT RULES
STATE BOARD OF HEALTH

[Filed January 4, 2017, 4:39 p.m., effective July 1, 2017]

Effective Date of Rule: July 1, 2017.

Purpose: Chapter 246-760 WAC, Rules concerning vision screening. The board updated the rule to improve a school's ability to detect vision disorders that impact learning. The board added WAC 246-760-071 to require new tools for near and distance vision screening and to specify referral criteria by grade; added a definition section; and made amendments to allow optional vision screening, provide guidance for referring, and outline qualifications for screening personnel.

Citation of Existing Rules Affected by this Order: Repealing WAC 246-760-090; amending WAC 246-760-001, 246-760-020, 246-760-070, 246-760-080 and 246-760-100; and new section WAC 246-760-010.

Statutory Authority for Adoption: RCW 28A.210.020.

Adopted under notice filed as WSR 16-20-043 on September 28, 2016.

Changes Other than Editing from Proposed to Adopted Version: The board added a definition for test-retest protocol; added language to allow a school to refer a child without rescreening the child if they have been identified as needing a referral by a nationally recognized service organization; and added language allowing a school to waive a vision screening for any student who the district has reported as having a visual impairment under RCW 72.40.060.

A final cost-benefit analysis is available by contacting Sierra Rotakhina, P.O. Box 47990, Olympia, WA 98504-7990, phone (360) 236-4106, fax (360) 236-4088, email sierra.rotakhina@sboh.wa.gov.

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 2, Amended 2, 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 5, 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 2, Amended 5, Repealed 1.

Date Adopted: November 9, 2016.

Michelle A. Davis
Executive Director

AMENDATORY SECTION (Amending WSR 02-20-079, filed 9/30/02, effective 10/31/02)

WAC 246-760-001 ((~~What is the purpose of these rules?~~)) Purpose and application of auditory and visual screening standards for school districts. ((~~These rules implement chapter 32, Laws of 1971. Under this chapter,~~)) Each board of school directors in the state shall provide for and require screening of the auditory and visual acuity of children attending schools in their districts to determine if any ((~~children have defects sufficient to retard them in their studies~~)) child demonstrates auditory or visual problems that may negatively impact their learning. Each board of school directors shall establish procedures to implement these rules.

NEW SECTION

WAC 246-760-010 Definitions, abbreviations, and acronyms. The definitions, abbreviations, and acronyms in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "AAPOS" or "American Association for Pediatric Ophthalmology and Strabismus" means the national organization that advances the quality of children's eye care, supports the training of pediatric ophthalmologists, supports research activities in pediatric ophthalmology, and advances the care of adults with strabismus.

(2) "Crowding bars" means four individual lines surrounding a single optotype.

(3) "Crowding box" or "surround box" means crowding bars on all four sides extended to form a crowding rectangle surrounding a single line of optotypes.

(4) "Distance vision" means the ability of the eye to see images clearly at a calibrated distance.

(5) "HOTV letters" means a test using the letters H, O, T, and V calibrated of a certain size used to assess visual acuity.

(6) "Instrument-based vision screening device" means a U.S. Food and Drug Administration approved instrument for vision screening that uses automated technology to provide information about amblyopia and reduced-vision risk factors such as estimates of refractive error and eye misalignment.

(7) "Lay person" means any individual who is conducting school-based vision screening other than a school nurse, a school principal or his or her designee, a licensed vision care professional, or an individual trained by and conducting vision screening on behalf of a nationally recognized service organization that utilizes a test-retest protocol for vision screening. This includes, but is not limited to, retired nurses, nursing students, parents, and school staff.

(8) "LEA vision test(s)" means a test used to measure visual acuity using specific symbols or numbers, designed for those who do not know how to read the letters of the alphabet.

(9) "Licensed vision care professional" means a licensed ophthalmologist or licensed optometrist.

(10) "Near vision acuity" means the ability of the human eye to see objects with clarity at close range, also termed near point acuity or near acuity.

(11) "Optotype" means figures, numbers or letters of different sizes used in testing visual acuity.

(12) "Principal's designee" means a public health nurse, special educator, teacher or administrator designated by the school principal and responsible for supervision, training, reporting and referral of vision screening in instances where the school nurse or school principal is not filling this role.

(13) "School nurse" means a registered nurse acting as the health professional in a school whose specialized practice and attendant tasks and activities advance student health, well-being and achievement; and conforms to Washington state educational and nursing laws according to chapters 18.79 RCW and 246-840 WAC, and WAC 181-79A-223.

(14) "Sloan letters" means a test using ten specially formed letters which include C, D, H, K, N, O, R, S, V and Z to assess visual acuity.

(15) "Test-retest protocol" means a method of screening where a screener conducts two or more screenings for any student who meets the referral criteria in order to ensure the reliability of the initial screening.

(16) "Visual acuity" refers to the ability of the visual system to discern fine distinctions in the environment as measured with printed or projected visual stimuli.

AMENDATORY SECTION (Amending WSR 02-20-079, filed 9/30/02, effective 10/31/02)

WAC 246-760-020 ((~~How frequently must~~)) Frequency for schools to screen children((~~?~~)). (1) A school((~~s~~)) shall conduct auditory and ((~~visual~~)) distance vision and near vision acuity screening of children:

((~~(1)~~)) (a) In kindergarten and grades one, two, three, five, and seven; and

((~~(2) For any child~~)) (b) Showing symptoms of possible loss in auditory or visual acuity and who are referred to the district by parents, guardians, ((~~or~~)) school staff, or student self-report.

(2) If resources are available, a school may:

(a) Expand vision screening to any other grade;

(b) Conduct other optional vision screenings at any grade using evidence-based screening tools and techniques; or

(c) Expand vision screening to other grades and conduct optional vision screenings as outlined in (a) and (b) of this subsection.

(3) If resources permit, schools shall annually ((~~screen~~)) conduct auditory screening for children at other grade levels.

AMENDATORY SECTION (Amending WSR 02-20-079, filed 9/30/02, effective 10/31/02)

WAC 246-760-070 ((~~What visual acuity screening equipment must be used?~~)) Vision screening. ((~~Personnel conducting the screening must use a Snellen test chart for screening for distance central vision acuity. Either the Snellen E chart or the standard Snellen distance acuity chart may be used as appropriate to the child's age and abilities. The test chart must be properly illuminated and glare free.~~

~~Other screening procedures equivalent to the Snellen test may be used only if approved by the state board of health.~~)) (1) A school shall conduct all vision screening using tools and procedures that are linguistically, developmentally and age-appropriate. For distance vision and near vision acuity screening schools shall use screening tools identified in WAC 246-760-071.

(2) A school shall conduct vision screening according to the tool's instructions and screening protocol and consistent with AAPOS and National Association of School Nurses guidance.

(3) A school is not required to screen a student who has already had a comprehensive vision examination by a licensed vision care professional within the previous twelve months. In order to waive the screening, schools need to have a report or form signed by a licensed vision care professional indicating that an examination has been administered. A school must place this report or form in the student's health record.

(4) A school is not required to screen a student who the school district has reported as having a visual impairment as required under RCW 72.40.060.

NEW SECTION

WAC 246-760-071 Required and alternative vision screening tools and referral criteria (1) A school must use the standardized optotype-based distance vision and near vision acuity screening tools approved for each grade as well as the rescreening and referral criteria by grade outlined in Table 1 of this section. When using a screening tool with a single isolated optotype or a single line of optotypes, the tool must include the use of crowding bars or crowding boxes.

(2) A school may use an instrument-based vision screening device in lieu of the optotype-based tools outlined in this section. Referral using instrument-based vision screening devices is determined through the manufacturer's criteria. If the instrument-based screening device does not generate a result for a student, a school must screen that student using the optotype-based tools outlined in this section.

Table 1

Purpose of Screening	Grade	Screening Tools	Rescreening and Referral Criteria
Distance Vision	Kindergarten	LEA vision test: Single LEA symbol (at 5 feet), or HOTV letter	Visual acuity worse than 20/40 in either eye
Distance Vision	Grade one	LEA vision test: Single LEA symbol (at 5 feet), or HOTV letter	Visual acuity worse than 20/32 in either eye
Distance Vision	Grades two and above	LEA vision tests: LEA symbols or numbers, or HOTV letters, or Sloan letters	Visual acuity worse than 20/32 in either eye
Near Vision Acuity	Kindergarten	LEA vision tests: LEA symbols near vision, HOTV, or Sloan letters	Visual acuity worse than 20/40 in either eye
Near Vision Acuity	Grade one and above	LEA vision tests: LEA symbols near vision, HOTV, or Sloan letters	Visual acuity worse than 20/32 in either eye

AMENDATORY SECTION (Amending WSR 02-20-079, filed 9/30/02, effective 10/31/02)

WAC 246-760-080 ((~~What are the visual acuity~~)) Vision screening procedures((~~?~~)). (1) A school((~~s~~)) shall:

(a) Screen children with ((~~corrective lenses for distance viewing with~~)) their corrective lenses on;

(b) Place the results of screening, any referrals, and referral results in each student's health ((~~and/or school~~)) record; and

(c) Forward the results to the student's new school if the student transfers.

(2) If a student meets the referral criteria set forth in WAC 246-760-071 during the first vision screening and the screening was conducted by a lay person, then the school nurse, or the school principal or his or her designee as qualified under WAC 246-760-100(4) shall rescreen the student within two weeks or as soon as possible after the original screening before referring the child to a licensed vision care professional for an assessment.

(3) If the student meets the referral criteria set forth in WAC 246-760-071 during the first vision screening, and the screening was conducted by the school nurse; the school

principal or his or her designee; a volunteer who is a licensed vision care professional; or an individual trained by and conducting vision screening on behalf of a nationally recognized service organization that utilizes a test-retest protocol for vision screening, a school may either refer the student after the first screening or rescreen the student at the discretion of the school nurse, or the school principal or his or her designee.

(4) A school shall notify a child's parent or guardian with a written referral if a child meets the referral criteria set forth in WAC 246-760-071 during:

(a) The first screening if a rescreening is not required; or

(b) The second screening if a rescreening is required or is conducted at the discretion of the school nurse, or the school principal or his or designee.

(5) This written referral shall indicate that school-based vision screening is not a substitute for a comprehensive eye examination, include the screening results, and include language recommending that:

(a) The parent or guardian take the child to a licensed vision care professional to receive a comprehensive eye examination; and

(b) An appropriate remedy, such as corrective lenses, be obtained if indicated.

(6) Only the school nurse, or the school principal or his or her designee may notify a child's parent or guardian in order to refer the student for professional care. A school nurse, or school principal or his or her designee shall notify parents or guardians in writing that their child should be evaluated by a licensed vision care professional when:

(a) The student meets the referral criteria for vision screening tests conducted under WAC 246-760-071; or

(b) The school ((~~personnel observe a child with~~)) nurse, or school principal or his or her designee observes other signs or symptoms related to eye problems ((~~and if the signs or symptoms~~)) that negatively ((~~influence the child in his or her studies, school personnel shall refer the child to the parents or guardians for professional care~~)) impact the student's learning; or

(c) The student is unable to complete vision screening for any reason.

AMENDATORY SECTION (Amending WSR 10-15-100, filed 7/20/10, effective 8/20/10)

WAC 246-760-100 ((~~What are the~~)) Qualifications for the visual acuity screening personnel((~~?~~)). (1) Persons performing visual screening may include, but are not limited to, school nurses, school principals, other school personnel, or lay persons who have completed training in vision screening; and ophthalmologists, optometrists, or opticians who donate their professional services to schools or school districts. If an ophthalmologist, optometrist, or optician who donates his or her services identifies a visual problem that may impact a student's learning, the vision professional shall notify the school nurse, or the school principal or his or her designee of the results of the screening in writing but may not contact the student's parents or guardians directly per RCW 28A.210.020.

(2) Screening must be performed in a manner consistent with this chapter and RCW 28A.210.020 ((~~by persons~~)). Any person conducting vision screening must be competent to administer screening procedures as a function of their professional training and background or special training and demonstrated competence under supervision by the school nurse, or the school principal or his or her designee.

((~~(2) Technicians and nonprofessional volunteers must have adequate preparation and thorough understanding of the tests as demonstrated by their performance under supervision.~~))

(3) A lay person shall demonstrate his or her competence at administering the screening tools including controlling for lighting or distractions that could affect the screening results.

(4) Supervision, training, reporting and referral of vision screening shall be the responsibility of ((~~a professional person specifically designated by the school administration. He or she may be a school nurse or public health nurse, a special educator, teacher or administrator who possesses basic knowledge of the objectives and methods of visual acuity screening, supervisory experience and ability, demonstrated ability to teach others and demonstrated capacity to work well with people~~)) the school nurse, or the school principal or his or her designee. The principal or his or her designee must demonstrate his or her competence in vision screening through supervised training by a competent school or public health nurse or licensed vision care professional, have supervisory ability and experience, and have the ability to work well with school staff and lay persons. Ideally, the person should demonstrate the ability to teach vision screening techniques and operations to others.

(5) Students in grades kindergarten through twelve may not assist with or conduct vision screening of other students in their school district, unless students are supervised and conducting screening within the scope of an advanced vocational health-related curriculum such as nursing.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 246-760-090 What are the visual acuity screening referral procedures?

WSR 17-03-014
PERMANENT RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed January 5, 2017, 3:14 p.m., effective March 1, 2017]

Effective Date of Rule: March 1, 2017.

Purpose: The agency is proposing new rules under chapter 182-558 WAC that will provide parameters for program operations of the premium payment program.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 16-17-062 on August 15, 2016.

Changes Other than Editing from Proposed to Adopted Version:

• **WAC 182-558-0010 Premium payment program (PPP)**.

Revised as follows: The medicaid agency may pay a premium assistance subsidy for comprehensive health insurance premiums and other cost-sharing when the agency determines it would cost less ~~cost-effective~~ to maintain a client's available health care coverage than it would cost to provide comparable medicaid coverage.

• **WAC 182-558-0020 Definitions**.

Average cost per user - revised as follows: means the ~~agency's~~ average medicaid expenditure for a person of the same age ~~and~~, sex, and eligibility type as the applicant, per fiscal year~~, including administrative costs~~ as calculated by the agency.

Cost-effective - revised as follows: … means ~~the cost to~~ it would cost less for the agency ~~for a premium assistance subsidy for a client is less than:~~ to pay premium assistance than not to pay premium assistance. The agency determines cost-effectiveness by comparing the anticipated cost of premiums, cost-sharing, and administrative costs to:

(a) The average cost per user; or

(b) The medicaid expenditures to be incurred if the client does not receive the ~~subsidy~~ premium assistance, based on the client's documented medical condition.

Overpayment - added definition for overpayment to "mean the same definition for purposes of this chapter as that term is defined in RCW 41.05A.010."

• **WAC 182-558-0030**.

Struck subsection (1)(c) - "~~The client must not be eligible for medicare.~~"

Added new subsections (3)(e) and (4) and renumbered the rest of the subsections.

(3) A comprehensive health insurance plan does not include:

(a) A health savings account or flexible health spending arrangement;

(b) A high-deductible plan;

(c) A high-risk plan, including a Washington state health insurance pool (WSHIP) plan; ~~or~~

(d) A limited or supplemental plan, including a medicare supplemental plan; or

(e) A medicare advantage plan (medicare part C).

(4) Exceptions to comprehensive health insurance requirement in subsection (1)(b)(i) of this section.

(a) The agency will continue eligibility for clients currently in the premium payment program with a plan as described in subsection (3)(c), (d), or (e) of this section as long as:

(i) The client remains continuously eligible for medicaid benefits under subsection (1)(a) of this section; and

(ii) The client was approved for the premium payment program on or before January 1, 2012.

(b) The agency limits the premium assistance subsidy for a client eligible under subsection (4)(a) of this section to an amount the agency determines cost-effective.

Revised subsection (6)(b) as follows:

(6)(b) That the cost of the medicaid expenditures would be greater if the agency does not pay ~~a~~ premium assistance ~~subsidy~~.

Revised subsection (7) as follows:

(7) The agency pays no more than one premium per client, per month. PPP enrollment begins no sooner than the date on which:

(a) A ~~The date on which a~~ client is approved for medicaid;

(b) The ~~date on which the medicaid~~ agency receives and accepts the completed Application for HCA Premium Payment (HCA 13-705) form; and

(c) A ~~The date on which a~~ client's apple health managed care enrollment, if applicable, ends.

Added subsection (8) as follows:

(8) A client enrolled in the PPP is exempt from otherwise mandatory managed care under chapter 182-538 WAC.

Revised subsection (13) as follows:

(13) The agency may review a client's eligibility for the PPP at any time, including~~,~~ but not limited to when the client's:

(a) ~~A reported increase in the client's premium;~~

~~(b)~~ Health insurance plan has an ~~An~~ annual open enrollment ~~for the client's health insurance plan~~; ~~or~~

~~(c)~~ (b) ~~A change in~~ Medicaid eligibility changes or ends~~, or the medical assistance unit~~;

(c) Medical assistance unit changes;

(d) Premium changes; or

(e) Private health insurance coverage changes or ends.

• **WAC 182-558-0040** - revised as follows:

Added "and" after subsection (2)(a).

Struck subsection (2)(c) ~~Is not eligible for medicare.~~

• **WAC 182-558-0050** - revised as follows:

Subsection (1) - added "as defined in WAC 182-558-0020" and added "and" after ;.

Subsection (2)(c) - struck "~~Is not eligible for medicare.~~"

• **WAC 182-558-0060** - revised as follows:

Subsection (1) "**General rule**. Under section 1906A of the Social Security Act, the agency pays an eligible person's premium assistance subsidy and other cost-sharing obligations when the agency determines it is cost-effective as defined in WAC 182-558-0020 ~~for a qualified employer-sponsored group health insurance plan~~.["]

Subsection (2) **Eligible persons**. An eligible person is ~~a client~~:

(a) A client under age nineteen who is:

(i) Covered under a qualified employer-sponsored group health insurance plan as defined in WAC 182-558-0020;

(ii~~b~~) Receiving benefits under:

(A~~i~~) Alternative benefits plan coverage;

(B~~ii~~) Categorically needy coverage; or

(C~~iii~~) Medically needy coverage.

(~~c~~b) The parent of the client in (a) of this subsection, if:

(i) Enrollment in the health plan depends on a parent's enrollment; and

(ii) The client is a dependent of the parents~~; and~~

~~(d) Not eligible for medicare.~~

• **WAC 182-558-0070** - revised as follows:

Subsection (2) Under chapter 41.05A RCW, the agency may recover any overpayment of a premium assistance subsidy or cost-sharing amount ~~made in error under chapter 41.05A RCW,~~ whether due to ~~client error,~~ an agency administrative error, or client error or misrepresentation.

• **WAC 182-558-0080 Administrative hearings** - revised as follows:

"A client may request an administrative hearing under RCW 41.05A.110, 74.09.741 and chapter 182-526 WAC if the client does not agree with an agency decision …"

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 8, 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 8, Repealed 0.

Date Adopted: January 5, 2017.

Wendy Barcus
Rules Coordinator

Chapter 182-558 WAC

PREMIUM PAYMENT PROGRAM

NEW SECTION

WAC 182-558-0010 Premium payment program (PPP). The medicaid agency may pay a premium assistance subsidy for comprehensive health insurance premiums and other cost-sharing when the agency determines it would cost less to maintain a client's available health care coverage than it would cost to provide comparable medicaid coverage.

NEW SECTION

WAC 182-558-0020 Definitions. The following definitions, and those found in chapter 182-500 WAC, apply to this chapter.

"Average cost per user" means the average medicaid expenditure for a person of the same age, sex, and eligibility type as the applicant, per fiscal year, as calculated by the agency.

"Comprehensive" means coverage comparable to the services offered under the agency's medicaid state plan that provides at least the following: Physician-related services, inpatient hospital services, outpatient hospital services, prescription drugs, immunizations, and laboratory and X-ray costs.

"Cost-effective" means it would cost less for the agency to pay premium assistance than not to pay premium assistance. The agency determines cost-effectiveness by comparing the anticipated cost of premiums, cost-sharing, and administrative costs to:

(a) The average cost per user; or

(b) The medicaid expenditures to be incurred if the client does not receive the premium assistance, based on the client's documented medical condition.

"Employer-sponsored group health insurance" means a comprehensive group health plan provided through an employer or other entity, for which the employer or entity pays some portion of the cost. Group health plans must cover all applicants whose employment qualifies them for coverage and cannot increase the cost for an applicant with a preexisting condition.

"Flexible health spending arrangement" means the portion of an employee's wages set aside in an account to pay for qualified expenses such as medical or child care costs.

"Health savings account" means a medical savings account available to employees enrolled in a high-deductible health insurance plan.

"High-deductible health insurance plan" means coverage that meets the definition in Section 223(c)(2) of the Internal Revenue Code.

"Overpayment" has the same definition for purposes of this chapter as that term is defined in RCW 41.05A.010.

"Qualified employer-sponsored group health insurance" means a comprehensive group health plan provided through an employer that is offered in a nondiscriminatory manner under 26 U.S.C. Sec. 105(h)(3), and for which the employer subsidizes at least forty percent of the cost of the premium.

NEW SECTION

WAC 182-558-0030 Overview of eligibility. (1) To be eligible for the premium payment program (PPP):

(a) A member of the client's medical assistance unit, as described in chapter 182-506 WAC, must be receiving benefits under:

(i) Alternative benefits plan coverage;

(ii) Categorically needy coverage; or

(iii) Medically needy coverage.

(b) The client must provide the medicaid agency with proof of:

(i) Enrollment in a comprehensive individual or comprehensive employer-sponsored health insurance plan;

(ii) A Social Security Number or tax identification number for the policy holder; and

(iii) Premium expenditures.

(2) A comprehensive health insurance plan includes:

(a) An individual health insurance plan;

(b) An employer-sponsored group health insurance plan; or

(c) A qualified employer-sponsored group health insurance plan.

(3) A comprehensive health insurance plan does not include:

(a) A health savings account or flexible health spending arrangement;

(b) A high-deductible plan;

(c) A high-risk plan, including a Washington state health insurance pool (WSHIP) plan;

(d) A limited or supplemental plan, including a medicare supplemental plan; or

(e) A medicare advantage plan (medicare Part C).

(4) Exceptions to comprehensive health insurance requirement in subsection (1)(b)(i) of this section:

(a) The agency will continue eligibility for clients currently in the premium payment program with a plan as described in subsection (3)(c), (d), or (e) of this section as long as:

(i) The client remains continuously eligible for medicaid benefits under subsection (1)(a) of this section; and

(ii) The client was approved for the premium payment program on or before January 1, 2012.

(b) The agency limits the premium assistance subsidy for a client eligible under subsection (4)(a) of this section to an amount the agency determines cost-effective.

(5) A comprehensive health insurance plan must be cost effective as defined in WAC 182-558-0020.

(6) If a client's comprehensive health insurance premium is more than the average cost per user, the client must provide the agency proof from the client's provider(s):

(a) Of an existing medical condition that requires or will be requiring extensive medical care; and

(b) That the cost of the medicaid expenditures would be greater if the agency does not pay premium assistance.

(7) The agency pays no more than one premium per client, per month. PPP enrollment begins no sooner than the date on which:

(a) A client is approved for medicaid;

(b) The agency receives and accepts the completed Application for HCA Premium Payment Program (HCA 13-705) form; and

(c) A client's apple health managed care enrollment, if applicable, ends.

(8) A client enrolled in the PPP is exempt from otherwise mandatory managed care under chapter 182-538 WAC.

(9) The agency's premium assistance subsidy may not exceed the minimum amount required to maintain comprehensive health insurance for the medicaid-eligible client.

(10) Proof of premium expenditures must be submitted to the agency no later than the end of the third month following the last month of coverage.

(11) The agency's cost-sharing benefit for copays, coinsurance, and deductibles is limited to services covered under the medicaid state plan.

(12) Proof of cost-sharing must be submitted to the agency no later than the end of the sixth month following the date of service.

(13) The agency may review a client's eligibility for the PPP at any time including, but not limited to, when the client's:

(a) Health insurance plan has an annual open enrollment;

(b) Medicaid eligibility changes or ends;

(c) Medical assistance unit changes;

(d) Premium changes; or

(e) Private health insurance coverage changes or ends.

NEW SECTION

WAC 182-558-0040 PPP for a client with an individual health insurance plan. (1) **General rule.** Under section 1905(a) of the Social Security Act, the agency pays a premium assistance subsidy up to an eligible person's individual health insurance premium obligation when the agency determines it is cost effective.

(2) **Eligible persons.** An eligible person is any client who:

(a) Has a comprehensive individual health insurance plan; and

(b) Is receiving categorically needy or medically needy coverage.

NEW SECTION

WAC 182-558-0050 PPP for a client with an employer-sponsored group health insurance plan. (1) **General rule.** Under section 1906 of the Social Security Act, the agency pays a premium assistance subsidy up to an eligible person's employer-sponsored group health insurance plan premium obligation when the agency determines it is cost effective as defined in WAC 182-558-0020.

(2) **Eligible persons.** An eligible person is any client who:

(a) Has a comprehensive employer-sponsored group health insurance plan, which may be a Consolidated Omnibus Budget Reconciliation Act (COBRA) health insurance plan as described in 26 C.F.R. 54.4980; and

(b) Is receiving categorically needy or medically needy coverage.

NEW SECTION

WAC 182-558-0060 PPP for a client with a qualified employer-sponsored group health insurance plan. (1) **General rule.** Under section 1906A of the Social Security Act, the agency pays an eligible person's premium assistance subsidy and other cost-sharing obligations when the agency determines it is cost-effective as defined in WAC 182-558-0020.

(2) **Eligible persons.** An eligible person is:

(a) A client under age nineteen who is:

(i) Covered under a qualified employer-sponsored group health insurance plan as defined in WAC 182-558-0020;

(ii) Receiving benefits under:

(A) Alternative benefits plan coverage;

(B) Categorically needy coverage; or

(C) Medically needy coverage.

(b) The parent of the client in (a) of this subsection, if:

(i) Enrollment in the health plan depends on a parent's enrollment; and

(ii) The client is a dependent of the parents.

(3) **Cost-sharing benefit.** The PPP provides cost-sharing reimbursement limited to services for the medicaid-eligible client or their parents.

NEW SECTION

WAC 182-558-0070 Program monitoring. (1) The agency monitors payments under the premium payment program.

(2) Under chapter 41.05A RCW, the agency may recover any over-payment of a premium assistance subsidy or cost-sharing amount, whether due to an agency administrative error, or client error or misrepresentation.

NEW SECTION

WAC 182-558-0080 Administrative hearings. A client may request an administrative hearing under RCW 41.05A.110, 74.09.741, and chapter 182-526 WAC if the client does not agree with an agency decision regarding eligibility for the premium payment program, the amount of a premium assistance subsidy, or an overpayment of a premium assistance subsidy.

WSR 17-03-025
PERMANENT RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed January 6, 2017, 10:38 a.m., effective February 6, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: These rule revisions expand the definition of "accredited institution of higher education" to include institutions of higher education accredited by all national or regional accrediting associations approved by the Washington student achievement council and the secretary of the United States Department of Education, as codified in the recently revised professional educator standards board, WAC 181-78A-010.

Citation of Existing Rules Affected by this Order: Amending WAC 392-121-249 and 392-121-280.

Statutory Authority for Adoption: RCW 28A.150.290(1) and 28A.415.024.

Adopted under notice filed as WSR 16-23-123 on November 21, 2016.

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 2, 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 0, Repealed 0.

Date Adopted: January 6, 2017.

Randy Dorn
State Superintendent
of Public Instruction

AMENDATORY SECTION (Amending WSR 11-21-065, filed 10/17/11, effective 11/17/11)

WAC 392-121-249 Definition—Accredited institution of higher education. As used in this chapter, "accredited institution of higher education" means ((~~a community college, college, or university which is accredited, or is a candidate for accreditation, by one of the regional accrediting associations, pursuant to WAC 181-78A-010(6), or by the distance education and training council,~~)) an institution of higher education that has been accredited by a national or regional accrediting association recognized by the Washington student achievement council and the secretary of the U.S. Department of Education pursuant to WAC 181-78A-010(7).

AMENDATORY SECTION (Amending WSR 15-18-078, filed 8/28/15, effective 9/28/15)

WAC 392-121-280 Placement on LEAP salary allocation documents—Documentation required. School districts and charter schools shall have documentation on file and available for review which substantiates each certificated instructional employee's placement on LEAP salary allocation documents. The minimum requirements are as follows:

(1) Districts and charter schools shall document the date of awarding or conferring of the highest degree including the date upon which the degree was awarded or conferred as recorded on the diploma or transcript from the registrar of the accredited institution of higher education.

(a) If the highest degree is a master's degree, the district or charter school shall also document the date of awarding or conferring of the first bachelor's degree.

(b) If the degree was awarded by an institution which does not confer degrees after each term, and all degree requirements were completed at a time other than the date recorded on the diploma or transcript, a written statement from the registrar of the institution verifying a prior completion date shall be adequate documentation.

(c) If the degree program was completed in a country other than the United States, documentation must include documentation in English of degree equivalency for the appropriate degree as allowed by WAC 181-79A-260: Provided, That documentation of degree equivalency is not required if that institution of higher education is already ((~~regionally~~)) accredited ((~~or accredited by the distance education and training council,~~)) pursuant to WAC 181-78A-010(7).

(2) Districts and charter schools shall document academic credits by having on file a transcript from the registrar of the accredited institution of higher education granting the credits. For purposes of this subsection:

(a) An academic credit is deemed "earned" at the end of the term for which it appears on the transcript: Provided, That a written statement from the registrar of the institution verifying a prior earned date may establish the date a credit was earned;

(b) Washington state community college credits numbered one hundred and above are deemed transferable for purposes of WAC 392-121-255(4) subject to the limitations of that same subsection;

(c) Credits are not deemed "earned" at an institution of higher education which transfers-in credits. Such credits must be documented using a transcript from the initial granting institution and are subject to all the limitations of WAC 392-121-255;

(d) If the credits were completed in a country other than the United States, documentation must include a written statement of credit equivalency for the appropriate credits from a foreign credentials' evaluation agency approved by the office of superintendent of public instruction: Provided, That documentation of degree equivalency is not required if that institution of higher education is already ((~~regionally~~)) accredited ((~~or accredited by the distance education and training council,~~)) pursuant to WAC 181-78A-010(7); and

(e) For credits earned after September 1, 1995, districts and charter schools shall document that the course content meets one or more of the criteria of WAC 392-121-262(1). At a minimum, such documentation must include a dated signature of the immediate principal, supervisor, or other authorized school district or charter school representative and must be available to the employee's future employers.

(3) Districts and charter schools shall document in-service credits:

(a) By having on file a document meeting standards established in WAC 181-85-107; and

(b) For credits earned after September 1, 1995, districts and charter schools shall document that the course content meets one or more of the criteria of WAC 392-121-262(1). At a minimum, such documentation must include a dated signature of the immediate principal, supervisor, or other authorized school district or charter school representative and must be available to the employee's future employers.

(4) Districts and charter schools shall document nondegree credits.

(a) For vocational/career and technical education educator training credits pursuant to WAC 392-121-259(3) districts and charter schools shall have on file a document meeting standards established in WAC 181-85-107 and evidence that the training was authorized pursuant to WAC 181-77-003 (2), (9), or (12).

(b) For credits calculated from converted occupational experience pursuant to WAC 392-121-259(3) districts and charter schools shall have on file documents which provide:

(i) Evidence that the occupational experience meets the requirements of WAC 181-77-003(7);

(ii) Evidence of the individual's actual number of hours of employment for each year including dates of employment; and

(iii) The district or charter school calculation of converted credits pursuant to WAC 392-121-259(3).

(c) For credits earned after September 1, 1995, districts shall document that the course content meets one or more of the criteria of WAC 392-121-262(1). At a minimum, such documentation must include a dated signature of the immediate principal, supervisor, or other authorized school district representative and must be available to the employee's future employers.

(5) Districts and charter schools shall document certificated years of experience as follows:

(a) For certificated years of experience obtained and reported on Report S-275 prior to the 1994-95 school year districts and charter schools shall have on file documents that provide evidence of employment including dates of employment.

(b) For certificated years of experience reported on Report S-275 for the first time after the 1993-94 school year districts and charter schools shall have on file:

(i) The total number of hours, or other unit of measure, per year for an employee working full-time with each employer;

(ii) The number of hours, or other unit of measure (worked by the employee), per year and dates of employment with each employer, including paid leave and excluding unpaid leave: Provided, That documentation of hours in excess of one full-time certificated year of experience in any twelve-month period is not required;

(iii) The quotient of the hours, or other unit of measure, determined in (b)(ii) of this subsection divided by the hours, or other unit of measure, in (b)(i) of this subsection rounded to two decimal places for each year;

(iv) The name and address of the employer;

(v) For those counting experience outside of the school district or charter school pursuant to WAC 392-121-264 (1)(a), evidence whether or not the position required professional education certification pursuant to WAC 392-121-264 (1)(a)(ii);

(vi) For those counting experience pursuant to WAC 392-121-264 (1)(b), a brief description of the previous employment which documents the school district's or charter school's decision that the position was comparable to one requiring certification in the Washington school districts;

(vii) For those counting management experience pursuant to WAC 392-121-264 (1)(e), evidence that the experience meets the requirements of WAC 181-77-003(6);

(viii) For those counting experience (for educational staff associates) pursuant to WAC 392-121-264 (1)(f), evidence that the previous employment meets the requirements in the applicable subsections of WAC 392-121-264 (1)(f).

(6) Any documentation required by this section may be original or copies of the original: Provided, That each copy is subject to school district or charter school acceptance or rejection.

(7) The falsification or deliberate misrepresentation, including omission of a material fact concerning degrees, credits, or experience by an education practitioner as defined in WAC 181-87-035 shall be deemed an act of unprofessional conduct pursuant to WAC 181-87-050. In such an event the provisions of chapters 181-86 and 181-87 WAC shall apply.

WSR 17-03-028
PERMANENT RULES
PUBLIC DISCLOSURE COMMISSION
[Filed January 6, 2017, 11:36 a.m., effective February 6, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Define the terms "day" and "business day" as they are used throughout chapter 42.17A RCW and Title 390 WAC. Clarify and make consistent the terms "day" and "business day" and remove variations "working days" and [″]calendar days" throughout Title 390 WAC.

Citation of Existing Rules Affected by this Order: Amending WAC 390-12-250, 390-16-033, 390-16-240, 390-16-312, 390-28-060, and 390-32-030.

Statutory Authority for Adoption: RCW 42.17A.110.

Adopted under notice filed as WSR 16-22-057 on October 31, 2016.

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 6, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 6, 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: January 6, 2017.

Jana Y. Greer
Executive Assistant

NEW SECTION

WAC 390-05-255 Definition of terms "day" and "business day." (1) "Day" as that term is used in chapter 42.17A RCW and Title 390 WAC, unless otherwise specified, means a calendar day, including Saturday, Sunday and legal holidays.

(2) "Business day" as used in chapter 42.17A RCW and Title 390 WAC, means a calendar day, excluding Saturday, Sunday and legal holidays defined in WAC 357-31-005.

AMENDATORY SECTION (Amending WSR 90-16-083, filed 7/31/90, effective 8/31/90)

WAC 390-12-250 Declaratory order—Petition requisites—Consideration—Disposition. (1) Any person may submit a petition for a declaratory order pursuant to RCW 34.05.240 in any form so long as it:

(a) Clearly states the question the declaratory order is to answer((~~,~~)); and

(b) Provides a statement of the facts which raise the question.

(2) The executive director may conduct an independent investigation in order to fully develop the relevant facts.

(3) The executive director will present the petition to the commission at the first meeting when it is practical to do so and will provide the petitioner with at least five business days notice of the time and place of such meeting. Such notice may be waived by the petitioner.

(4) The petitioner may present additional material and/or argument at any time prior to the issuance of the declaratory order.

(5) The commission may issue either a binding or a nonbinding order or decline to issue any order.

(6) The commission may decide that a public hearing would assist its deliberations and decisions. If such a hearing is ordered, it will be placed on the agenda of a meeting and at least five business days notice of such meeting shall be provided to the petitioner.

(7) If an order is to be issued, the petitioner shall be provided a copy of the proposed order and invited to comment.

(8) The declaratory order cannot be a substitute for a compliance action and is intended to be prospective in effect.

(9) The commission will decline to consider a petition for a declaratory or to issue an order when (a) the petition requests advice regarding a factual situation which has actually taken place, or (b) when a pending investigation or compliance action involves a similar factual situation.

AMENDATORY SECTION (Amending WSR 16-04-027, filed 1/25/16, effective 2/25/16)

WAC 390-16-033 Earmarked contributions—Reporting—Form. The official form for reporting the details surrounding an earmarked contribution, as required by RCW 42.17A.270, is designated "Special Report E," revised ((~~2/16~~)) 2/17. This report shall be filed within two ((~~working~~)) business days of receiving a contribution earmarked for another candidate or committee. Copies of this form are available on the commission's web site, www.pdc.wa.gov, and at the Commission Office, Room 206, Evergreen Plaza Building, Olympia, Washington 98504-0908.

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PUBLIC DISCLOSURE COMMISSION
711 CAPITOL WAY RM 206
PO BOX 40908
OLYMPIA WA 98504-0908
(360) 753-1111
TOLL FREE 1-877-601-2828

EARMARKED CONTRIBUTION

SPECIAL REPORT **E**
2/16

PDC OFFICE USE
POSTMARK
RECEIVED

1. Name of committee filing this report (Candidate or committee which received a contribution earmarked for another.)

Address

City County Zip

2. Original source of earmarked contribution

Name

Address

City State Zip

3. Contribution Date	Amount/Value	Description (Fully describe in-kind contributions)	If contribution is to benefit a state office candidate, designate whether it's for Primary or General Election. Primary ________ General ________

4. Name of candidate or committee to be benefited

Address

City County Zip

If candidate, what office is the person seeking?____________________________

5. Certification: I certify that the information contained herein is true, complete and correct to the best of my knowledge.

Treasurer's signature ______________________________ Date ______________

The purpose of this report is to highlight receipt of an earmarked contribution. (That is, a contribution given to one candidate or political committee with the understanding, intent or instruction that it be used to benefit another candidate or committee.) This report is filed in addition to any other required reporting of the transaction.

A separate "Special Report E" is filed for each earmarked contribution received by any candidate or political committee.

File this report within two working days of receiving the earmarked contribution. Mail or deliver the original to PDC. Send a copy to the benefiting candidate or committee, also within two working days.

NOTE: Candidates for legislative and statewide executive office are subject to state contribution limits. Earmarked contributions count toward the applicable limit and are attributed to the original source of the contribution (unless another person controlled the choice of recipient). It's a violation for anyone to accept a contribution in excess of the relevant limit. Verify with the campaign of a legislative or statewide office candidate before accepting a contribution earmarked for the benefit of such a candidate.

PDC E

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PUBLIC DISCLOSURE COMMISSION
711 CAPITOL WAY RM 206
PO BOX 40908
OLYMPIA WA 98504-0908
(360) 753-1111
TOLL FREE 1-877-601-2828

EARMARKED CONTRIBUTION

SPECIAL REPORT **E**
2/17

POSTMARK

RECEIVED

PDC OFFICE USE

1. Name of committee filing this report (Candidate or committee which received a contribution earmarked for another.)

Address

City County Zip

2. Original source of earmarked contribution

Name
Address
City State Zip

3. Contribution Date	Amount/Value	Description (Fully describe in-kind contributions)	If contribution is to benefit a state office candidate, designate whether it's for Primary or General Election. Primary ________ General ________

4. Name of candidate or committee to be benefited

Address
City County Zip

If candidate, what office is the person seeking?______________________________

5. Certification: I certify that the information contained herein is true, complete and correct to the best of my knowledge.

Treasurer's signature ______________________________ Date ____________

The purpose of this report is to highlight receipt of an earmarked contribution. (That is, a contribution given to one candidate or political committee with the understanding, intent or instruction that it be used to benefit another candidate or committee.) This report is filed in addition to any other required reporting of the transaction.

A separate "Special Report E" is filed for each earmarked contribution received by any candidate or political committee.

File this report within two business days of receiving the earmarked contribution. Mail or deliver the original to the Public Disclosure Commission. Deliver a copy to the benefiting candidate or committee, also within two business days.

NOTE: Candidates for legislative and statewide executive office are subject to state contribution limits. Earmarked contributions count toward the applicable limit and are attributed to the original source of the contribution (unless another person controlled the choice of recipient). It's a violation for anyone to accept a contribution in excess of the relevant limit. Verify with the campaign of a legislative or statewide office candidate before accepting a contribution earmarked for the benefit of such a candidate.

PDC E

AMENDATORY SECTION (Amending WSR 12-03-002, filed 1/4/12, effective 2/4/12)

WAC 390-16-240 Earmarked contributions—Definition and use. (1) Earmarked contributions, as that term is used in RCW 42.17A.270 and 42.17A.460, means any contribution given to an intermediary or conduit, either a political committee, candidate or third party, with a designation, instruction, or encumbrance, whether direct or indirect, express or implied, oral or written, which is intended to result in or which does result in all or any part of the contribution being made to or for the promotion of a certain candidate, state official, or ballot proposition.

(2) For purposes of RCW 42.17A.405 and 42.17A.410, an earmarked contribution is deemed to be for the promotion of, and attributable to any limit applicable to the candidate, authorized committee, bona fide political party, caucus of the

state legislature or political committee designated by the original contributor.

(3) If an earmarked contribution is given to an intermediary or conduit to be spent on behalf of a candidate and the entire amount given is not used for this purpose, the remainder of the contribution shall be given to the designated candidate unless its use is redesignated by the original contributor. If the conduit or intermediary exercise any direction or control over the use of the remainder of the contribution, then the amount of the remainder shall be considered a contribution from the original contributor and the conduit or intermediary to the recipient.

(4) The intermediary or conduit receiving the earmarked contribution shall notify the candidate or political committee for whose use or benefit the contribution is designated within two ((~~working~~)) business days after receipt of the contribution.

(5) If an earmarked contribution is refused by the designated recipient candidate or political committee, the earmarked contribution must be returned by the intermediary or conduit to the original contributor within five ((~~working~~)) business days of refusal.

AMENDATORY SECTION (Amending WSR 12-03-002, filed 1/4/12, effective 2/4/12)

WAC 390-16-312 Handling contributions of uncertain origin. No contribution shall be deposited by any candidate or treasurer who believes, from the face of the contribution instrument or for any other reason, the contribution was made in a fictitious name, by one person through an agent, relative, political committee, or any other person so as to conceal the source of the contribution or to exceed the contribution limits provided in RCW 42.17A.420, 42.17A.405, or 42.17A.410. The candidate or treasurer shall return such contributions within ten ((~~calendar~~)) days to the original contributor if his or her identity is known. Otherwise, the contribution instrument shall be endorsed and made payable to "Washington state treasurer" and the contribution sent to the public disclosure commission for deposit in the state's general fund.

AMENDATORY SECTION (Amending WSR 12-03-002, filed 1/4/12, effective 2/4/12)

WAC 390-28-060 Hearing to modify reporting—Administrative law judge proceedings. (1) The commission may request through the office of administrative hearings the appointment of an administrative law judge to hear individual applicants.

(2) After such hearing is concluded, the administrative law judge shall prepare and distribute to the applicant and each commissioner a proposed decision determining the issue. The applicant shall have five business days to file with the commission specific objections to the administrative law judge's **proposed** decision and to request an opportunity to present additional evidence to the commission. When written objections are timely filed, the commission, at the time of review and ratification, shall consider the whole record or such portions as may be cited by the administrative law judge, applicant or executive director. The commission may also hear additional testimony.

(3) If the applicant files objections to the administrative law judge's proposed decision, the filing requirement from which the applicant has sought modification shall not be suspended unless the commission, upon notice of the filing of objections, determines that a temporary suspension is justifiable pursuant to the criteria set out in RCW 42.17A.120. Such suspension of filing requirements shall be granted only until the decision is finalized by formal action of the commission.

(4) At the next meeting at which the matter can be lawfully considered, the commission shall review and either ratify or modify or revise the proposed order.

AMENDATORY SECTION (Amending WSR 16-01-015, filed 12/4/15, effective 1/4/16)

WAC 390-32-030 Complaint publication—Fair Campaign Practices Code—Alternative to investigation or adjudicative proceeding. (1) Written and signed complaints alleging a violation of one or more specific provisions of WAC 390-32-010. The Fair Campaign Practices Code may be submitted to the commission by any person.

(a) Subject to the limitations in subsection (4) of this section, upon receipt of a complaint under subsection (1) of this section, the executive director shall forward a copy of the complaint to the respondent within twenty-four hours, accompanied by a request for a response to the complaint returned within five business days from the date of mailing.

(b) Upon receipt of any response, the executive director shall forward a copy of the response to the complainant. A copy of the complaint and the response shall be sent to news media at the expiration of the five business days for response. The complaint and the response shall be available at the commission office for public inspection and copying. If no response is received within five business days, the complaint shall be made public without a response.

(c) The commission will not issue comments or opinions about complaints or responses received under this subsection.

(2) As provided by WAC 390-37-055, and considering the factors set forth in WAC 390-37-056, the executive director may authorize the processing of a complaint alleging violations of chapter 42.17A RCW or Title 390 WAC according to the complaint publication process provided in this section.

(a) Subject to the limitations in subsection (4) of this section, upon receipt of a complaint authorized by the executive director for processing under this subsection, the executive director shall forward a copy of the complaint to the respondent, accompanied by a request for a response to the complaint to be returned within five business days from the date of mailing.

(b) Complaints authorized by the executive director for processing under this subsection shall be forwarded to the respondent within ((~~ten business days of receipt, or~~)) eight days prior to the date that ballots must be available under RCW 29A.40.070(1)((~~, whichever is earlier~~)).

(c) Upon receipt of any response, the executive director shall forward a copy of the response to the complainant. A copy of the complaint and the response shall be sent to news media at the expiration of the five business days for response. The complaint and the response shall be available at the commission office for public inspection and copying. If no response is received within five days, the complaint shall be made public without a response.

(d) Except as provided under (a) or (b) of this subsection, the publication of complaints or responses under this subsection shall constitute the final disposition of complaints authorized by the executive director for processing under this section.

(3) Following the processing of a complaint under subsection (2) of this section, the executive director shall review the complaint and any response received. Whenever a complaint and response indicate that a material violation of chapter 42.17A RCW may have occurred and/or the respondent may not be in substantial compliance with the relevant statutes and rules, considering the factors set forth in WAC 390-37-056, the executive director may:

(a) Dispose of the complaint through an additional alternative response as provided in WAC 390-37-055; or

(b) Direct a formal investigation be conducted.

(4) The commission will make no attempt to secure a reply to and will make no public release of complaints received within eight days of the date that ballots must be mailed to voters under RCW 29A.40.070(1).

(5) The filing of a complaint with the commission under this section or any provision of chapter 390-37 WAC constitutes implied consent to have the complainant's identity disclosed.

WSR 17-03-073
PERMANENT RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed January 11, 2017, 1:38 p.m., effective February 11, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The agency is amending WAC 182-551-1510 to add new language that reflects a two percent payment reduction for hospice providers who did not comply with the medicare quality data reporting program. Amendments are necessary to implement CMS requirements under 42 U.S.C. Sec. 1395f (i)(5)(A)(i). Housekeeping changes are also included.

Citation of Existing Rules Affected by this Order: Amending WAC 182-551-1510.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; 42 U.S.C. Sec. 1395f (i)(5)(A)(i).

Adopted under notice filed as WSR 16-24-056 on December 2, 2016.

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

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

Date Adopted: January 11, 2017.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 16-14-009, filed 6/23/16, effective 7/24/16)

WAC 182-551-1510 Rates methodology and payment method for hospice agencies. This section describes rates methodology and payment methods for hospice care provided to hospice clients.

(1) The medicaid agency uses the same rates methodology as medicare uses for the four levels of hospice care identified in WAC 182-551-1500.

(2) Each of the four levels of hospice care has the following three rate components:

(a) Wage component;

(b) Wage index; and

(c) Unweighted amount.

(3) To allow hospice payment rates to be adjusted for regional differences in wages, the medicaid agency bases payment rates on the core-based statistical area (CBSA) county location. CBSAs are identified in the medicaid agency's provider guides.

(4) The medicaid agency pays hospice agencies for services (not room and board) at a daily rate methodology as follows:

(a) Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence.

(b) Payments for routine home care ((~~(RHC)~~)) are based on a two-tiered payment methodology.

(i) Days one through sixty are paid at the base ((~~RHC~~)) routine home care rate.

(ii) Days sixty-one and after are paid at a lower ((~~RHC~~)) routine home care rate.

(iii) If a client discharges and readmits to a hospice agency's program within sixty calendar days of that discharge, the prior hospice days will continue to follow the client and count towards the client's eligible days in determining whether the hospice agency may bill at the base or lower ((~~RHC~~)) routine home care rate.

(iv) If a client discharges from a hospice agency's program for more than sixty calendar days, a readmit to the hospice agency's program will reset the client's hospice days.

(c) Hospice services are eligible for an end-of-life service intensity add-on ((~~(SIA)~~)) payment when the following criteria are met:

(i) The day on which the services are provided is ((~~an RHC~~)) a routine home care level of care;

(ii) The day on which the service is provided occurs during the last seven days of life, and the client is discharged deceased;

(iii) The service is provided by a registered nurse or social worker that day for at least fifteen minutes and up to four hours total; and

(iv) The service is not provided by the social worker via telephone.

(d) Payments for respite and general inpatient care are based on the county location of the providing hospice agency.

(5) The medicaid agency:

(a) Pays for routine ((~~hospice~~)) home care, continuous home care, respite care, or general inpatient care for the day of death;

(b) Does not pay room and board for the day of death; and

(c) Does not pay hospice agencies for the client's last day of hospice care when the last day is for the client's discharge, revocation, or transfer.

(6) Hospice agencies must bill the medicaid agency for their services using hospice-specific revenue codes.

(7) For hospice clients in a nursing facility:

(a) The medicaid agency pays nursing facility room and board payments at a daily rate directly to the hospice agency at ninety-five percent of the nursing facility's current medicaid daily rate in effect on the date the services were provided; and

(b) The hospice agency pays the nursing facility at a daily rate no more than the nursing facility's current medicaid daily rate.

(8) The medicaid agency:

(a) Pays a hospice care center a daily rate for room and board based on the average room and board rate for all nursing facilities in effect on the date the services were provided.

(b) Does not pay hospice agencies or hospice care centers a nursing facility room and board payment for:

(i) A client's last day of hospice care (e.g., client's discharge, revocation, or transfer); or

(ii) The day of death.

(9) The daily rate for authorized out-of-state hospice services is the same as for in-state non-CBSA hospice services.

(10) The medicaid agency reduces hospice payments by two percent for providers who did not comply with the annual medicare quality data reporting program as required under 42 U.S.C. Sec. 1395f (i)(5)(A)(i). The payment reduction is effective for the fiscal reporting year in which the provider failed to submit data required for the annual medicare quality reporting program.

(a) The two percent payment reduction applies to routine home care, including the service intensity add-on, continuous home care, inpatient respite care, and general inpatient care.

(b) The two percent payment reduction does not apply to pediatric palliative care, the hospice care center daily rate, and the nursing facility room and board rate.

(c) Any provider affected by the two percent payment reduction will receive written notification.

(d) Any provider affected by the two percent payment reduction may appeal the rate reduction per WAC 182-502-0220.

(11) The client's notice of action (award) letter states the amount the client is responsible to pay each month towards the total cost of hospice care. The hospice agency receives a copy of the award letter and:

(a) Is responsible to collect the correct amount that the client is required to pay, if any; and

(b) Must show the client's monthly required payment on the hospice claim. (Hospice providers may refer to the medicaid agency's provider guides for how to bill a hospice claim.) If a client has a required payment amount that is not reflected on the claim and the medicaid agency reimburses the amount to the hospice agency, the amount is subject to recoupment by the medicaid agency.

WSR 17-03-074
PERMANENT RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2016-24—Filed January 11, 2017, 2:21 p.m., effective February 11, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Adoption of the 2017 commissioner's standard ordinary (CSO) mortality tables. The 2017 CSO mortality tables are a new series of mortality tables developed jointly, at the request of the National Association of Insurance Commissioners, by the American Academy of Actuaries Life Experience Committee and the Society of Actuaries Preferred Mortality Oversight Group; they reflect changes in mortality since the development of the 2001 CSO tables. The 2001 CSO tables are the current mortality table set; the 2017 tables would provide a new minimum valuation standard of mortality for life insurance products. The new table series includes tables for male/female, smoker/nonsmoker and age-nearest birthday/age-last birthday. The commissioner is proposing that the 2017 CSO mortality tables be adopted.

Statutory Authority for Adoption: RCW 48.02.060, 48.74.030, 48.76.050, 48.02.160.

Adopted under notice filed as WSR 16-23-066 on November 14, 2016.

A final cost-benefit analysis is available by contacting Jim Keogh, P.O. Box 40260, Olympia, WA 98504, phone (360) 725-7056, fax (360) 586-3109, email rulescoordinator @oic.wa.gov.

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 12, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 12, 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 12, Amended 0, Repealed 0.

Date Adopted: January 11, 2017.

Mike Kreidler
Insurance Commissioner

NEW SECTION

WAC 284-74-525 Purpose. The purpose of this regulation, WAC 284-74-525 through 284-74-555, is to recognize and prescribe the use of the 2017 commissioners standard ordinary (CSO) mortality table in compliance with RCW 48.74.030 (1)(a)(iii), 48.76.050 (4)(h)(vi), and WAC 284-74-340 (1) and (2).

NEW SECTION

WAC 284-74-530 Definitions. (1) "2017 CSO mortality table" means that mortality table, consisting of separate rates of mortality for male and female lives, adopted by the National Association of Insurance Commissioners (NAIC) in April of 2016. The 2017 CSO mortality table is included in the *2015 Proceedings of the NAIC (Fall Volume I)*. Unless the context indicates otherwise, the "2017 CSO mortality table" includes both the ultimate form and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables.

(2) "2017 CSO mortality table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2017 CSO mortality table.

(3) "2017 CSO mortality table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2017 CSO mortality table.

(4) "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(5) "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

NEW SECTION

WAC 284-74-535 2017 CSO mortality table. (1) The 2017 commissioners standard ordinary (CSO) mortality table may be used as allowed in RCW 48.74.030 (1)(a)(iii), 48.76.-050 (4)(h)(vi), and WAC 284-74-340 (1) and (2), subject to the conditions in this regulation.

(2) An insurer may elect to use the 2017 CSO mortality table as the minimum standard for policies issued on or after January 1, 2017, until January 1, 2020. This table may be used for any one or more specified plans of insurance subject to the conditions in this regulation. If the insurer elects to use the 2017 CSO mortality table, it must do so for both valuation and nonforfeiture purposes.

(3) An insurer must use the 2017 CSO mortality table as the minimum standard for policies issued on or after January 1, 2020.

NEW SECTION

WAC 284-74-540 Conditions. (1) For each plan of insurance with separate rates for smokers and nonsmokers an insurer may use:

(a) Composite mortality tables to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits;

(b) Smoker and nonsmoker mortality tables to determine the valuation net premiums and additional minimum reserves, if any, required by RCW 48.74.070 and use composite mortality tables to determine the basic minimum reserves, minimum cash surrender values and amounts of paid-up nonforfeiture benefits; or

(c) Smoker and nonsmoker mortality to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits.

(2) The composite mortality tables must be used for plans of insurance without separate rates for smokers and nonsmokers.

(3) The insurer for each plan of insurance may use the 2017 CSO mortality table in its ultimate or select and ultimate form to determine minimum reserve liabilities and minimum cash surrender values and amounts of paid-up nonforfeiture benefits. This is subject to the restrictions of WAC 284-74-545 and 284-74-300 through 284-74-380 regarding the use of the select and ultimate form.

(4) When the 2017 CSO mortality table is the minimum reserve standard for any plan for an insurer, the actuarial opinion in the annual statement filed with the commissioner must be based on an asset adequacy analysis as specified in WAC 284-07-380. The commissioner may exempt an insurer from this requirement if it only does business in Washington.

NEW SECTION

WAC 284-74-545 Applicability to WAC 284-74-300 through 284-74-380. (1) The 2017 CSO mortality table may be used in applying WAC 284-74-300 through 284-74-380 in the following manner, subject to the transition dates for use of the 2017 CSO mortality table in WAC 284-74-535 of this regulation (unless otherwise noted, the references in this section are to WAC 284-74-300 through 284-74-380):

(a) WAC 284-74-320 (1)(b)(ii): The net level reserve premium is based on the ultimate mortality rates in the 2017 CSO mortality table.

(b) WAC 284-74-330(2): All calculations are made using the 2017 CSO mortality rate, and, if elected, the optional minimum mortality standard for deficiency reserves stipulated in (d) of this subsection. The value of "$q_{x+k+t-1}$" is the valuation mortality rate for deficiency reserves in policy year k+t, but using the unmodified select mortality rates if modified select mortality rates are used in the computation of deficiency reserves.

(c) WAC 284-74-340(1): The 2017 CSO mortality table is the minimum standard for basic reserves.

(d) WAC 284-74-340(2): The 2017 CSO mortality table is the minimum standard for deficiency reserves. If select mortality rates are used, they may be multiplied by X percent for durations in the first segment, subject to the conditions specified in WAC 284-74-340 (3)(a) through (i). In demonstrating compliance with those conditions, the demonstrations may not combine either: (i) The results of tests that utilize the 1980 CSO mortality table with those tests that utilize the 2017 CSO mortality table; or (ii) the results of tests that utilize the 2001 CSO mortality table with those tests that utilize the 2017 CSO mortality table, unless the combination is explicitly required by regulation or necessary to be in compliance with relevant actuarial standards of practice.

(e) WAC 284-74-350(3): The valuation mortality table used in determining the tabular cost of insurance is the ultimate mortality rates in the 2017 CSO mortality table.

(f) WAC 284-74-350 (5)(e): The calculations specified in WAC 284-74-350(5) must use the ultimate mortality rates in the 2017 CSO mortality table.

(g) WAC 284-74-350 (6)(e): The calculations specified in WAC 284-74-350(6) must use the ultimate mortality rates in the 2017 CSO mortality table.

(h) WAC 284-74-350 (7)(b): The calculations specified in WAC 284-74-350(7) must use the ultimate mortality rates in the 2017 CSO mortality table.

(i) WAC 284-74-360 (1)(a)(ii): The one-year valuation premium must be calculated using the ultimate mortality rates in the 2017 CSO mortality table.

(2) Nothing in this section expands the applicability of WAC 284-74-300 through 284-74-380 to include life insurance policies exempted under WAC 284-74-320(1).

NEW SECTION

WAC 284-74-550 Gender blended tables. (1) On or after January 1, 2017, an insurer may substitute a blended mortality table for the 2017 CSO mortality table for any ordinary life insurance policy delivered or issued for delivery in this state. The ordinary life policy must have (a) utilized the same premium rates and charges for male and female lives and (b) been issued in circumstances where applicable law does not permit distinctions on the basis of gender. The substituted table may blend the 2017 CSO mortality table (M) and the 2017 CSO mortality table (F) for use in determining minimum cash surrender values and amounts of paid-up nonforfeiture benefits. The table may be used for any one or more specified plans of insurance subject to the conditions in this regulation. No change in minimum valuation standards is implied by this subsection.

(2) The insurer may choose from among the blended tables developed by the American Academy of Actuaries CSO task force and adopted by the NAIC in April of 2016. The mortality table chosen must be based on the blend of lives by gender expected for the policies to be issued. The 2017 CSO mortality table (M) and 2017 CSO mortality table (F) may only be used where the proportion of individuals insured is anticipated to be ninety percent or more of one gender or the other.

(3) An insurer shall not use gender blended mortality tables unless:

(a) The Norris decision (Arizona Governing Committee v. Norris, 463 U.S. 1073, 103 S. Ct. 3492, 77 1. Ed 2d 1236 (1983)) or other federal law is known to apply to the policies involved; or

(b) The insurer has a bona fide concern that the Norris decision or other federal law might reasonably be construed to apply by a court having jurisdiction.

(4) It is not a violation of RCW 48.30.300 for an insurer to issue the same kind of policy of life insurance on both a gender distinct and gender neutral basis.

NEW SECTION

WAC 284-74-555 Effective date. The effective date of this regulation is January 1, 2017.

NEW SECTION

WAC 284-74-560 Purpose. The purpose of these rules, WAC 284-74-560 through 284-74-580, is to recognize, permit and prescribe the use of mortality tables that reflect differences in mortality between preferred and standard lives in determining minimum reserve liabilities in accordance with RCW 48.74.030 (1)(a)(iii), and WAC 284-74-340 (1) and (2).

NEW SECTION

WAC 284-74-565 Definitions. (1) "2017 CSO mortality table" means that mortality table, consisting of separate rates of mortality for male and female lives, developed by the American Academy of Actuaries CSO task force from the Valuation Basic Mortality Table developed by the Society of Actuaries individual life insurance valuation mortality task force, and adopted by the National Association of Insurance Commissioners (NAIC) in April of 2016. The 2017 CSO mortality table is included in the *2015 Proceedings of the NAIC (Fall Volume I)* and supplemented by the 2017 CSO preferred class structure mortality table defined in subsection (2) of this section. Unless the context indicates otherwise, the 2017 CSO mortality table includes both the ultimate form and the select and ultimate form of that table and includes both the smoker and nonsmoker mortality tables and the composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality tables. Mortality tables in the 2017 CSO mortality table include the following:

(a) "2017 CSO mortality table (F)" means that mortality table consisting of the rates of mortality for female lives from the 2017 CSO mortality table.

(b) "2017 CSO mortality table (M)" means that mortality table consisting of the rates of mortality for male lives from the 2017 CSO mortality table.

(c) "Composite mortality tables" means mortality tables with rates of mortality that do not distinguish between smokers and nonsmokers.

(d) "Smoker and nonsmoker mortality tables" means mortality tables with separate rates of mortality for smokers and nonsmokers.

(2) "2017 CSO preferred class structure mortality table" means mortality tables with separate rates of mortality for super preferred nonsmokers, preferred nonsmokers, residual standard nonsmokers, preferred smokers, and residual standard smoker splits of the 2017 CSO nonsmoker and smoker tables, as adopted by the NAIC at the April, 2016 national

meeting and published in the *2015 Proceedings of the NAIC (Fall Volume I)*. Unless the context indicates otherwise, the 2017 CSO preferred class structure mortality table includes both the ultimate form of that table and the select and ultimate form of that table. It includes both the smoker and nonsmoker mortality tables. It includes both the male and female mortality tables and the gender composite mortality tables. It also includes both the age-nearest-birthday and age-last-birthday bases of the mortality table.

(3) "Statistical agent" means an entity with proven systems for protecting the confidentiality of individual insured and insurer information; demonstrated resources for and history of ongoing electronic communications and data transfer ensuring data integrity with insurers, which are its members or subscribers; and a history of and means for aggregation of data and accurate promulgation of the experience modifications in a timely manner.

NEW SECTION

WAC 284-74-570 2017 CSO preferred class structure table. (1) At the election of the company, for each calendar year of issue, for any one or more specific plans of insurance and subject to satisfying the conditions stated in this regulation, the 2017 CSO preferred class structure mortality table may be substituted in place of the 2017 CSO smoker or nonsmoker mortality table as the minimum valuation standard for policies issued on or after January 1, 2017.

(2) For policies issued on or after January 1, 2017, and prior to January 1, 2020, these tables may be substituted with the consent of the commissioner and subject to the conditions of WAC 284-74-575. In determining such consent, the commissioner may rely on the consent of the commissioner of the company's state of domicile. No such election shall be made until the company demonstrates at least twenty percent of the business to be valued on this table is in one or more of the preferred classes.

(3) A table from the 2017 CSO preferred class structure mortality table used in place of a 2017 CSO mortality table, pursuant to the requirements of this rule, will be treated as part of the 2017 CSO mortality table only for purposes of reserve valuation pursuant to the requirements of these rules, WAC 284-74-525 through 284-74-555.

NEW SECTION

WAC 284-74-575 Conditions. (1) For each plan of insurance with separate rates for preferred and standard nonsmoker lives, an insurer may use the super preferred nonsmoker, preferred nonsmoker, and residual standard nonsmoker tables to substitute for the nonsmoker mortality table found in the 2017 CSO mortality table to determine minimum reserves. At the time of election and annually thereafter, except for business valued under the residual standard nonsmoker table, the appointed actuary shall certify that:

(a) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(b) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the valuation basic table corresponding to the valuation table being used for that class.

(2) For each plan of insurance with separate rates for preferred and standard smoker lives, an insurer may use the preferred smoker and residual standard smoker tables to substitute for the smoker mortality table found in the 2017 CSO mortality table to determine minimum reserves. At the time of election and annually thereafter, for business valued under the preferred smoker table, the appointed actuary shall certify that:

(a) The present value of death benefits over the next ten years after the valuation date, using the anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table corresponding to the valuation table being used for that class.

(b) The present value of death benefits over the future life of the contracts, using anticipated mortality experience without recognition of mortality improvement beyond the valuation date for each class, is less than the present value of death benefits using the preferred smoker valuation basic table.

(3) Unless exempted by the commissioner, every authorized insurer using the 2017 CSO preferred class structure table must annually file with the commissioner, with the NAIC, or with a statistical agent designated by the NAIC and acceptable to the commissioner, statistical reports showing mortality and such other information as the commissioner may deem necessary or expedient for the administration of the provisions of this regulation. The form of the reports must be established by the commissioner or the commissioner may require the use of a form established by the NAIC or by a statistical agent designated by the NAIC and acceptable to the commissioner.

(4) The use of the 2017 CSO preferred class structure table for the valuation of policies issued prior to January 1, 2017, must not be permitted in any statutory financial statement in which a company reports, with respect to any policy or portion of a policy coinsured, either of the following:

(a) In cases where the mode of payment of the reinsurance premium is less frequent than the mode of payment of the policy premium, a reserve credit that exceeds, by more than the amount specified in this subsection as Y, the gross reserve calculated before reinsurance. Y is the amount of the gross reinsurance premium that:

(i) Provides coverage for the period from the next policy premium due date to the earlier of the end of the policy year and the next reinsurance premium due date; and

(ii) Would be refunded to the ceding entity upon the termination of the policy.

(b) In cases where the mode of payment of the reinsurance premium is more frequent than the mode of payment of the policy premium, a reserve credit that is less than the gross reserve, calculated before reinsurance, by an amount that is less than the amount specified in this subsection as Z. Z is the amount of the gross reinsurance premium that the ceding entity would need to pay the assuming company to provide reinsurance coverage from the period of the next reinsurance premium due date to the next policy premium due date minus any liability established for the proportionate amount not remitted to the reinsurer.

(c) For purposes of this condition, the reserve:

(i) For the mean reserve method must be defined as the mean reserve minus the deferred premium asset; and

(ii) For the midterminal reserve method must include the unearned premium reserve. A company may estimate and adjust its accounting on an aggregate basis in order to meet the conditions to use the 2017 CSO preferred class structure table.

NEW SECTION

WAC 284-74-580 Effective date. The effective date of this regulation is January 1, 2017.

WSR 17-03-087
PERMANENT RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2016-22—Filed January 12, 2017, 4:16 p.m., effective February 12, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: To align state law with federal law, changes are necessary to add specificity regarding the substitution process for a consumer to request a nonformulary drug. The rule adds specific time frames for carriers to process a consumer's request. Consumers need predictability when a nonformulary drug is necessary for their condition.

Citation of Existing Rules Affected by this Order: Amending WAC 284-43-5080 and 284-43-5110.

Statutory Authority for Adoption: RCW 48.02.060, 48.18.140, 48.43.510.

Adopted under notice filed as WSR 16-22-092 on November 2, 2016.

A final cost-benefit analysis is available by contacting Jim Freeburg, P.O. Box 40260, Olympia, WA 98504-0260, phone (360) 725-7170, fax (360) 586-3109, email rulescoordinator@oic.wa.gov.

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: January 12, 2017.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 16-01-081, filed 12/14/15, effective 12/14/15)

WAC 284-43-5080 Prescription drug benefit design. (1) A carrier may design its prescription drug benefit to include cost control measures, including requiring preferred drug substitution in a given therapeutic class, if the restriction is for a less expensive, equally therapeutic alternative product available to treat the condition.

(2) A carrier may include elements in its prescription drug benefit design that, where clinically feasible, create incentives for the use of generic drugs. Examples of permitted incentives include, but are not limited to, refusal to pay for higher cost drugs until it can be shown that a lower cost drug or medication is not effective (also known as step therapy protocols or fail-first policies), establishing a preferred brand and nonpreferred brand formulary, or otherwise limiting the benefit to the use of a generic drug in lieu of brand name drugs, subject to a substitution process as set forth in subsection (3) of this section.

(3) A carrier must establish a process that a provider and enrollee (or their designee) may use to request a substitution for a ((~~covered~~)) prescribed therapy, drug or medication that is not on the formulary.

(a) The process must not unreasonably restrict an enrollee's access to nonformulary or alternate medications for refractory conditions. Used in this context, "refractory" means "not responsive to treatment."

(b) ((~~A carrier's substitution process must not result in delay in treating an enrollee's emergency fill or urgent care needs, or expedited requests for authorization.~~)) For an individual or small group plan, a carrier must make its determination on a standard exception and notify the enrollee or the enrollee's designee and the prescribing provider (or other prescriber, as appropriate) of its coverage determination no later than seventy-two hours following receipt of the request. A carrier that grants a standard exception request must provide coverage of the nonformulary drug for the duration of the prescription, including refills.

(c) For an individual or small group plan, a carrier must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing provider (or other prescriber) to request an expedited review based on exigent circumstances. For purposes of this section, "exigent circumstances" exist when an enrollee is experiencing a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

(i) A carrier must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designees and the prescribing provider (or other prescriber) of its coverage determination no later than twenty-four hours following receipt of the request.

(ii) A carrier that grants an exception based on exigent circumstances must provide coverage of the nonformulary drug for the duration of the exigency.

(d) Subject to the terms and conditions of the policy that otherwise limit or exclude coverage, the carrier must permit substitution of a covered generic drug or formulary drug if:

(i) An enrollee does not tolerate the covered generic or formulary drug; or

(ii) An enrollee's provider determines that the covered generic or formulary drug is not therapeutically efficacious for an enrollee. A carrier may require the provider to submit specific clinical documentation as part of the substitution request; or

(iii) The provider determines that a dosage is required for clinically efficacious treatment that differs from a carrier's formulary dosage limitation for the covered drug. A carrier may require the provider to submit specific clinical documentation as part of the substitution request and must review that documentation prior to making a decision.

(4) A carrier may include a preauthorization requirement for its prescription drug benefit and its substitution process, based on accepted peer reviewed clinical studies, Federal Drug Administration black box warnings, the fact that the drug is available over-the-counter, objective and relevant clinical information about the enrollee's condition, specific medical necessity criteria, patient safety, or other criteria that meet an accepted, medically applicable standard of care.

(a) Neither the substitution process criteria nor the type or volume of documentation required to support a substitution request may be unreasonably burdensome to the enrollee or their provider.

(b) The substitution process must be administered consistently, and include a documented consultation with the prescribing provider prior to denial of a substitution request.

(5) Use of a carrier's substitution process is not a grievance or appeal pursuant to RCW 48.43.530 and 48.43.535. Denial of a substitution request is an adverse benefit determination, and an enrollee, their representative provider or facility, or representative may request review of that decision using the carrier's appeal or adverse benefit determination review process.

(6) In an individual or small group plan, if the carrier denies a request for a standard exception or for an expedited exception, the carrier must have a process for the enrollee, the enrollee's designee, or the enrollee's prescribing provider (or other prescriber) to request that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

(a) A carrier must determine whether or not to grant an external exception request review and notify the enrollee or the enrollee's designee and the prescribing provider (or other prescriber, as appropriate) of its decision no later than seventy-two hours following its receipt of the request, if the original request was a standard exception request, and no later than twenty-four hours following its receipt of the request, if the original request was an expedited exception request.

(b) If a standard exception request is granted after an external review, the health plan must provide coverage of the nonformulary drug for the duration of the prescription. If an expedited exception request is granted after an external review, the health plan must provide coverage of the nonformulary drug for the duration of the exigency. If such an exigency ceases, any drug previously covered under such exigency may only be reauthorized through the standard exception request process.

AMENDATORY SECTION (Amending WSR 16-19-086, filed 9/20/16, effective 10/21/16)

WAC 284-43-5110 Cost-sharing for prescription drugs. (1) A carrier and health plan unreasonably restrict the treatment of patients if an ancillary charge, in addition to the plan's normal copayment or coinsurance requirements, is imposed for a drug that is covered because of one of the circumstances set forth in either WAC ((~~[284-43-5080] [284-43-817] or [284-43-5100] [284-43-818]~~)) 284-43-5080 or 284-43-5100. An ancillary charge means any payment required by a carrier that is in addition to or excess of cost-sharing explained in the policy or contract form as approved by the commissioner. Cost-sharing means amounts paid directly to a provider or pharmacy by an enrollee for services received under the health benefit plan, and includes copayment, coinsurance, or deductible amounts.

(2) When an enrollee requests a brand name drug from the formulary in lieu of a therapeutically equivalent generic drug or a drug from a higher tier within a tiered formulary, and there is not a documented clinical basis for the substitution, a carrier may require the enrollee to pay for the difference in price between the drug that the formulary would have required, and the covered drug, in addition to the copayment. This charge must reflect the actual cost difference.

(3) When a carrier approves a substitution drug, whether or not the drug is in the carrier's formulary, the enrollee's cost-sharing for the substitution drug must be adjusted to reflect any discount agreements or other pricing adjustments for the drug that are available to a carrier. Any charge to the enrollee for a substitution drug must not increase the carrier's underwriting gain for the plan beyond the gain contribution calculated for the original formulary drug that is replaced by the substitution.

(4) If a carrier uses a tiered formulary in its prescription drug benefit design, and a substitute drug that is in the formulary is required based on one of the circumstances in either WAC ((~~[284-43-5080] [284-43-817] or [284-43-5100] [284-43-818]~~)) 284-43-5080 or 284-43-5100, the enrollee's cost sharing may be based on the tier in which the carrier has placed the substitute drug.

(5) If a carrier requires cost-sharing for enrollees receiving an emergency fill as defined in WAC 284-170-470, then issuers must disclose that information to enrollees within their policy forms.

(6) For individual and small group plans, if a substitution is granted, the carrier must treat the drug as an essential health benefit, including by counting any cost-sharing towards the plan's annual limitation on cost-sharing and towards any deductible.

WSR 17-03-089
PERMANENT RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2013-29—Filed January 13, 2017, 10:34 a.m., effective July 1, 2017]

Effective Date of Rule: July 1, 2017.

Purpose: The rule requires long-term care insurance carriers to demonstrate that they use due diligence to attempt to locate policyholders or named lapse designees when they receive notification of nondelivery of lapse notices. The rule also changes the consumer disclosures related to lapse designees. The changes are intended to reduce the likelihood that an unintentional lapse in a long-term care insurance policy occurs.

Citation of Existing Rules Affected by this Order: Amending WAC 284-54-253 and 284-83-025.

Statutory Authority for Adoption: RCW 48.02.060, 48.83.170, 48.84.030.

Adopted under notice filed as WSR 16-22-090 on November 2, 2016.

A final cost-benefit analysis is available by contacting Jim Freeburg, P.O. Box 40260, Olympia, WA 98504-0260, phone (360) 725-7170, fax (360) 586-3109, email rulescoordinator@oic.wa.gov.

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 2, 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: January 13, 2017.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 95-19-028, filed 9/11/95, effective 10/12/95)

WAC 284-54-253 Unintentional lapse. The purpose of this section is to protect insureds from unintentional lapse by establishing standards for notification of a designee to receive notice of lapse for nonpayment of premiums at least thirty days prior to the termination of coverage and to provide for a limited right to reinstatement of coverage unintentionally lapsed by a person with a cognitive impairment or loss of functional capacity. These are minimum standards and do not prevent an insurer from including benefits more favorable to the insured. This section applies to every insurer providing long-term care coverage to a resident of this state, which coverage is issued for delivery or renewed on or after January 1, 1996, through December 31, 2008.

(1) Every insurer shall permit an insured to designate at least one additional person to receive notice of lapse or termination for nonpayment of premium, if the premium is not paid on or before its due date. The designation shall include the designee's full name and home address.

(a) The notice shall provide that the contract or certificate will not lapse until at least thirty days after the issuer sends the notice ((~~is mailed~~)) to the insured's designee.

(i) Issuers must be able to show:

(A) Proof that they produced the notice;

(B) Proof that they sent the notice;

(C) The name and address of the person or persons to whom they sent the notice. The address may consist of either:

(I) A physical mailing address; or

(II) An electronic mailing address for delivery by electronic means under the requirements of RCW 48.185.005.

(D) The date that they sent the notice.

(ii) Upon request of the commissioner, to verify that they sent the notice, issuers must be able to provide:

(A) An attestation from the person who sent the notice or supervised sending the notice; or

(B) Proof of sending the notice, which regardless of delivery method, may consist of, but is not limited to a confirmation document that shows the date the issuer mailed the item, the name and address of the insured, and the lapse designee if the insured has named a lapse designee for the policy. Delivery of the notice may occur using one of these or similar methods:

(I) Certified mail, which may be proven by obtaining a certificate of mailing from the United States Postal Service;

(II) A commercial delivery service;

(III) First class United States mail, postage prepaid; or

(IV) Proof of delivery by electronic means under the requirements of RCW 48.185.005.

(iii) If the insured has an insurance producer of record, then the issuer must also provide notice to the insured's producer of record within seventy-two hours after the issuer sends the notice to the insured and to the lapse designee, if the insured has named a lapse designee for the policy. In sending this notice, issuers must comply with the mailing requirements in (a)(ii) of this subsection.

(iv) An issuer may not give notice until thirty days after a premium is due and unpaid. Notice is deemed to have been given as of five days after the date that the issuer sent the notice.

(v) Upon the request of the commissioner, issuers must be able to demonstrate that they use due diligence to attempt to locate policyholders or named lapse designees when they receive notification of nondelivery of lapse notices.

(b) Where a policyholder or certificate holder pays premium through a payroll or pension deduction plan, the insurer shall permit the insured to designate a person to receive notice of lapse or termination for nonpayment of premium within sixty days after the insured is no longer on such a premium payment plan. The application or enrollment form for contracts or certificates where premium will be paid through a payroll or pension deduction plan shall clearly indicate the payment plan selected by the applicant.

(c) The insurer shall offer ((~~each insured~~)) in writing an opportunity to each insured to change the lapse designee, or update the information concerning the lapse designee, no less frequently than once ((~~in every twenty-four months~~)) a year.

(i) Issuers must print this notice in not less than twelve point type either:

(A) On the front side of the first page of the billing statement; or

(B) On a separate document that is not printed on the billing statement.

(ii) If the insured has named a lapse designee for the account, then the issuer must print on the notice the name and contact information that the issuer has on record for the lapse designee.

(2) Every insurer shall provide a limited right to reinstate coverage in the event of lapse or termination for nonpayment of premium, if the insurer is provided proof of the insured's cognitive impairment or loss of functional capacity and reinstatement is requested within the five months after the policy lapsed or terminated due to nonpayment of premium.

(a) The standard of proof of cognitive impairment or loss of functional capacity shall be no more restrictive than the benefit eligibility criteria for cognitive impairment or loss of functional capacity contained in the contract or certificate.

(b) Current good health of the insured shall not be required for reinstatement if the request otherwise meets the requirements of this section.

(3) An insurer shall permit an insured to waive ((~~his or her~~)) the right to designate an additional person to receive notice of lapse or termination for nonpayment of premium.

(a) The waiver shall be in writing, and shall be dated and signed by the applicant or insured.

(b) No less frequently than once in every twenty-four months, the insured shall be permitted to revoke this waiver and to name a designee.

(4) Designation by the insured to receive notice of lapse or termination for nonpayment of premium does not constitute acceptance of any liability on the part of the designee for services provided to the insured or applicant.

AMENDATORY SECTION (Amending WSR 08-24-019, filed 11/24/08, effective 12/25/08)

WAC 284-83-025 Unintentional lapse. As a protection against unintentional lapse, each issuer offering long-term care insurance must comply with all of the following:

(1)(a) Notice before lapse or termination. No individual long-term care policy or certificate may be issued until the issuer has received from the applicant either a written designation of at least one person in addition to the applicant ((~~who is~~)) to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive notice.

(i) The applicant has the right to designate at least one person ((~~who is~~)) to receive the notice of termination, in addition to the insured.

(ii) Designation does not constitute acceptance of any liability on the third party for services provided to the insured.

(iii) The form used for the written designation must provide space clearly designated for listing at least one person.

(iv) The designation must include each person's full name and home address.

(v) If the applicant elects not to designate an additional person, the waiver must state: "Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long-term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty days after a premium is due and unpaid. I elect NOT to designate a person to receive this notice."

(vi) No less frequently than once every ((~~two~~)) year((~~s~~)) the issuer must notify the insured of the right to change this written designation or to add a lapse designee, if the insured has not already designated a lapse designee.

(A) Issuers must print this notice in not less than twelve point type either:

(I) On the front side of the first page of the billing statement; or

(II) On a separate document that is not printed on the billing statement.

(B) If the insured has named a lapse designee for the account, then the issuer must print on the notice the name and contact information that the issuer has on record for the lapse designee.

(b) When the policyholder or certificate holder pays premium for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in (a) of this subsection need not be met until sixty days after the policyholder or certificate holder is no longer on the payment plan. The application or enrollment form for such policies or certificates must clearly show the payment plan selected by the applicant.

(c) Lapse or termination for nonpayment of premium. No individual long-term care policy or certificate shall lapse or be terminated for nonpayment of premium unless the issuer, at least thirty days before the effective date of the lapse or termination, has given notice to the insured and to those persons designated pursuant to (a) of this subsection, at the address provided by the insured for purposes of receiving notice of lapse or termination. ((~~Notice must be given by first class United States mail, postage prepaid, and notice may not be given until thirty days after a premium is due and unpaid. Notice is deemed to have been given as of five days after the date of mailing.~~))

(i) Issuers must be able to show:

(A) Proof that they produced the notice;

(B) Proof that they sent the notice;

(C) The name and address of the person or persons to whom they sent the notice. The address may consist of either:

(I) A physical mailing address; or

(II) An electronic mailing address for delivery by electronic means under the requirements of RCW 48.185.005;

(D) The date that they sent the notice.

(ii) Upon request of the commissioner, to verify that they sent the notice, issuers must be able to provide:

(A) An attestation from the person who sent the notice or supervised sending the notice; or

(B) Proof of sending the notice, which regardless of delivery method, may consist of, but is not limited to a confirmation document that shows the date the issuer mailed the item, the name and address of the insured, and the lapse designee if the insured has named a lapse designee for the policy. Delivery of the notice may occur using one of these or similar methods:

(I) Certified mail, which may be proven by obtaining a certificate of mailing from the United States Postal Service;

(II) A commercial delivery service;

(III) First class United States mail, postage prepaid; or

(IV) Proof of delivery by electronic means under the requirements of RCW 48.185.005.

(iii) If the insured has an insurance producer of record, then the issuer must also provide notice to the insured's producer of record within seventy-two hours after the issuer sends the notice to the insured and to the lapse designee, if the insured has named a lapse designee for the policy. In sending this notice, issuers must comply with the mailing requirements in (c)(ii) of this subsection.

(iv) An issuer may not give notice until thirty days after a premium is due and unpaid. Notice is deemed to have been given as of five business days after the date that the issuer sent the notice.

(v) Upon the request of the commissioner, issuers must be able to demonstrate that they use due diligence to attempt to locate policyholders or named lapse designees when they receive notification of nondelivery of lapse notices.

(2) Reinstatement. In addition to the requirements in subsection (1) of this section, a long-term care insurance policy or certificate must include a provision that provides for reinstatement of coverage in the event of lapse if the issuer ((~~is provided proof~~)) receives proof, as per the standards stated in (b) of this subsection, that the policyholder or certificate holder was cognitively impaired or had a loss of functional capacity before the policy's grace period ((~~contained in the policy~~)) expired.

(a) Reinstatement must be available to the insured if requested within five months after lapse ((~~and may allow for the collection of past due premium, where appropriate~~)). When appropriate, issuers may collect past due premiums as part of the reinstatement process as set forth in the policy or certificate.

(b) The standard of proof of cognitive impairment or loss of functional capacity must not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity contained in the policy or certificate.

WSR 17-03-092
PERMANENT RULES
HORSE RACING COMMISSION

[Filed January 13, 2017, 2:00 p.m., effective February 13, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: To update safety equipment ratings to reflect current industry standards.

Citation of Existing Rules Affected by this Order: Amending WAC 260-12-180.

Statutory Authority for Adoption: RCW 67.16.020.

Adopted under notice filed as WSR 16-23-127 on November 21, 2016.

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 1, Repealed 0.

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

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

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

Date Adopted: January 13, 2017.

Douglas L. Moore
Executive Secretary

AMENDATORY SECTION (Amending WSR 13-13-041, filed 6/14/13, effective 7/15/13)

WAC 260-12-180 Safety equipment required. (1) When on association grounds, all persons on horseback must wear a securely fastened safety helmet that meets current standards for equipment designed and manufactured for use while riding horses as established by ((~~the~~)):

(a) American Society for Testing and Materials (ASTM F1163)((~~,~~)).

(b) UK Standards (EN-1384 ((~~and~~)) or PAS-015((~~); or,~~)) or VG1).

(c) Australian/New Zealand Standard (AS/NZ 3838 or ARB HS 2012).

(d) Snell Equestrian Standard 2001.

(2) All persons on horseback must wear a securely fastened safety vest that is designed to provide shock-absorbing protection of:

(a) British Equestrian Trade Association (BETA):2000 Level 1.

(b) American Society for Testing and Materials (ASTM ((~~1163~~))) F2681-08 or ((~~1937 (Specification for Body Protectors Used in Horse Sports and Horseback Riding)~~))) F1937-04.

(c) Euro Norm (EN) 13158:2000 Level 1.

(d) Shoe and Allied Trade Research Association (SATRA) Jockey Vest Document M6 Issue 3.

(e) Australian Racing Board (ARB) Standard ((~~1.1198~~)) 1.1998.

(3) All persons on horseback must wear equestrian footwear that covers the rider's ankle with a minimum of a 1/2 inch heel, except jockeys while riding in a race who must wear jockey boots as required by WAC 260-32-100.

This rule does not apply to nonracing related events conducted for entertainment purposes. Safety equipment for such entertainment events shall be at the discretion of the racing association.

WSR 17-03-093
PERMANENT RULES
HORSE RACING COMMISSION

[Filed January 13, 2017, 2:01 p.m., effective February 13, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: To correct a typographical error discovered, changing the word "prize" to price.

Citation of Existing Rules Affected by this Order: Amending WAC 260-40-090.

Statutory Authority for Adoption: RCW 67.16.020.

Adopted under notice filed as WSR 16-23-124 on November 21, 2016.

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 1, Repealed 0.

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

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

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

Date Adopted: January 13, 2017.

Douglas L. Moore
Executive Secretary

AMENDATORY SECTION (Amending WSR 07-07-010, filed 3/8/07, effective 4/8/07)

WAC 260-40-090 Registration certificate. No horse may be allowed to start unless a Jockey Club registration certificate, American Quarter Horse Association certificate of registration, or other applicable breed certificate of registration is on file in the office of the racing secretary, except that the stewards may waive this requirement, if the horse is otherwise properly identified and the horse is not entered for a claiming ((~~prize~~)) price.

WSR 17-03-094
PERMANENT RULES
HORSE RACING COMMISSION

[Filed January 13, 2017, 2:01 p.m., effective February 13, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: To clarity [clarify] the tote company's ability to display "will pays" of probably payouts to the public.

Citation of Existing Rules Affected by this Order: Amending WAC 260-48-920.

Statutory Authority for Adoption: RCW 67.16.020.

Adopted under notice filed as WSR 16-23-126 on November 21, 2016.

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 1, Repealed 0.

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

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

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

Date Adopted: January 13, 2017.

Douglas L. Moore
Executive Secretary

AMENDATORY SECTION (Amending WSR 12-03-074, filed 1/13/12, effective 2/13/12)

WAC 260-48-920 Pick (n) pools. (1) The pick (n) requires selection of the first-place finisher in each of a designated number of races. The association must obtain written approval from the executive secretary concerning the scheduling of pick (n) races, the designation of one of the methods prescribed in part (2), and the amount of any cap to be set on the carryover. The number of races so designated must be more than three (3), but no greater than ten (10). Any changes to the approved pick (n) format require prior approval from the executive secretary.

(2) The pick (n) pool will be apportioned under one of the following methods:

(a) Method 1, pick (n) with carryover: The net pick (n) pool and carryover, if any, will be distributed as a single price pool to those who selected the first-place finisher in each of the pick (n) races, based upon the official order of finish. If there are no such wagers, then a designated percentage of the net pool will be distributed as a single price pool to those who selected the first-place finisher in the greatest number of pick (n) races; and the remainder will be added to the carryover.

(b) Method 2, pick (n) with minor pool and carryover: The major share of the net pick (n) pool and the carryover, if any, will be distributed to those who selected the first-place finisher in each of the pick (n) races, based upon the official order of finish. The minor share of the net pick (n) pool will be distributed to those who selected the first-place finisher in the second greatest number of pick (n) races, based upon the official order of finish. If there are no wagers selecting the first-place finisher of all pick (n) races, the minor share of the net pick (n) pool will be distributed as a single price pool to those who selected the first-place finisher in the greatest number of pick (n) races; and the major share will be added to the carryover.

(c) Method 3, pick (n) with no minor pool and no carryover: The net pick (n) pool will be distributed as a single price pool to those who selected the first-place finisher in the greatest number of pick (n) races, based upon the official order of finish. If there are no winning wagers, the pool is refunded.

(d) Method 4, pick (n) with minor pool and no carryover: The major share of the net pick (n) pool will be distributed to those who selected the first place finisher in the greatest number of pick (n) races, based upon the official order of finish. The minor share of the net pick (n) pool will be distributed to those who selected the first-place finisher in the second greatest number of pick (n) races, based upon the official order of finish. If there are no wagers selecting the first-place finisher in a second greatest number of pick (n) races, the minor share of the net pick (n) pool will be combined with the major share for distribution as a single price pool to those who selected the first-place finisher in the greatest number of pick (n) races. If the greatest number of first-place finishers selected is one (1), the major and minor shares are combined for distribution as a single price pool. If there are no winning wagers, the pool is refunded.

(e) Method 5, pick (n) with minor pool and no carryover: The major share of net pick (n) pool will be distributed to those who selected the first-place finisher in each of the pick (n) races, based upon the official order of finish. The minor share of the net pick (n) pool will be distributed to those who selected the first-place finisher in the second greatest number of pick (n) races, based upon the official order of finish. If there are no wagers selecting the first-place finisher in all pick (n) races, the entire net pick (n) pool will be distributed as a single price pool to those who selected the first-place finisher in the greatest number of pick (n) races. If there are no wagers selecting the first-place finisher in a second greatest number of pick (n) races, the minor share of the net pick (n) pool will be combined with the major share for distribution as a single price pool to those who selected the first-place finisher in each of the pick (n) races. If there are no winning wagers, the pool is refunded.

(f) Method 6, pick (n) with minor pool, jackpot pool, major carryover and jackpot carryover: Predetermined percentages of the net pick (n) pool will be set aside as a major pool, minor pool and jackpot pool. The major share of the net pick (n) pool and the major carryover, if any, will be distributed to those who selected the first-place finisher of each of the pick (n) races, based on the official order of finish. If there are no tickets selecting the first-place finisher in each of the pick (n) races, the major net pool will be added to the major carryover. If there is only one single ticket selecting the first-place finisher of each of the pick (n) races, based on the official order of finish, the jackpot share of the net pick (n) pool and the jackpot carryover, if any, will be distributed to the holder of that single ticket, along with the major net pool and the major carryover, if any. If more than one ticket selects the first-place finisher of each of the pick (n) races the jackpot net pool will be added to the jackpot carryover. The minor share of the net pick (n) pool will be distributed to those who selected the first-place finisher of the second greatest number of pick (n) races, based on the official order of finish. If there are no wagers selecting the first-place finisher of all pick (n) races, the minor net pool of the pick (n) pool will be distributed as a single price pool to those who selected the first-place finisher of the greatest number of pick (n) races.

(3) If there is a dead heat for first in any of the pick (n) races involving:

(a) Horses representing the same betting interest, the pick (n) pool will be distributed as if no dead heat occurred.

(b) Horses representing two or more betting interests, the pick (n) pool will be distributed as a single price pool with each winning wager receiving an equal share of the profit.

(4) Should a betting interest in any of the pick (n) races be scratched:

(a) The racing association may allow patrons the option of selecting an alternate betting interest prior to the running of the first leg of the pick (n). The selected alternate betting interest will be substituted for the scratched betting interest, for all purposes, including pool calculations.

(b) If no alternate betting interest is selected or the selected alternate betting interest is also scratched, the actual favorite, as evidenced by total amounts wagered in the win pool at the close of wagering on that race, will be substituted for the scratched betting interest for all purposes, including pool calculations. In the event that the win pool total for two or more favorites is identical, the substitute selection will be the betting interest with the lowest program number. The parimutuel system will produce reports showing each of the wagering combinations with substituted betting interests which became winners as a result of the substitution, in addition to the normal winning combination.

(5) The pick (n) pool will be canceled and all pick (n) wagers for the individual race day will be refunded if:

(a) At least three races included as part of a pick 4, pick 5 or pick 6 are canceled or declared "no contest."

(b) At least four races included as part of a pick 7, pick 8 or pick 9 are canceled or declared "no contest."

(c) At least five races included as part of a pick 10 are canceled or declared "no contest."

(6) If at least one race included as part of a pick (n) is canceled or declared "no contest," but not more than the number specified in subsection 5 of this rule, the net pool will be distributed as a single price pool to those whose selection finished first in the greatest number of pick (n) races for that race day. Such distribution will include the portion ordinarily retained for the pick (n) carryover but not the carryover from previous race days.

(7) The pick (n) carryover may be capped at a designated level approved by the commission so that if, at the close of any race day, the amount in the pick (n) carryover equals or exceeds the designated cap, the pick (n) carryover will be frozen until it is won or distributed under other provisions of this rule. After the pick (n) carryover is frozen, 100 percent of the net pool, part of which ordinarily would be added to the pick (n) carryover, will be distributed to those whose selection finished first in the greatest number of pick (n) races for that race day.

(8) A written request for permission to distribute the pick (n) carryover on a specific race day may be submitted to the executive secretary. The request must contain justification for the distribution, an explanation of the benefit to be derived, and the intended date and race day for the distribution.

(9) Should the pick (n) carryover be designated for distribution on a specified date and race day in which there are no

wagers selecting the first-place finisher in each of the pick (n) races, the entire pool will be distributed as a single price pool to those whose selection finished first in the greatest number of pick (n) races. The pick (n) carryover will be designated for distribution on a specified date and race day only under the following circumstances:

(a) Upon written approval from the commission as provided in subsection 8 of this rule.

(b) Upon written approval from the executive secretary when there is a change in the carryover cap, a change from one type of pick (n) wagering to another, or when the pick (n) is discontinued.

(c) On the closing race day of the meet or split meet.

(10) If, for any reason, the pick (n) carryover must be held over to the corresponding pick (n) pool of a subsequent meet, the carryover will be deposited in an interest-bearing account approved by the commission. The pick (n) carryover plus accrued interest will then be added to the net pick (n) pool of the following meet on a date and race day so designated by the commission.

(11) With the written approval of the executive secretary, the association may contribute to the pick (n) carryover a sum of money up to the amount of any designated cap.

(12) Providing information to any person that is not made available to the public regarding covered combinations, amounts wagered on specific combinations, number of tickets sold, or number of live tickets remaining is ((~~strictly~~)) prohibited.

(13) The total amount of the net pool and information of probable payouts for each of the runners when the last race of the pick (n) wager is the only race remaining to be run may be displayed to the public.

This will not prohibit necessary communication between parimutuel system and parimutuel department employees for processing of pool data.

((~~(13)~~)) (14) The association may suspend previously-approved pick (n) wagering with the prior approval of the executive secretary. Any carryover will be held until the suspended pick (n) wagering is reinstated. An association may request approval of a pick (n) wager or separate wagering pool for specific race day.

WSR 17-03-095
PERMANENT RULES
HORSE RACING COMMISSION

[Filed January 13, 2017, 2:02 p.m., effective February 13, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: To give the Washington horse racing commission the authority to collect hair samples as a means of testing for prohibited substances.

Citation of Existing Rules Affected by this Order: Amending WAC 260-70-590.

Statutory Authority for Adoption: RCW 67.16.020.

Adopted under notice filed as WSR 16-23-125 on November 21, 2016.

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 1, Repealed 0.

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

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

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

Date Adopted: January 13, 2017.

Douglas L. Moore
Executive Secretary

AMENDATORY SECTION (Amending WSR 07-07-036, filed 3/12/07, effective 4/12/07)

WAC 260-70-590 Reporting to the test barn. (1) The official winning horse and any other horse ordered by the stewards, official veterinarian or the commission must be taken to the test barn to have a ((~~blood and/or urine sample~~)) hair, blood, urine sample, or a combination of each, taken at the direction of an official veterinarian.

(2) Random or extra testing may be required by the stewards, an official veterinarian, or the commission at any time on any horse on association grounds.

(3) A horse selected for testing must be taken directly to the test barn, unless otherwise directed by the stewards or an official veterinarian.

(4) Only persons currently licensed by the commission may enter the test barn on a race day. Licensees must have a valid reason for being in the test barn, and may be required to display their license. When accompanying a horse to the test barn no more than three licensees will be permitted to enter the test barn.

WSR 17-03-104
PERMANENT RULES
BUILDING CODE COUNCIL

[Filed January 17, 2017, 10:16 a.m., effective May 1, 2017]

Effective Date of Rule: May 1, 2017.

Purpose: The purpose of this filing is to amend the 2015 Washington State Fire Code to permanently adopt Chapter 38: Marijuana Processing and Extraction Facilities; adoption of this permanent rule will ensure safe operation of marijuana processing and production facilities throughout Washington state.

Citation of Existing Rules Affected by this Order: Amending WAC 51-54A-3800.

Statutory Authority for Adoption: Chapter 19.27 RCW.

Adopted under notice filed as WSR 16-16-118 on August 3, 2016.

Changes Other than Editing from Proposed to Adopted Version: The state building code council adopted language to clarify that in marijuana extraction facilities, any egress door serving an extraction room shall swing in the direction of egress travel.

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

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

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

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

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

Date Adopted: November 18, 2016.

Steve Simpson
Chair

NEW SECTION

WAC 51-54A-3800 Marijuana processing or extraction facilities.

SECTION 3801—ADMINISTRATION

3801.1 Scope. Facilities used for marijuana processing or extraction that utilize chemicals or equipment as regulated by the International Fire Code shall comply with this chapter and the International Building Code. The extraction process includes the act of extraction of the oils and fats by use of a solvent, desolventizing of the raw material and production of the miscella, distillation of the solvent from the miscella and solvent recovery. The use, storage, transfilling, and handling of hazardous materials in these facilities shall comply with this chapter and the International Building Code.

3801.2 Application. The requirements set forth in this chapter are requirements specific only to marijuana processing and extraction facilities and shall be applied as exceptions or additions to applicable requirements set forth elsewhere in this code.

3801.2.1 For the purposes of this chapter, marijuana processing and extraction shall be limited to those processes and extraction methods that utilize chemicals defined as hazardous by the International Fire Code and are regulated as such. Such processes and extraction methods shall meet the requirements of this chapter and other applicable requirements elsewhere in this code and its referenced standards.

EXCEPTION: Provisions of WAC 314-55-104 do not apply to this chapter.

3801.2.2 The use of equipment regulated by the International Fire Code for either marijuana processing or marijuana extraction shall meet the requirements of this chapter and other applicable requirements elsewhere in this code.

3801.3 Multiple hazards. Where a material, its use or the process it is associated with poses multiple hazards, all hazards shall be addressed in accordance with Section 5001.1 and other material specific chapters.

3801.4 Existing building or facilities. Existing buildings or facilities used for the processing of marijuana shall comply with this chapter.

3801.5 Permits. Permits shall be required as set forth in Section 105.6 and 105.7.

SECTION 3802—DEFINITIONS

Desolventizing. The act of removing a solvent from a material.

Finding. The results of an inspection, examination, analysis or review.

Marijuana processing. Processing that uses chemicals or equipment as regulated by the International Fire Code; this does not include the harvesting, trimming, or packaging of the plant.

Miscella. A mixture, in any proportion, of the extracted oil or fat and the extracting solvent.

Observation. A practice or condition not technically noncompliant with other regulations or requirements, but could lead to noncompliance if left unaddressed.

Transfilling. The process of taking a gas source, either compressed or in liquid form (usually in bulk containers), and transferring it into a different container (usually a smaller compressed cylinder).

SECTION 3803—PROCESSING OR EXTRACTION OF MARIJUANA

3803.1 Location. Marijuana processing shall be located in a building complying with the International Building Code and this code. Requirements applied to the building shall be based upon the specific needs for mitigation of the specific hazards identified.

3803.2 Systems, equipment and processes. Systems, equipment, and processes shall be in accordance with Sections 3803.2.1 through 3803.2.7. In addition to the requirements of this chapter, electrical equipment shall be listed or evaluated for electrical fire and shock hazard in accordance with RCW 19.28.010(1).

3803.2.1 Application. Systems, equipment and processes shall include, but are not limited to, vessels, chambers, containers, cylinders, tanks, piping, tubing, valves, fittings, and pumps.

3803.2.2 General requirements. In addition to the requirements in Section 3803, systems, equipment and processes shall also comply with Section 5003.2, other applicable provisions of this code, the International Building Code, and the International Mechanical Code. The use of ovens in post-process purification or winterization shall comply with Section 3803.2.7.

3803.2.3 Systems and equipment. Systems or equipment used for the extraction of oils from plant material shall be listed and approved for the specific use. If the system used for extraction of oils and products from plant material is not listed, then a technical report prepared by a Washington licensed engineer shall be provided to the code official for review and approval.

3803.2.4 Change of extraction medium. Where the medium of extraction or solvent is changed from the material indicated in the technical report, or as required by the manufacturer, the technical report shall be revised at the cost of the facility owner, and submitted for review and approval by the fire code official prior to the use of the equipment with the new medium or solvent.

3803.2.5 Required technical report. The technical report documenting the equipment design shall be submitted for review and approval by the fire code official prior to the equipment being installed at the facility.

3803.2.5.1 Content of technical report and engineering analysis. All, but not limited to, the items listed below shall be included in the technical report.

1. Manufacturer information.
2. Engineer of record information.
3. Date of review and report revision history.
4. Signature page shall include:

4.1 Author of the report;

4.2 Date of report;

4.3 Seal, date and signature of engineer of record performing the design; and

5. Model number of the item evaluated. If the equipment is provided with a serial number, the serial number shall be included for verification at the time of site inspection.
6. Methodology of the design review process used to determine minimum safety requirements. Methodology shall consider the basis of design, and shall include a code analysis and code path to demonstrate the reason why specific codes or standards are applicable or not.
7. Equipment description. A list of all components and subassemblies of the system or equipment, indicating the material, solvent compatibility, maximum temperature and pressure limits.
8. A general flow schematic or general process flow diagram (PFD) of the process, including maximum temperatures, pressures and solvent state of matter shall be identified in each step or component. It shall provide maximum operating temperature and pressure in the system.
9. Analysis of the vessel(s) if pressurized beyond standard atmospheric pressure. Analysis shall include purchased and fabricated components.
10. Structural analysis for the frame system supporting the equipment.
11. Process safety analysis of the extraction system, from the introduction of raw product to the end of the extraction process.
12. Comprehensive process hazard analysis considering failure modes and points of failure throughout the process. This portion of the review should include review of emergency procedure information provided by the manufacturer of the equipment or process and not that of the facility, building or room.
13. Review of the assembly instructions, operational and maintenance manuals provided by the manufacturer.
14. Report shall include findings and observations of the analysis.
15. List of references used in the analysis.

3803.2.6 Building analysis. The technical report, provided by the engineer of record, shall include a review of the construction documents for location, room, space or building and include recommendations to the fire code official.

3803.2.6.1 Site inspection. The engineer of record of the equipment shall inspect the installation of the extraction equipment for conformance with the technical report and provide documentation to the fire code official that the equipment was installed in conformance with the approved design.

3803.2.7 Post-process purification and winterization. Post-processing and winterization involving the heating or pressurizing of the miscella shall be approved and performed in an appliance listed for such use. Domestic or commercial cooking appliances shall not be used. The use of industrial ovens shall comply with Chapter 30.

EXCEPTION: An automatic fire extinguishing system shall not be required for batch-type Class A ovens having less than 3.0 cubic feet of work space.

3803.3 Construction requirements.

3803.3.1 Location. Marijuana extraction shall not be located in any building containing a Group A, E, I or R occupancy.

3803.3.1.1 Extraction room. The extraction equipment and processes utilizing hydrocarbon solvents shall be located in a room or area dedicated to extraction.

3803.3.2 Egress. Any egress door serving an extraction room shall swing in the direction of egress travel and be equipped with panic hardware and self-closing hardware.

3803.3.2.1 Facility egress. Egress requirements shall be in compliance with Chapter 10 of the International Building Code.

3803.3.3 Ventilation. Ventilation shall be provided in compliance with Chapter 4 of the International Mechanical Code.

3803.3.4 Control area. Control areas shall comply with Section 5003.8.3.

3803.3.5 Ignition source control. Extraction equipment and processes using flammable or combustible gas or liquid solvents shall be provided with ventilation rates for the room to maintain the concentration of flammable constituents in air below 25% of the lower flammability limit of the respective solvent. If not provided with the required ventilation rate, Class I Division II electrical requirements shall apply to the entire room.

3803.3.6 Interlocks. When a hazardous exhaust system is provided, all electrical components within the extraction room or area shall be interlocked with the hazardous exhaust system, and when provided, the gas detection system. When the hazardous exhaust system is not operational, then light switches and electrical outlets shall be disabled. Activation of the gas detection system shall disable all light switches and electrical outlets.

3803.3.7 Emergency power.

3803.3.7.1 Emergency power for extraction process. Where power is required for the operation of the extraction process, an automatic emergency power source in accordance with Section 5004.7 and 604 shall be provided. The emergency power source shall have sufficient capacity to allow safe shutdown of the extraction process plus an additional 2 hours of capacity beyond the shutdown process.

3803.3.7.2 Emergency power for other than extraction process. An automatic emergency power system in accordance with Section 604 shall be provided when any of the following items are installed:

1. Extraction room lighting;
2. Extraction room ventilation system;
3. Solvent gas detection system;
4. Emergency alarm systems;
5. Automatic fire extinguishing systems.

3803.3.8 Continuous gas detection system. For extraction processes utilizing gaseous hydrocarbon-based solvents, a continuous gas detection system shall be provided. The gas detection threshold shall not exceed 25% of the LEL/LFL limit of the materials.

3803.4 Carbon dioxide enrichment or extraction. Extraction processes using carbon dioxide shall comply with this section.

3803.4.1 Scope. Carbon dioxide systems with more than 100 pounds of carbon dioxide shall comply with Sections 3803.4 through 3803.4.3. This section is applicable to carbon dioxide systems utilizing compressed gas systems, liquefied-gas systems, dry ice, or on-site carbon dioxide generation.

3803.4.2 Permits. Permits shall be required as set forth in Sections 105.6 and 105.7.

3803.4.3 Signage. At the entrance to each area using or storing carbon dioxide, signage shall be posted indicating the hazard. Signs shall be durable and permanent in nature and not less than 7 inches wide by 10 inches tall. Signs shall bear the warning "DANGER! POTENTIAL OXYGEN DEFICIENT ATMOSPHERE." NFPA 704 signage shall be provided at the building main entry and the rooms where the carbon dioxide is used and stored.

3803.5 Flammable or combustible liquid. The use of a flammable or combustible liquid for the extraction of oils and fats from marijuana shall comply with this section.

3803.5.1 Scope. The use of flammable and combustible liquids for liquid extraction processes where the liquid is boiled, distilled, or evaporated shall comply with this section and NFPA 30.

3803.5.2 Location. The process using a flammable or combustible liquid shall be located within a hazardous exhaust fume hood, rated for exhausting flammable vapors. Electrical equipment used within the hazardous exhaust fume hood shall be listed or approved for use in flammable atmospheres. Heating of flammable or combustible liquids over an open flame is prohibited.

WSR 17-03-109
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed January 17, 2017, 11:32 a.m., effective April 1, 2017]

Effective Date of Rule: April 1, 2017.

Purpose: The department is adopting changes effective April 1, 2017, to reclassify firms that perform paver stone installation work to Classification 0301, Landscape construction. Paver stone installation work is currently reported in 0302, Masonry.

- Reclassifying paver firms from 0302, Masonry, to 0301, Landscape construction, would create a more fair playing field between specialty paver firms and landscape contractors who also perform paver stone installation. Currently, specialty paver installation firms report in risk classification 0302, Masonry, which carries a higher base rate than landscape construction.
- Paver stone installation companies and landscape construction companies have similar risk exposure to injury due to the similar work processes performed.
- The department is revising wording and formatting of the affected classifications to make the rules easier to understand and apply; and updating references in the classifications to ensure the rule language reflects that paver installation work is to be classified in Classification 0301, Landscape construction.

Citation of Existing Rules Affected by this Order: Amending WAC 296-17A-0217, 296-17A-0301, and 296-17A-0302.

Statutory Authority for Adoption: RCW 51.16.035 (directs the department to classify all businesses by degree of hazard in accordance with recognized insurance principles).

Other Authority: WAC 296-17-31029 (outlines our insurance principles for classifying).

Adopted under notice filed as WSR 16-21-076 on October 18, 2016.

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 3, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 3, 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: January 17, 2017

Joel Sacks
Director

AMENDATORY SECTION (Amending WSR 13-11-128, filed 5/21/13, effective 7/1/13)

WAC 296-17A-0217 Classification 0217. ((~~**0217-00 Concrete flatwork - Construction and/or repair: N.O.C.**~~

~~Applies to contractors engaged in the construction and/or repair of concrete flatwork not covered by another classification (N.O.C.) such as, but not limited to, walkways, pathways, fences, and curbing. Work in this classification includes the set-up and tear down of forms, placement of reinforcing steel and wire mesh, and the pouring and finishing of concrete.~~

~~This classification excludes land clearing and excavation which is to be reported separately in classification 0101; concrete work performed on or in connection with highway, street, or roadway projects including sidewalks, curbs, gutters, median or retaining walls, sawing, drilling, or cutting operations which is to be reported separately in classification 0214; concrete work contained within a concrete, masonry, iron or steel frame building or structure such as the foundation, floor slabs, precast or poured in place bearing floors or wall panels, columns, pillars, metal erection or any other portion of the building or structure itself which is to be reported separately in classification 0518; and the installation of preformed concrete or stone pavers which is to be reported separately in classification 0302.~~

~~**0217-01 Concrete foundation and flatwork construction and repair: Wood structural buildings**~~

~~Applies to contractors engaged in the construction and/or repair of concrete foundation and flatwork for wood structural buildings not to exceed three stories in height. This classification includes the set-up and tear down of forms, placement of reinforcing steel and wire mesh, pouring, and finishing of concrete footings, stem walls, floor pads, cellar or basement floors, garage floors, swimming pools and ponds. This includes incidental concrete work such as walkways or driveways when performed by a foundation contractor.~~

~~This classification excludes land clearing and excavation which is to be reported separately in classification 0101; concrete work performed on or in connection with highway, street, or roadway projects including sidewalks, curbs, gutters, median or retaining walls, sawing, drilling, or cutting operations as part of the roadway which is to be reported separately in classification 0214; concrete landscape curbing which is included in classification 0301-08; concrete work contained within a concrete, masonry, iron or steel frame building or structure such as the foundation, floor slabs, precast or poured in place bearing floors or wall panels, columns, pillars, metal erection or any other portion of the building or structure itself which is to be reported separately in classification 0518; and the installation of preformed concrete or stone pavers which is to be reported separately in classification 0302.~~

~~**0217-02 Concrete sawing, drilling and cutting, N.O.C.**~~

~~Applies to contractors engaged in concrete sawing, drilling and cutting not covered by another classification (N.O.C.), including repairs. Work contemplated by this classification includes concrete sawing, drilling and cutting operations in connection with wood frame and nonwood frame buildings or structures, including flatwork, which may or may not be part of the building structure, such as, but not limited to, foundations, walkways, driveways, patios and swimming pools which may or may not be part of the building or structure. Activities include, but are not limited to, the sawing, cutting and drilling for ventilation boxes in the footings or stem walls, cutting out for windows or door ways, preparing to mount brackets for stairways or interior bearing walls, cutting interior walls as part of a building renovation project, cutting out for electrical and switch boxes, and repairing defective areas.~~

~~This classification excludes concrete sawing, drilling, and cutting operations performed on or in connection with highway, street, or roadway projects including sidewalks, curbs, gutters, median or retaining walls as part of roadways which are to be reported separately in classification 0214; bridge construction which is to be reported separately in classification 0201; and new dam construction which is to be reported separately in classification 0701.~~)) Applies to:

Contractors engaged in the construction and/or repair of:

• Concrete flatwork not covered by another classification (N.O.C.);

• Concrete foundations and flatwork for wood structural buildings;

• Concrete sawing, drilling and cutting not covered by another classification (N.O.C.).

Work contemplated by this classification includes, but is not limited to:

• Set-up and tear down of forms;

• Placement of reinforcing steel and wire mesh;

• Pouring and finishing of concrete;

• Concrete sawing, drilling and cutting operations in connection with wood frame and nonwood frame buildings and structures.

Projects could include, but are not limited to:

• Walkways, pathways, patios, fences and curbing;

• Concrete footings, stem walls, floor pads, cellar or basement floors, garage floors;

• Swimming pools and ponds;

• Sawing, cutting and drilling for ventilation boxes in the footings or stem walls;

• Cutting out for windows or doorways;

• Preparing to mount brackets for stairways or interior bearing walls;

• Cutting interior walls as part of a building renovation project;

• Cutting out for electrical and switch boxes;

Repairing defective areas.

Excluded phases of work:

• Worker hours engaged in land clearing or excavation work for a land clearing or excavation contract, which are classified in **0101**;

• Worker hours engaged in concrete work contained within a building or structure made of concrete, masonry, iron or steel frame, such as the foundation, floor slab, precast or poured in place bearing floors or wall panels, columns, pillars, metal erection or any other portion of the building or structure itself, which are classified in **0518**;

• Worker hours engaged in paver stone installation projects such as, but not limited to: Driveways, walkways, patios and pool decks, which are classified in **0301**;

• Worker hours engaged in concrete work performed on or in connection with projects on highways, streets, or roadways, including sidewalks, curbs, gutters, median or retaining walls, or sawing, drilling or cutting operations as part of the roadway which are classified in **0214**;

• Worker hours engaged in bridge construction which are classified in **0201**;

• Worker hours engaged in new dam construction which are classified in **0701**;

• Worker hours engaged in concrete landscape curbing which are classified in **0301**.

For administrative purposes, classification 0217 is divided into the following subclassifications:

0217-00 Concrete flatwork - Construction and/or repair: N.O.C.

0217-01 Concrete foundation and flatwork construction and repair: Wood structural buildings

0217-02 Concrete sawing, drilling and cutting, N.O.C.

AMENDATORY SECTION (Amending WSR 14-17-085, filed 8/19/14, effective 9/19/14)

WAC 296-17A-0301 Classification 0301. ((~~**0301-04 Lawn type sprinkler systems: Installation, service or repair**~~

~~Applies to contractors engaged in the installation, service or repair of lawn type sprinkler systems. This type of activity is performed by landscaping contractors, plumbing contractors, and irrigation specialist contractors. Generally, lawn type sprinkler systems are installed at private residences or commercial businesses. The process involves identifying the area of land to be covered to determine the size and amount of pipe and sprinkler heads needed for the job. The installation involves cutting a trench in the ground (twelve to eighteen inches deep and wide enough to accommodate the pipe) with a vibrating plow or pipe pulling machine. Next, pipe is laid in the trench, glued, or otherwise joined, heads and canisters are installed, and the timer is hooked up. The system is checked for leaks, needed adjustments are made, and the pipe and heads are buried.~~

~~This classification excludes open canal type irrigation systems which are to be reported separately in classification 0108; the installation, service or repair of above or below ground agricultural/irrigation systems which is to be reported separately in classification 0301-06; and maintenance and cleaning of lawn sprinkler system pipes and heads done in connection with a landscape maintenance contract which is to be reported separately in classification 0308.~~

~~**0301-06 Agricultural sprinkler/irrigation systems, N.O.C.: Installation, service or repair**~~

~~Applies to contractors engaged in the installation, service or repair of above or below ground agricultural sprinkler and irrigation systems not covered by another classification (N.O.C.). The more common types of systems include below ground, fixed or movable, and wheel or impulse. Generally, these types differ from lawn sprinkler systems in that the size of pipes and pumps installed are much larger to produce the water pressure needed to irrigate large areas of land. Installation of below ground systems involves the use of trenching equipment to dig trenches, which are usually more than two feet deep to lay pipe. The above ground systems are laid out and assembled based on the need of the land area.~~

~~This classification excludes open canal type irrigation systems which are to be reported separately in classification 0108, and the installation, service or repair of lawn type sprinkler systems which is to be reported separately in classification 0301-04.~~

~~**0301-08 Landscape construction operations, N.O.C.**~~

~~Applies to landscape contractors engaged in new landscape construction or renovation projects not covered by another classification (N.O.C.). This classification also applies to specialist contractors engaged in the installation of invisible fences which are usually used to confine animals within a given area. Landscape construction work contemplated by this classification includes producing a preliminary drawing of the landscape or renovation project, preparing the ground (which may include tilling and spreading top soils or custom mix soils), installing sprinkler systems, planting trees, plants or shrubs, planting or replanting grass from seed or sod, installing ground cover material or plastic to retard weeds, placing concrete borders, the incidental construction of rockery, extruded concrete curbing, fences, ponds, paths, walkways, arbors, trellis and gazebos when performed by employees of a landscape contractor as part of a landscape contract. If these activities are conducted separately from a landscape contract and not part of the landscape project, they must be reported separately in the classification applicable to the work being performed. Equipment used by contractors subject to this classification includes, but is not limited to, tractors with till attachments, small front end loaders, trenchers, mowers, fertilizer spreaders, wheelbarrows, and electric power tools.~~

~~Invisible fence construction work contemplated by this classification includes identifying the land area to be fenced, sketching a preliminary drawing, burying the wire in a narrow trench (about one inch wide by two to six inches deep) that has been dug along the field perimeter (or just securing the wire onto the ground around the perimeter), and connecting the low voltage transmitter box (usually about the size of a hand-held calculator) that plugs into a 110 volt electrical outlet. This classification includes training sessions for the animal and related maintenance and repair at the customer's location. Equipment used to install invisible fences includes, but is not limited to, rakes or other hand tools, and small trench diggers.~~

~~This classification excludes all grading, clearing, or contouring of land which is to be reported separately in classification 0101; bulkheads not adjacent to water, or similar structures built of rock, which are to be reported separately in classification 0302; the installation or on-site maintenance of roofing materials composed of impermeable barriers, sod, soil, and plants, sometimes termed landscape roofing, living~~

~~roofing, garden roofing, green/environmentally beneficial roofing, brown/biodiverse roofing, or vegetative roofing, which is to be reported in classification 0507; any installation or maintenance of a landscape roofing irrigation system, which is reported in classification 0507; and lawn care maintenance or chemical spraying or fumigating which is to be reported separately in classification 0308.~~)) Applies to:

Contractors engaged in the installation, service and repair of:

• Lawn type sprinkler systems;

• Agriculture sprinkler and irrigation systems, including above or below ground;

• New landscape construction or renovation projects;

• Invisible fence installation, which is used to confine animals within a given area;

• Paver stone installation projects such as, but not limited to: Driveways, walkways, patios and pool decks. Common types of pavers used include brick, concrete and stone.

Common methods of paver installation include:

- **Interlocking concrete pavers**, which are primarily sand set, but in some cases mortar set;

- **Permeable interlocking concrete pavers**, which are installed to help reduce storm water runoff;

- **Pedestal set pavers**, when used for roof top decks and plaza areas to increase living space, or to meet certain environmental requirements (not acting as a roofing system).

Work contemplated by this classification includes, but is not limited to:

• Producing preliminary drawings of a landscape or renovation project;

• Identifying area of land to be covered, to determine size and amount of pipe and sprinkler heads needed for irrigation/sprinkler system install;

• Preparing the ground (may include tilling and spreading of top soils);

• Trenching;

• Burying wire in trench (invisible fencing);

• Connecting low voltage transmitter box for invisible fencing;

• Installing/repairing sprinkler systems;

• Planting trees, plants or shrubs;

• Planting or replacing grass from seed or sod;

• Installing ground cover material or plastic to retard weeds;

• Placing concrete borders;

• Installing concrete, brick or stone pavers to create walkways, pathways, pool decks, or patios.

Typical machinery includes, but is not limited to:

• Electric power tools;

• Fertilizer spreaders;

• Hand tools/rakes;

• Mowers;

• Small front end loaders;

• Tractors with till attachments;

• Trenchers;

• Wheelbarrows;

• Vibrating plow or pipe pulling machine.

This classification includes:

• Incidental construction of rockery, extruded concrete curbing, fences, ponds, walls, arbors, trellises and gazebos when performed by employee of a landscape contractor as part of a landscape contract.

- If these activities are conducted separately from a landscape contract and not part of a landscape project, they must be reported separately in the classification applicable to the work being performed.

• Incidental construction of walls and rockery performed by employees of a paver stone installation contractor as part of a paver installation contract.

- If these activities are conducted separately from a paver stone installation contract and not part of a paver stone project, they must be reported separately in the classification applicable to the work being performed.

Note: Incidental work is a minor part of an overall project or contract.

Example: A paving installation company creates the driveway, walkways, and patio at a residential home. The company finds that the lawn will slide onto the driveway unless a three foot tall retaining wall the length of the driveway is created. The creation of the retaining wall to protect the driveway is *incidental* to the paving installation project and may be reported in **0301**.

Excluded phases of work:

• Worker hours engaged in open canal type irrigation systems, which are classified in **0108**.

• Worker hours engaged in maintenance and cleaning of lawn sprinkler system pipes and heads done in connection with a landscape maintenance contract which are classified in **0308**.

• Worker hours engaged in grading, clearing, or contouring of land which are classified in **0101**.

• Worker hours engaged in bulkheads not adjacent to water, or similar structures built of rock, which are classified in **0302**.

• Worker hours engaged in installation or on-site maintenance of roofing materials composed of impermeable barriers, sod, soil, and plants, sometimes termed landscape roofing, living roofing, or vegetative roofing, which are classified in **0507**.

• Worker hours engaged in paver installation on a roof by a roofing contractor, when acting as part of the roofing system, which are classified in **0507**.

• Worker hours engaged in installation or maintenance of a landscape roofing irrigation system, which are classified in **0507**.

• Worker hours engaged in lawn care maintenance or chemical spraying or fumigating which are classified in **0308**.

Note: For rules on assigning and reporting in more than one basic classification, see WAC 296-17-31017 Multiple classifications.

For administrative purposes, classification 0301 is divided into the following subclassifications:

0301-04 Lawn type sprinkler systems: Installation, service or repair

0301-06 Agricultural sprinkler/irrigation systems, N.O.C.: Installation, service or repair

0301-08 Landscape construction operations, N.O.C.

AMENDATORY SECTION (Amending WSR 12-11-109, filed 5/22/12, effective 7/1/12)

WAC 296-17A-0302 Classification 0302.

0302-01 Brick, block, and stone masonry work, including repairs N.O.C.

Applies to contractors engaged in interior or exterior work in brick, block, stone, brick or stone veneer, granite, marble, slate, or quartz, not covered by another classification (N.O.C.). ((~~Applications in this classification also include, but are not limited to, concrete block, glass block, pavers, and slab or engineered stone products. Projects in this classification include, but are not limited to:~~

~~• Decorative additions to buildings and landscapes;~~

~~• Hardscape installations such as, but not limited to:~~

~~- Driveways;~~

~~- Fences;~~

~~- Patios;~~

~~- Steps;~~

~~- Walkways;~~

~~- Walls;~~

~~• Installation of slab stone or concrete countertops;~~

~~• Construction of entire buildings or structures with brick, block or stone products;~~

~~• Setting tombstones.~~

~~Work contemplated by this classification includes, but is not limited to:~~

~~• Cutting;~~

~~• Laying or installing;~~

~~• Polishing;~~

~~• Dry setting or adhering with mortar;~~

~~• Tuck pointing (filling and/or finishing brickwork or stonework joints with cement or mortar).~~

~~This classification excludes:~~

~~• Tile setting and countertop installations as described in classification 0502;~~

~~• Plastering, stuccoing or lathing work which is to be reported separately in classification 0303;~~

~~• Incidental construction of rockery, paths, and walkways when performed by employees of a landscape contractor as part of a landscape project, which is to be reported in classification 0301;~~

~~• Mechanically placed block or prefab panels next to a roadway for noise barrier, median or retaining walls, which is to be reported in classification 0219;~~

~~• Concrete flat work which is to be reported separately in the classification applicable to the work being performed; and~~

~~• Masonry work as described in classification 0302-02.~~

~~***Special notes:*** Contractors who operate a shop to cut, mill and polish stone products are to be assigned classification 3104-53 for the shop work; contractors operating a shop to make finished concrete products are to be assigned classification 3509 for the shop work. When a business is assigned classification 3104 or 3509 for the shop operation, then classification 5206 "Permanent yard or shop" may no longer be applicable to the business.~~

~~Contractors often have a showroom to display examples of their work and products which they install. If all the conditions of the general reporting rules covering standard exception employees have been met, then employees engaged exclusively in showing the display area or showrooms to customers are to be assigned classification 6303.~~

~~**0302-02 Masonry**~~

~~Applies to contractors engaged in interior or exterior masonry work including, but not limited to, the construction, lining or relining of:~~

~~• Fireplaces;~~

~~• Chimneys;~~

~~• Blast furnaces;~~

~~• Fire pits;~~

~~• Ovens.~~

~~Work contemplated by this classification includes:~~

~~• Cutting and laying brick, block or stone;~~

~~• Tuck pointing (filling and/or finishing brickwork or stonework joints with cement or mortar).~~

~~This classification excludes:~~

~~• Plastering, stuccoing or lathing work which is to be reported separately in classification 0303;~~

~~• Tile setting as described in classification 0502;~~

~~• Concrete work which is to be reported separately in the classification applicable to the work being performed; and~~

~~• All other masonry work which is to be reported in classification 0302-01.~~))

Projects in this classification include, but are not limited to:

• Decorative additions to buildings;

• Fences;

• Walls;

• Installation of slab stone or concrete countertops;

• Construction of entire buildings or structures with brick, block or stone products;

• Setting tombstones.

Work contemplated by this classification includes, but is not limited to:

• Cutting;

• Laying or installing;

• Polishing;

• Dry setting or adhering with mortar;

• Tuck pointing (filling and/or finishing brickwork or stonework joints with cement or mortar).

Excluded phases of work:

• Worker hours engaged in tile setting and countertop installations, as described in 0502, which are classified in **0502**;

• Worker hours engaged in plastering, stuccoing or lathing work which are classified in **0303**;

• Worker hours engaged in paver stone installation work projects such as, but not limited to, driveways, walkways, patios and pool decks which, if the conditions of WAC 296-17-31013 Building construction are met, may be reported separately in **0301**;

• Worker hours engaged in mechanically placed block or prefab panels next to a roadway for noise barrier, median or retaining walls, which are to be reported in classification **0219**;

• Worker hours engaged in concrete flat work which are to be classified separately in the classification applicable to the work being performed;

• Worker hours engaged in all other masonry work (as described in 0302-02), which are classified in **0302-02**.

***Special notes*:** Contractors who operate a shop to cut, mill and polish stone products are to be assigned classification 3104-53 for the shop work; contractors operating a shop to make finished concrete products are to be assigned classification 3509 for the shop work. When a business is assigned classification 3104 or 3509 for the shop operation, then classification 5206 "Permanent yard or shop" may no longer be applicable to the business.

Contractors often have a showroom to display examples of their work and products which they install. If all the conditions of the general reporting rules covering standard exception employees have been met, then employees engaged exclusively in showing the display area or showrooms to customers are to be assigned classification **6303**.

0302-02 Masonry

Applies to contractors engaged in interior or exterior masonry work including, but not limited to, the construction, repair, lining or relining of:

• Blast furnaces;

• Benches;

• Chimneys;

• Decorative columns;

• Fire pits;

• Fireplaces/pads;

• Outdoor barbeques;

• Ovens;

• Planter boxes.

Work contemplated by this classification includes, but is not limited to:

• Cutting and laying brick, block or stone;

• Tuck pointing (filling and/or finishing brickwork or stonework joints with cement or mortar).

Excluded phases of work:

• Worker hours engaged in plastering, stuccoing or lathing work which are classified in **0303**;

• Worker hours engaged in tile setting and countertop installations, as described in 0502, which are classified in **0502**;

• Worker hours engaged in concrete work, which is classified in the classification applicable to the work being performed;

• Worker hours engaged in all other masonry work (as described in 0302-01), which are classified in **0302-01**.

WSR 17-03-116
PERMANENT RULES
HEALTH CARE AUTHORITY
(Washington Apple Health)

[Filed January 17, 2017, 3:07 p.m., effective February 17, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose:

- The agency revised eligibility rules for institutional medical assistance programs, and [is] creating new regulations to implement the Patient Protection and Affordable Care Act established under Public Law 111-148.
- The agency referenced rules that are final January 1, 2014, in the long-term care medical rule in addition to the elimination of the presumptive disability program as an eligibility group.
- The agency added the residential waiver service program as a home and community based (HCB) waiver in chapter 182-515 WAC.
- The agency implemented the community first choice option as directed by the Washington state legislature.
- The agency added clarifying language regarding countable assets for institutional services.
- The agency updated links and references and [is] changing language for readability and clarity.

Citation of Existing Rules Affected by this Order: Repealing WAC 182-513-1300, 182-513-1301, 182-513-1305, 182-513-1364, 182-513-1365, 182-513-1366 and 182-515-1500; and amending WAC 182-507-0125, 182-512-0400, 182-512-0960, 182-513-1315, 182-513-1320, 182-513-1325, 182-513-1330, 182-513-1340, 182-513-1345, 182-513-1350, 182-513-1363, 182-513-1367, 182-513-1380, 182-513-1395, 182-513-1396, 182-513-1397, 182-513-1400, 182-513-1405, 182-513-1410, 182-513-1415, 182-513-1420, 182-513-1425, 182-513-1430, 182-513-1435, 182-513-1440, 182-513-1445, 182-513-1450, 182-513-1455, 182-515-1505, 182-515-1506, 182-515-1507, 182-515-1508, 182-515-1509, 182-515-1510, 182-515-1511, 182-515-1512, 182-515-1513, and 182-515-1514.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

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

Adopted under notice filed as WSR 16-24-087 on December 7, 2016.

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 17, Amended 38, Repealed 7.

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 17, Amended 38, Repealed 7.

Date Adopted: January 17, 2017.

Wendy Barcus
Rules Coordinator

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

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

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

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

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

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

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

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

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

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

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

~~(a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a),(b), (e), and(f);~~

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

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

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

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

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

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

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

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

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

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

~~(b) WAC 388-505-0255 for adults related to family institutional medical.~~

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

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

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

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

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

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

~~(11) A person eligible for the state-funded long-term care services program is certified for a twelve month period.~~)) (1) **Caseload limits.**

(a) The state-funded long-term care services program is subject to caseload limits determined by legislative funding.

(b) The aging and long-term support administration (ALTSA) must preauthorize state-funded long-term care service before payments begin.

(c) ALTSA cannot authorize a service, under chapter 388-106 WAC, if doing so would exceed statutory caseload limits.

(2) **Location of services.** State-funded long-term care services may be provided in:

(a) The person's own home, defined in WAC 388-106-0010;

(b) An adult family home, defined in WAC 182-513-1100;

(c) An assisted living facility, defined in WAC 182-513-1100;

(d) An enhanced adult residential care facility, defined in WAC 182-513-1100;

(e) An adult residential care facility, defined in WAC 182-513-1100; or

(f) A nursing facility, defined in WAC 182-500-0050, but only if nursing facility care is necessary to sustain life.

(3) **Client eligibility.** To be eligible for the state-funded long-term care services program, a person must meet all of the following conditions:

(a) General eligibility requirements for medical programs under WAC 182-503-0505, except (c) and (d) of this subsection;

(b) Be age nineteen or older;

(c) Reside in one of the locations under subsection (2) of this section;

(d) Attain institutional status under WAC 182-513-1320;

(e) Meet the functional eligibility requirements under WAC 388-106-0355 for nursing facility level of care;

(f) Not have a penalty period due to a transfer of assets under WAC 182-513-1363;

(g) Not have equity interest in a primary residence more than the amount under WAC 182-513-1350; and

(h) Meet the requirements under chapter 182-516 WAC for annuities owned by the person or the person's spouse.

(4) **General limitations.**

(a) If a person entered Washington only to obtain medical care, the person is ineligible for state-funded long-term care services.

(b) The certification period for state-funded long-term care services may not exceed twelve months.

(c) People who qualify for state-funded long-term care services receive categorically needy (CN) medical coverage under WAC 182-501-0060.

(5) **Supplemental security income (SSI)-related program limitations.**

(a) A person who is related to the SSI program under WAC 182-512-0050 (1), (2), and (3) must meet the financial requirements under WAC 182-513-1315 to be eligible for state-funded long-term care services.

(b) An SSI-related person who is not eligible for the state-funded long-term care services program under CN rules may qualify under medically needy (MN) rules under WAC 182-513-1395.

(c) The agency determines how much an SSI-related person is required to pay toward the cost of care, using:

(i) WAC 182-513-1380, if the person resides in a nursing facility.

(ii) WAC 182-515-1505 or 182-515-1510, if the person resides in one of the locations listed in subsection (2)(a) through (e) of this section.

(6) **Modified adjusted gross income (MAGI)-based program limitations.**

(a) A person who is related to the MAGI-based program may be eligible for state-funded long-term care services under this section and chapter 182-514 WAC if the person resides in a nursing facility.

(b) A MAGI-related person is not eligible for residential or in-home care state-funded long-term care services unless the person also meets the SSI-related eligibility criteria under subsection (5)(a) of this section.

(c) A MAGI-based person does not pay toward the cost of care in a nursing facility.

(7) Current resource, income, PNA, and room and board standards are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/standards-ltc.

AMENDATORY SECTION (Amending WSR 14-07-059, filed 3/14/14, effective 4/14/14)

WAC 182-512-0400 SSI-related medical—Vehicles excluded as resources. (1) For SSI-related medical programs, a vehicle is defined as anything used for transportation. In addition to cars and trucks, a vehicle can include boats, snowmobiles, and animal-drawn vehicles.

(2) One vehicle is excluded regardless of its value, if it is used to provide transportation for the ((~~disabled~~)) SSI-related person or a member of the person's household.

(3) ((~~For a person receiving SSI-related institutional coverage who has a community spouse, one vehicle is excluded regardless of its value or its use. See WAC 182-513-1350 (7)(b).~~

~~(4)~~)) A vehicle used as the person's primary residence is excluded as the home, and does not count as the one excluded vehicle under subsection (2) ((~~or (3)~~)) of this section.

((~~(5) All other vehicles, except those excluded under WAC 182-512-0350 (11) through (14), are treated as nonliquid resources and the equity value is counted toward the resource limit.~~))

AMENDATORY SECTION (Amending WSR 14-07-059, filed 3/14/14, effective 4/14/14)

WAC 182-512-0960 SSI-related medical—Allocating income—((~~How the agency considers income and resources when determining eligibility for a person applying for noninstitutional Washington apple health (WAH) when another household member is receiving institutional WAH~~)) Determining eligibility for a spouse when the other spouse receives long-term services and supports. (((~~1) The agency follows rules described in WAC 182-513-1315 for a person considered to be in institutional WAH, which means a person who is either residing in a medical institution, or approved for a home and community based waiver, or approved for the WAH institutional hospice program. The rules in this section describe how the agency considers household income and resources when the household contains both institutional and noninstitutionalized household members.~~

~~(2) An institutionalized person (adult or child) who is not SSI-related may be considered under the long-term care for families and children programs described in WAC 182-514-0230 through 182-514-0265.~~

~~(3) The agency considers the income and resources of spouses as available to each other through the end of the month in which the spouses stopped living together. See WAC 182-513-1330 and 182-513-1350 when a spouse is institutionalized.~~

~~(4) The agency considers income and resources separately as of the first day of the month following the month of separation when spouses stop living together because of placement into a boarding home (assisted living, enhanced adult residential center, adult residential center), adult family home (AFH), adult residential rehabilitation center/adult residential treatment facility (ARRC/ARTF), or division of developmental disabilities-group home (DDD-GH) facility when:~~

~~(a) Only one spouse enters the facility;~~

~~(b) Both spouses enter the same facility but have separate rooms; or~~

~~(c) Both spouses enter separate facilities.~~

~~(5) The agency considers income and resources jointly when both spouses are placed in a boarding home, AFH, ARRC/ARTF, or DDD-GH facility and share a room.~~

~~(6) When determining SSI-related WAH categorically needy (CN) or medically needy (MN) eligibility for a community spouse applying for health care coverage, the agency counts:~~

~~(a) The separate income of the community spouse; plus~~

~~(b) One half of any community income received by the community spouse and the institutionalized spouse; plus~~

~~(c) Any amount allocated to the community spouse from the institutionalized spouse. The terms "community spouse" and "institutional spouse" are defined in WAC 182-513-1301.~~

~~(7) For the purposes of determining the countable income of a community spouse applying for health care coverage as described in subsection (6) of this section, it does not matter whether the spouses reside together or not. Income that is allocated and actually available to a community spouse is considered that person's income.~~

~~(8) For the purposes of determining the countable income of a community spouse or children applying for health care coverage under modified adjusted gross income (MAGI)-based family, pregnancy or children's WAH programs, the agency uses the following rules to determine if the income of the institutionalized person is considered in the eligibility calculation:~~

~~(a) When the institutionalized spouse or parent lives in the same home with the community spouse and/or children, their income is counted in the determination of household income following the rules for the medical program that is being considered.~~

~~(b) When the institutionalized spouse or parent does not live in the same home as the spouse and/or children, only income that is allocated and available to the household is counted.~~

~~(9) When determining the countable income of a community spouse applying for health care coverage under the WAH MN program, the agency allocates income from the community spouse to the institutionalized spouse in an amount up to the one-person effective medically needy income level (MNIL) less the institutionalized spouse's income, when:~~

~~(a) The community spouse is living in the same household as the institutionalized spouse;~~

~~(b) The institutionalized spouse is receiving home and community-based waiver or institutional hospice services described in WAC 182-515-1505; and~~

~~(c) The institutionalized spouse has gross income of less than the MNIL.~~

~~(10) See WAC 182-506-0015 for rules on how to determine medical assistance units for households that include SSI-related persons. A separate medical assistance unit is always established for persons who meet institutional status described in WAC 182-513-1320.~~)) (1) General information.

(a) This section describes how the agency determines household income and resources when the household contains both institutional and noninstitutional household members.

(b) A separate medical assistance unit is established for people who meet institutional status under WAC 182-513-1320. See WAC 182-506-0015 for rules on how to determine medical assistance units for households that include people related to the supplemental security income (SSI) program.

(c) Throughout this section, "home" means "own home" as defined in WAC 388-106-0010.

(d) The income and resources of each spouse are available to the other through the end of the month in which the spouses stopped living together, unless subsection (3) of this section applies.

(e) The agency determines income and resources separately starting the first day of the month following the month of separation if spouses stop living together in the same home.

(f) When one, or both members of a couple live in an alternative living facility (ALF), the agency considers the couple to be living:

(i) Apart when:

(A) Only one spouse enters the ALF;

(B) Both spouses enter the same ALF but have separate rooms; or

(C) Both spouses enter separate ALFs.

(ii) Together when both spouses share a room in an ALF.

(2) The agency counts income and resources under this chapter when both members of a couple live in the same house and the community spouse or spousal impoverishment protections community (SIPC) spouse applies for coverage and his or her spouse receives:

(a) Home and community-based (HCB) waiver;

(b) Program for all inclusive care to the elderly (PACE);

(c) Roads to community living (RCL);

(d) Hospice; or

(e) Community first choice (CFC).

(3) When one member of a couple lives apart from their spouse and the community spouse or SIPC spouse applies for coverage, and the spouse who receives long-term services and supports lives:

(a) In an institution:

(i) The agency counts income under this chapter, plus any allocation the institutionalized spouse has made available to the community spouse; and

(ii) The agency counts resources under this chapter, plus any resources allocated to the community spouse when eligibility for the institutionalized spouse was determined, that remain in the name of the institutionalized spouse and are available to the community spouse under WAC 182-512-0250.

(b) In an ALF and receives HCB waiver, PACE, RCL, or hospice:

(i) The agency counts income under this chapter, plus any allocation the institutionalized spouse has made available to the community spouse; and

(ii) The agency counts resources under this chapter, plus any resources allocated to the community spouse when eligibility for the institutionalized spouse was determined, that remain in the name of the institutionalized spouse, and are available to the community spouse under WAC 182-512-0250; and

(c) In an ALF and receives CFC:

(i) The agency counts income under this chapter; and

(ii) The agency counts resources under this chapter, plus any resources allocated to the SIPC spouse when eligibility for the spousal impoverishment protections institutionalized (SIPI) spouse was determined, that remain in the name of the SIPI spouse and are available to the community spouse under WAC 182-512-0250.

(4) Determining household income when the spouse of an HCB waiver recipient is not eligible for categorically needy (CN) coverage.

(a) When the community spouse is not eligible for categorically needy (CN) coverage under subsection (2) of this section, the agency determines eligibility under the medically needy program;

(b) The agency counts income and resources as described under subsection (2) of this section;

(c) The agency allocates income to the institutionalized spouse before comparing the community spouse's income to the medically needy income level (MNIL) if:

(i) The community spouse lives in the same household as the institutionalized spouse;

(ii) The institutionalized spouse is receiving home and community-based waiver services under WAC 182-515-1505 or institutional hospice services under WAC 182-513-1240; and

(iii) The institutionalized spouse has gross income under the MNIL.

(d) The allocation in (c) of this subsection cannot exceed the one-person effective MNIL minus the institutionalized spouse's income.

NEW SECTION

WAC 182-513-1100 Definitions related to long-term services and supports (LTSS). This section defines the meaning of certain terms used in chapters 182-513 and 182-515 WAC. Within these chapters, institutional, home and community based (HCB) waiver, program of all-inclusive care for the elderly (PACE), and hospice in a medical institution are referred to collectively as long-term care (LTC). Long-term services and supports (LTSS) is a broader definition which includes institutional, HCB waiver, and other services such as medicaid personal care (MPC), community first choice (CFC), PACE, and hospice in the community. See chapter 182-500 WAC for additional definitions.

"Adequate consideration" means that the fair market value (FMV) of the property or services received, in exchange for transferred property, approximates the FMV of the property transferred.

"Administrative costs" or **"costs"** means necessary costs paid by the guardian including attorney fees.

"Aging and long-term support administration (ALTSA)" means the administration within the Washington state department of social and health services (DSHS).

"Alternate living facility (ALF)" is not an institution under WAC 182-500-0050; it is one of the following community residential facilities:

(a) An adult family home (AFH) licensed under chapter 70.128 RCW.

(b) An adult residential care facility (ARC) licensed under chapter 18.20 RCW.

(c) A mental health adult residential treatment facility under chapter 246-337 WAC.

(d) An assisted living facility (AL) licensed under chapter 18.20 RCW.

(e) A developmental disabilities administration (DDA) group home (GH) licensed as an adult family home under chapter 70.128 RCW or an assisted living facility under chapter 18.20 RCW.

(f) An enhanced adult residential care facility (EARC) licensed as an assisted living facility under chapter 18.20 RCW.

(g) An enhanced service facility (ESF) licensed under chapter 70.97 RCW.

"Assets" means all income and resources of a person and of the person's spouse, including any income or resources which that person or that person's spouse would otherwise currently be entitled to but does not receive because of action:

(a) By that person or that person's spouse;

(b) By another person, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse; or

(c) By any other person, including any court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

"Authorization date" means the date payment begins for long-term services and supports (LTSS) under WAC 388-106-0045.

"Clothing and personal incidentals (CPI)" means the cash payment (under WAC 388-478-0090, 388-478-0006, and 388-478-0033) issued by the department for clothing and personal items for people living in an ALF or medical institution.

"Community first choice (CFC)" means a medicaid state plan home and community based service developed under the authority of section 1915(k) of the Social Security Act under chapter 388-106 WAC.

"Community options program entry system (COPES)" means a medicaid HCB waiver program developed under the authority of section 1915(c) of the Social Security Act under chapter 388-106 WAC.

"Community spouse (CS)" means the spouse of an institutionalized spouse.

"Community spouse resource allocation (CSRA)" means the resource amount that may be transferred without penalty from:

(a) The institutionalized spouse (IS) to the community spouse (CS); or

(b) The spousal impoverishment protections institutionalized (SIPI) spouse to the spousal impoverishment protections community (SIPC) spouse.

"Community spouse resource evaluation" means the calculation of the total value of the resources owned by a married couple on the first day of the first month of the institutionalized spouse's most recent continuous period of institutionalization.

"Comprehensive assessment reporting evaluation (CARE) assessment" means the evaluation process defined under chapter 388-106 WAC used by a department designated social services worker or a case manager to determine a person's need for long-term services and supports (LTSS).

"Continuing care contract" means a contract to provide a person, for the duration of that person's life or for a term in excess of one year, shelter along with nursing, medical, health-related, or personal care services, which is conditioned upon the transfer of property, the payment of an entrance fee to the provider of such services, or the payment of periodic charges for the care and services involved.

"Continuing care retirement community" means an entity which provides shelter and services under continuing care contracts with its members and which sponsors or includes a health care facility or a health service.

"Dependent" means a minor child, or one of the following who meets the definition of a tax dependent under WAC 182-500-0105: Adult child, parent, or sibling.

"Developmental disabilities administration (DDA)" means an administration within the Washington state department of social and health services (DSHS).

"Developmental disabilities administration (DDA) home and community based (HCB) waiver" means a medicaid HCB waiver program developed under the authority of section 1915(c) of the Social Security Act under chapter 388-845 WAC authorized by DDA. There are five DDA HCB waivers:

(a) Basic Plus;

(b) Core;

(c) Community protection;

(d) Children's intensive in-home behavioral support (CIIBS); and

(e) Individual and family services (IFS).

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

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the open market in an agreement, made by two parties freely and independently of each other, in pursuit of their own self-interest, without pressure or duress, and without some special relationship (arm's length transaction), at the time of transfer or assignment.

"Guardianship fees" or **"fees"** means necessary fees charged by a guardian for services rendered on behalf of a client.

"Home and community based (HCB) waiver programs authorized by home and community services (HCS)" means medicaid HCB waiver programs developed under the authority of Section 1915(c) of the Social Security Act under chapter 388-106 WAC authorized by HCS. There are three HCS HCB waivers: Community options program entry system (COPES), new freedom consumer directed services (New Freedom), and residential support waiver (RSW).

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

"Institutional services" means services paid for by Washington apple health, and provided:

(a) In a medical institution;

(b) Through an HCB waiver; or

(c) Through programs based on HCB waiver rules for post-eligibility treatment of income under chapter 182-515 WAC.

"Institutionalized individual" means a person who has attained institutional status under WAC 182-513-1320.

"Institutionalized spouse" means a person who, regardless of legal or physical separation:

(a) Has attained institutional status under WAC 182-513-1320; and

(b) Is legally married to a person who is not in a medical institution.

"Life care community" see continuing care community.

"Likely to reside" means the agency or its designee reasonably expects a person will remain in a medical institution for thirty consecutive days. Once made, the determination stands, even if the person does not actually remain in the facility for that length of time.

"Long-term care services" see "Institutional services."

"Long-term services and supports (LTSS)" includes institutional and noninstitutional services authorized by the department.

"Medicaid personal care (MPC)" means a medicaid state plan home and community based service under chapter 388-106 WAC.

"Most recent continuous period of institutionalization (MRCPI)" means the current period an institutionalized spouse has maintained uninterrupted institutional status when the request for a community spouse resource evaluation is made. Institutional status is determined under WAC 182-513-1320.

"Noninstitutional medicaid" means any apple health program not based on HCB waiver rules under chapter 182-515 WAC, or rules based on a person residing in an institution for thirty days or more under chapter 182-513 WAC.

"Nursing facility level of care (NFLOC)" is under WAC 388-106-0355.

"Participation" means the amount a person must pay each month toward the cost of long-term care services received each month; it is the amount remaining after the post-eligibility process under WAC 182-513-1380, 182-515-1509, or 182-515-1514. Participation is not room and board.

"Penalty period" or **"period of ineligibility"** means the period of time during which a person is not eligible to receive services that are subject to transfer of asset penalties.

"Personal needs allowance (PNA)" means an amount set aside from a person's income that is intended for personal needs. The amount a person is allowed to keep as a PNA depends on whether the person lives in a medical institution, ALF, or at home.

"Room and board" means the amount a person must pay each month for food, shelter, and household maintenance requirements when that person resides in an ALF. Room and board is not participation.

"Short stay" means residing in a medical institution for a period of twenty-nine days or fewer.

"Special income level (SIL)" means the monthly income standard that is three hundred percent of the supplemental security income (SSI) federal benefit rate.

"Spousal impoverishment protections" means the financial provisions within Section 1924 of the Social Security Act that protect income and assets of the community spouse through income and resource allocation. The allocation process is used to discourage the impoverishment of a spouse due to the other spouse's need for LTSS. This includes services provided in a medical institution, HCB waivers authorized under 1915(c) of the Social Security Act, and through December 31, 2018, services authorized under 1115 and 1915(k) of the Social Security Act.

"Spousal impoverishment protections community (SIPC) spouse" means the spouse of a SIPI spouse.

"Spousal impoverishment protections institutionalized (SIPI) spouse" means a legally married person who qualifies for the noninstitutional categorically needy (CN) Washington apple health SSI-related program only because of the spousal impoverishment protections under WAC 182-513-1220.

"State spousal resource standard" means the minimum CSRA standard for a CS or SIPC spouse.

"Third-party resource (TPR)" means funds paid to or on behalf of a person by a third party, where the purpose of the funds is for payment of activities of daily living, medical services, or personal care. The agency does not pay for these services if there is a third-party resource available.

"Transfer" means, in the context of long-term care eligibility, the changing of ownership or title of an asset, such as income, real property, or personal property, by one of the following:

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

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

"Uncompensated value" means the fair market value (FMV) of an asset on the date of transfer, minus the FMV of the consideration the person receives in exchange for the asset.

"Undue hardship" means a person is not able to meet shelter, food, clothing, or health needs. A person may apply for an undue hardship waiver based on criteria under WAC 182-513-1367.

NEW SECTION

WAC 182-513-1200 Long-term services and supports (LTSS) authorized under Washington apple health programs. (1) Long-term services and supports (LTSS) programs available to people eligible for noninstitutional Washington apple health coverage who meet the functional requirements.

(a) Noninstitutional apple health coverage in an alternate living facility (ALF) under WAC 182-513-1205.

(b) Community first choice (CFC) under WAC 182-513-1210.

(c) Medicaid personal care (MPC) under WAC 182-513-1225.

(d) For people who do not meet institutional status under WAC 182-513-1320, skilled nursing or rehabilitation is available under the CN, medically needy (MN) or alternative benefits plan (ABP) scope of care if enrolled into a managed care plan.

(2) Non-HCB waiver LTSS programs that use institutional rules under WAC 182-513-1315 and 182-513-1380 or HCB waiver rules under chapter 182-515 WAC, depending on the person's living arrangement:

(a) Program of all-inclusive care for the elderly (PACE) under WAC 182-513-1230.

(b) Roads to community living (RCL) under WAC 182-513-1235.

(c) Hospice under WAC 182-513-1240.

NEW SECTION

WAC 182-513-1205 Determining eligibility for noninstitutional coverage in an alternate living facility (ALF). (1) This section describes the eligibility determination for noninstitutional coverage for a person who lives in a department-contracted alternate living facility (ALF) defined under WAC 182-513-1100.

(2) The eligibility criteria for noninstitutional Washington apple health in an ALF follows SSI-related rules under WAC 182-512-0050 through 182-512-0960 with the exception of the higher income standard under subsection (3) of this section.

(3) A person is eligible for noninstitutional coverage under the categorically needy (CN) program if the person's monthly income after allowable exclusions under chapter 182-512 WAC:

(a) Does not exceed the special income level (SIL) defined under WAC 182-513-1100; and

(b) Is less than or equal to the person's assessed state rate at a department-contracted facility. To determine the CN standard: (($y \times 31$) + \$38.84), where "y" is the state daily rate. \$38.84 is based on the cash payment standard for a person living in an ALF setting under WAC 388-478-0006.

(4) A person is eligible for noninstitutional coverage under the medically needy (MN) program if the person's monthly income after allowable exclusions under chapter 182-512 WAC is less than or equal to the person's private rate at a department-contracted facility. To determine the MN standard: (($z \times 31$) + \$38.84), where "z" is the facility's private daily rate. To determine MN spenddown liability, see chapter 182-519 WAC.

(5) For both CN and MN coverage, a person's countable resources cannot exceed the standard under WAC 182-512-0010.

(6) The agency or its designee approves CN noninstitutional coverage for twelve months.

(7) The agency or its designee approves MN noninstitutional coverage for a period of months under chapter 182-504 WAC for an SSI-related person, provided the person satisfies any spenddown liability under chapter 182-519 WAC.

(8) People who receive medicaid personal care (MPC) or community first choice (CFC) pay all of their income to the ALF except a personal needs allowance of \$62.79.

(9) A person may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the payment under this subsection.

NEW SECTION

WAC 182-513-1210 Community first choice (CFC) —Overview. (1) Community first choice (CFC) is a Washington apple health state plan benefit authorized under Section 1915(k) of the Social Security Act.

(2) CFC enables the agency and its contracted entities to deliver person-centered home and community based long-term services and supports (LTSS) to medicaid-eligible people who meet the institutional level of care under WAC 388-106-0355. See:

(a) WAC 388-106-0270 through 388-106-0295 for services included within the CFC benefit package.

(b) WAC 182-513-1215 for financial eligibility for CFC services.

NEW SECTION

WAC 182-513-1215 Community first choice (CFC)—Eligibility. (1) An applicant who is determined functionally eligible for community first choice (CFC) services under WAC 388-106-0270 through 388-106-0295 is financially eligible to receive CFC services if the applicant is:

(a) Eligible for a noninstitutional Washington apple health program which provides categorically needy (CN) or alternative benefits plan (ABP) scope of care;

(b) A spousal impoverishment protections institutional (SIPI) spouse under WAC 182-513-1220; or

(c) Determined eligible for a home and community based (HCB) waiver program under chapter 182-515 WAC.

(2) An applicant whose only coverage is through one of the following programs is not eligible for CFC:

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

(b) Premium-based children's program under WAC 182-505-0215;

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

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

(e) Take charge program under WAC 182-532-0720;

(f) Medical care services program under WAC 182-508-0005;

(g) Pregnant minor program under WAC 182-505-0117;

(h) Alien emergency medical program under WAC 182-507-0110 through 182-507-0120;

(i) State-funded long-term care (LTC) for noncitizens program under WAC 182-507-0125; or

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

(3) Transfer of asset penalties under WAC 182-513-1363 do not apply to CFC applicants, unless the applicant is applying for long-term services and supports (LTSS) that are available only through one of the HCB waivers under chapter 182-515 WAC.

(4) Home equity limits under WAC 182-513-1350 do apply.

(5) Post-eligibility treatment of income rules do not apply if the person is eligible under subsection (1)(a) or (b) of this section. People who reside in an alternate living facility (ALF) do pay up to the room and board standard. The room and board amount is based on the effective one-person medically needy income level (MNIL) minus the residential personal needs allowance (PNA) except when eligibility is based on the rules under WAC 182-513-1205.

(6) A person who receives CFC and aged, blind, disabled (ABD) cash assistance in an AFH keeps a clothing and personal incidentals (CPI) amount of $38.84 and pays the remainder of the cash grant and other available income towards room and board.

(7) A person who receives CFC services under the health care for workers with disabilities (HWD) program under chapter 182-511 WAC must pay the HWD premium in addition to room and board, if residing in a residential setting.

(8) Post-eligibility treatment of income rules do apply if a person is eligible under subsection (1)(c) of this section.

(9) A person may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the room and board and participation.

(10) PNA, MNIL, and room and board standards are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

NEW SECTION

WAC 182-513-1220 Community first choice (CFC)—Spousal impoverishment protections for noninstitutional Washington apple health clients. (1) The agency or its designee determines eligibility for community first choice (CFC) using spousal impoverishment protections under this section, when an applicant:

(a) Is married to, or marries, a person not in a medical institution;

(b) Meets institutional level of care and eligibility for CFC services under WAC 388-106-0270 through 388-106-0295;

(c) Is ineligible for a noninstitutional categorically needy (CN) SSI-related program:

(i) Due to spousal deeming rules under WAC 182-512-0920, or due to exceeding the resource limit in WAC 182-512-0010, or both; or

(ii) In an ALF due to combined spousal resources exceeding the resource limit in WAC 182-512-0010; and

(d) Meets the aged, blindness, or disability criteria under WAC 182-512-0050.

(2) The agency or its designee determines countable income using the SSI-related income rules under chapter 182-512 WAC but uses only the applicant's or recipient's separate income and not the income of the applicant's or recipient's spouse.

(3) The agency or its designee determines countable resources using the SSI-related resource rules under chapter 182-512 WAC, except pension funds owned by the spousal impoverishment protections community (SIPC) spouse are not excluded as described under WAC 182-512-0550:

(a) For the applicant or recipient, the resource standard is $2000.

(b) Before determining countable resources used to establish eligibility for the applicant, the agency allocates the state spousal resource standard to the SIPC spouse.

(c) The resources of the SIPC spouse are unavailable to the spousal impoverishment protections institutionalized (SIPI) spouse the month after eligibility for CFC services is established unless subsection (8) of this section applies.

(4) The SIPI spouse has until the end of the month of the first regularly scheduled eligibility review to transfer countable resources in excess of $2000 to the SIPC spouse.

(5) A redetermination of the couple's resources under subsection (3) of this section is required if:

(a) The SIPI spouse has a break in CFC services of at least thirty consecutive days;

(b) The SIPI spouse's countable resources exceed the standard under subsection (3)(a) of this section; or

(c) The SIPI spouse does not transfer the amount under subsection (4) of this section to the SIPC spouse by the end of the month of the first regularly scheduled eligibility review.

(6) If the applicant lives at home and the applicant's separate countable income is at or below the SSI categorically needy income level (CNIL) and the applicant is resource eligible, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(7) If the applicant lives in an ALF, has separate countable income at or below the standard under WAC 182-513-1205(2), and is resource eligible, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(8) If the applicant is employed and has separate countable income at or below the standard under WAC 182-511-1060, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(9) Once a person no longer receives CFC services for thirty consecutive days, the agency redetermines eligibility without using spousal impoverishment protection, under WAC 182-504-0125.

(10) If the applicant's separate countable income is above the standards under subsections (6), (7), and (8) of this section, the applicant is not eligible for CFC services under this section.

(11) The spousal impoverishment protections under this section expire on December 31, 2018.

(12) Standards are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

NEW SECTION

WAC 182-513-1225 Medicaid personal care (MPC). (1) Medicaid personal care (MPC) is a state-plan benefit available to a person who is determined:

(a) Functionally eligible for MPC services under WAC 388-106-0200 through 388-106-0235; and

(b) Financially eligible for a noninstitutional categorically needy (CN) or alternative benefits plan (ABP) Washington apple health program.

(2) MPC services may be provided to a person residing at home, in a department-contracted adult family home (AFH), or in a licensed assisted living facility that is contracted with the department to provide adult residential care services.

(3) A person who resides in an alternate living facility (ALF) listed in subsection (2) of this section:

(a) Keeps a personal needs allowance (PNA) of $62.79; and

(b) Pays room and board up to the statewide room and board amount, unless CN eligibility is determined using rules under WAC 182-513-1205.

(4) A person who receives MPC and aged, blind, disabled (ABD) cash assistance in an AFH keeps a clothing and personal incidentals (CPI) amount of $38.84 and pays the rest of the cash grant and other available income towards room and board.

(5) A person who receives MPC services under the health care for workers with disabilities (HWD) program under chapter 182-511 WAC must pay the HWD premium in addition to room and board, if residing in a residential setting.

(6) A person may have to pay third-party resources as defined under WAC 182-513-1100 in addition to room and board.

(7) Current PNA and room and board standards are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

NEW SECTION

WAC 182-513-1230 Program of all-inclusive care for the elderly (PACE). (1) The program of all-inclusive care for the elderly (PACE) provides long-term services and supports (LTSS), medical, mental health, and chemical dependency treatment through a department-contracted managed care plan using a personalized plan of care for each enrollee.

(2) Program rules governing functional eligibility for PACE are listed under WAC 388-106-0700, 388-106-0705, 388-106-0710, and 388-106-0715.

(3) A person is financially eligible for PACE if the person:

(a) Is age:

(i) Fifty-five or older and disabled under WAC 182-512-0050; or

(ii) Sixty-five or older;

(b) Meets nursing facility level of care under WAC 388-106-0355;

(c) Lives in a designated PACE service area;

(d) Meets financial eligibility requirements under this section; and

(e) Agrees to receive services exclusively through the PACE provider and the PACE provider's network of contracted providers.

(4) Although PACE is not a home and community based (HCB) waiver program, financial eligibility is determined using the HCB waiver rules under WAC 182-515-1505 when a person is living at home or in an alternate living facility (ALF), with the following exceptions:

(a) PACE enrollees are not subject to the transfer of asset rules under WAC 182-513-1363; and

(b) PACE enrollees may reside in a medical institution thirty days or longer and still remain eligible for PACE services. The eligibility rules for institutional coverage are under WAC 182-513-1315 and 182-513-1380.

(5) A person may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the room and board and participation.

NEW SECTION

WAC 182-513-1235 Roads to community living (RCL). (1) Roads to community living (RCL) is a demonstration project authorized under Section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) and extended through the Patient Protection and Affordable Care Act (P.L. 111-148).

(2) Program rules governing functional eligibility for RCL are described in WAC 388-106-0250 through 388-106-0265. RCL services are authorized by the department.

(3) A person must have a stay of at least ninety consecutive days in a qualified institutional setting such as a hospital, nursing home, or residential habilitation center, to be eligible for RCL. The ninety-day count excludes days paid solely by medicare, must include at least one day of medicaid paid inpatient services immediately prior to discharge, and the person must be eligible to receive any categorically needy (CN), medically needy (MN), or alternate benefit plan (ABP) medicaid program on the day of discharge. In addition to meeting the ninety-day criteria, a person who is being discharged from a state psychiatric hospital must be under age twenty-two or over age sixty-four.

(4) Once a person is discharged to home or to a residential setting under RCL, the person remains continuously eligible for medical coverage for three hundred sixty-five days unless the person:

(a) Returns to an institution for thirty days or longer;

(b) Is incarcerated in a public jail or prison;

(c) No longer wants RCL services;

(d) Moves out-of-state; or

(e) Dies.

(5) Changes in income or resources during the continuous eligibility period do not affect eligibility for RCL services. Changes in income or deductions may affect the amount a person must pay toward the cost of care.

(6) A person approved for RCL is not subject to transfer of asset provisions under WAC 182-513-1363 during the continuous eligibility period, but transfer penalties may apply if the person needs HCB waiver or institutional services once the continuous eligibility period has ended.

(7) A person who is not otherwise eligible for a noninstitutional medical program must have eligibility determined using the same rules used to determine eligibility for HCB waivers. If HCB rules are used to establish eligibility, the person must pay participation toward the cost of RCL services. HCB waiver eligibility and cost of care calculations are under:

(a) WAC 182-515-1508 and 182-515-1509 for home and community services (HCS); and

(b) WAC 182-515-1513 and 182-515-1514 for development disabilities administration (DDA) services.

(8) At the end of the continuous eligibility period, the agency or its designee redetermines a person's eligibility for other programs under WAC 182-504-0125.

NEW SECTION

WAC 182-513-1240 The hospice program. (1) General information.

(a) The hospice program provides palliative care to people who elect to receive hospice services and are certified as terminally ill by their physician.

(b) Program rules governing election of hospice services are under chapter 182-551 WAC.

(c) A person may revoke an election to receive hospice services at any time by signing a revocation statement.

(d) Transfer of asset rules under WAC 182-513-1363 do not apply to the hospice program in any setting, regardless of which apple health program the person is eligible to receive.

(2) When hospice is a covered service.

(a) A person who receives coverage under a categorically needy (CN), medically needy (MN), or alternative benefits plan (ABP) program is eligible for hospice services as part of the program specific benefit package.

(b) A person who receives coverage under the alien emergency medical (AEM) program under WAC 182-507-0110 may be eligible for payment for hospice services if preapproved by the agency.

(c) A person who receives coverage under the medical care services (MCS) program is not eligible for coverage of hospice services.

(3) When HCB waiver rules are used to determine eligibility for hospice.

(a) A person who is not otherwise eligible for a CN, MN, or ABP noninstitutional program who does not reside in a medical institution, may be eligible for CN coverage under the hospice program by using home and community based (HCB) waiver rules under WAC 182-515-1505 to determine financial eligibility.

(b) When HCB waiver rules are used, the following exceptions apply:

(i) A person on the hospice program may reside in a medical institution, including a hospice care center, thirty days or longer and remain eligible for hospice services; and

(ii) A person residing at home on the hospice program who has available income over the special income limit (SIL), defined under WAC 182-513-1100, is not eligible for CN coverage. If available income is over the SIL, the agency or its designee determines eligibility for medically needy coverage under WAC 182-519-0100.

(c) When HCB waiver rules are used, a person may be required to pay income and third-party resources (TPR) as defined under WAC 182-513-1100 toward the cost of hospice services. The cost of care calculation is described under WAC 182-515-1509.

(d) When a person already receives HCB waiver services and elects hospice, the person must pay any required cost of care towards the HCB waiver service provider first.

(4) Eligibility for hospice services in a medical institution:

(a) A person who elects to receive hospice services, resides in a medical institution for thirty days or longer, and has income:

(i) Equal to or less than the SIL is income eligible for CN coverage. Eligibility for institutional hospice is determined under WAC 182-513-1315; or

(ii) Over the SIL may be eligible for MN coverage under WAC 182-513-1245.

(b) A person eligible for hospice services in a medical institution may have to pay toward the cost of nursing facility or hospice care center services. The cost of care calculation is under WAC 182-513-1380.

(5) Changes in coverage. The agency or its designee redetermines a person's eligibility under WAC 182-504-0125 if the person:

(a) Revokes the election of hospice services and is eligible for coverage using HCB waiver rules only, described in subsection (3) of this section; or

(b) Loses CN, MN, or ABP eligibility.

(6) Personal needs allowance and income and resource standards for hospice and home and community based (HCB) waiver programs are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

NEW SECTION

WAC 182-513-1245 Medically needy hospice program in a medical institution. (1) General information.

(a) When living in a medical institution, a person may be eligible for medically needy coverage under the hospice program. A person must:

(i) Meet program requirements under WAC 182-513-1315;

(ii) Have available income that exceeds the special income level (SIL), defined under WAC 182-513-1100, but is below the institution's monthly state-contracted rate;

(iii) Meet the financial requirements of subsection (4) or (5) of this section; and

(b) Elect hospice services under chapter 182-551 WAC.

(2) Financial eligibility.

(a) The agency or its designee determines a person's resource eligibility, excess resources, and medical expense deductions using WAC 182-513-1350.

(b) The agency or its designee determines a person's countable income by:

(i) Excluding income under WAC 182-513-1340;

(ii) Determining available income under WAC 182-513-1325 or 182-513-1330;

(iii) Disregarding income under WAC 182-513-1345; and

(iv) Deducting medical expenses that were not used to reduce excess resources under WAC 182-513-1350.

(3) Determining the state-contracted daily rate in an institution, and the institutional medically needy income level (MNIL).

(a) The agency or its designee determines the state-contracted daily rate in an institution and the institutional MNIL based on the living arrangement, and whether the person is entitled to receive hospice services under medicare.

(b) When the person resides in a hospice care center:

(i) If entitled to medicare, the state-contracted daily rate is the state-contracted daily hospice care center rate. The institutional MNIL is calculated by multiplying the state-contracted daily rate by 30.42.

(ii) If not entitled to medicare, the state-contracted daily rate is the state-contracted daily hospice care center rate, plus the state-contracted daily hospice rate. To calculate the institutional MNIL, multiply the state-contracted daily rate by 30.42.

(c) When the person resides in a nursing facility:

(i) If entitled to medicare, the state-contracted daily rate is ninety-five percent of the nursing facility's state-contracted daily rate. The institutional MNIL is calculated by multiplying the state-contracted daily rate by 30.42.

(ii) If not entitled to medicare, the state-contracted daily rate is ninety-five percent of the nursing facility's state-contracted daily rate, plus the state-contracted daily hospice rate. The institutional MNIL is calculated by multiplying the state-contracted daily rate by 30.42.

(4) Eligibility for agency payment to the facility for institutional hospice services and the MN program.

(a) If a person's countable income plus excess resources is less than or equal to the state-contracted daily rate under subsection (3) of this section times the number of days the person has resided in the medical institution, the person:

(i) Is eligible for agency payment to the facility for institutional hospice services;

(ii) Is approved for MN coverage for a twelve-month certification period;

(b) Pays excess resources under WAC 182-513-1350; and

(c) Pays income towards the cost of care under WAC 182-513-1380.

(5) Eligibility for institutional MN spenddown.

(a) If a person's countable income is more than the state-contracted daily rate times the number of days the person has resided in the medical institution, but less than the institution's private rate for the same period, the person:

(i) Is not eligible for agency payment to the facility for institutional hospice services; and

(ii) Is eligible for the MN spenddown program for a three-month or six-month base period when qualifying medical expenses meet a person's spenddown liability.

(b) Spenddown liability is calculated by subtracting the institutional MNIL from the person's countable income for each month in the base period. The values from each month are added together to determine the spenddown liability.

(c) Qualifying medical expenses used to meet the spenddown liability are described in WAC 182-519-0110, except that only costs for hospice services not included within the state-contracted daily rate are qualifying medical expenses.

(6) Eligibility for MN spenddown.

(a) If a person's countable income is more than the institution's private rate times the number of days the person has resided in the medical institution, the person is not eligible for agency payment to the facility for institutional hospice services and institutional MN spenddown; and

(b) The agency or its designee determines eligibility for MN spenddown under chapter 182-519 WAC.

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

WAC 182-513-1315 ((~~Eligibility for long-term care (institutional, waiver, and hospice) services.~~)) General eligibility requirements for long-term care (LTC) programs. ((~~This section describes how the department determines a client's eligibility for medical for clients residing in a medical institution, on a waiver, or receiving hospice services~~

~~under the categorically needy (CN) or medically needy (MN) programs. Also described are the eligibility requirements for these services under the aged, blind, or disabled (ABD) cash assistance, medical care services (MCS) and the state funded long-term care services program described in subsection (11).~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(18) Clients not living in a medical institution who are considered to be receiving SSI-benefits for the purposes of medicaid do not pay service participation toward their cost of care. Clients living in a residential setting do pay room and board as described in WAC 388-515-1505 through 388-515-1509 or WAC 388-515-1514. Groups deemed to be receiving SSI and for medicaid purposes are eligible to receive CN medicaid. These groups are described in WAC 182-512-0880.~~)) This section lists the sections in this chapter that describe how the agency determines a person's eligibility for long-term care services. These sections are:

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

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

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

(4) WAC 182-513-1319 State-funded programs for noncitizens who are not eligible for a federally funded program.

NEW SECTION

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

(a) Meet the general eligibility requirements for medical programs under WAC 182-503-0505, except:

(i) An adult age nineteen or older must meet citizenship and immigration status requirements under WAC 182-503-0535 (2)(a) or (b);

(ii) A person under age nineteen must meet citizenship and immigration status requirements under WAC 182-503-0535 (2)(a), (b), (c), or (d); and

(iii) If a person does not meet the requirements in (a)(i) or (ii) of this subsection, the person is not eligible for medicaid and must have eligibility determined under WAC 182-513-1319.

(b) Attain institutional status under WAC 182-513-1320;

(c) Meet the functional eligibility under:

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

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

(d) Meet either:

(i) SSI-related criteria under WAC 182-512-0050; or

(ii) MAGI-based criteria under WAC 182-503-0510(2), if residing in a medical institution. A person who is eligible for MAGI-based coverage is not subject to the provisions under subsection (2) of this section.

(2) A supplemental security income (SSI) recipient or a person meeting SSI-related criteria who needs LTC services must also:

(a) Not have a penalty period of ineligibility due to the transfer of assets under WAC 182-513-1363;

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

(c) Disclose to the agency or its designee any interest the applicant or spouse has in an annuity, which must meet annuity requirements under chapter 182-516 WAC.

(3) A person who receives SSI must submit a signed health care coverage application form attesting to the provisions under subsection (2) of this section. A signed and completed eligibility review for LTC benefits can be accepted for people receiving SSI who are applying for long-term care services.

(4) To be eligible for HCB waiver services, a person must also meet the program requirements under:

(a) WAC 182-515-1505 through 182-515-1509 for HCS HCB waivers; or

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

NEW SECTION

WAC 182-513-1317 Income and resource criteria for an institutionalized person. (1) This section provides an overview of the income and resource eligibility rules for a person who lives in an institutional setting.

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

(a) Determines available income under WAC 182-513-1325 and 182-513-1330;

(b) Excludes income under WAC 182-513-1340; and

(c) Compares remaining available income to the special income level (SIL) defined under WAC 182-513-1100. A person's available income must be equal to or less than the SIL to be eligible for CN coverage.

(3) To determine income eligibility for an SSI-related LTC client under the medically needy (MN) program, the agency or its designee follows the income standards and eligibility rules under WAC 182-513-1395.

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

(a) Meet the resource eligibility requirements under WAC 182-513-1350;

(b) Not have a penalty period of ineligibility due to a transfer of assets under WAC 182-513-1363;

(c) Disclose to the state any interest the person or the person's spouse has in an annuity, which must meet the annuity requirements under chapter 182-516 WAC.

(5) A resident of eastern or western state hospital is eligible for medicaid if the person:

(a) Has attained institutional status under WAC 182-513-1320; and

(b) Is under age twenty-one; or

(c) Applies for or receives inpatient psychiatric treatment in the month of the person's twenty-first birthday that will likely continue through the person's twenty-first birthday, and can receive coverage until:

(i) The facility discharges the person; or

(ii) The end of the month in which the person turns age twenty-two, whichever occurs first; or

(d) Is at least age sixty-five.

(6) To determine long-term care CN or MN income eligibility for a person eligible under a MAGI-based program, the agency or its designee follows the rules under chapter 182-514 WAC.

(7) There is no asset test for MAGI-based LTC programs under WAC 182-514-0245.

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

(a) For an SSI-related person residing in a medical institution, see WAC 182-513-1380;

(b) For an SSI-related person on a home and community based waiver, see chapter 182-515 WAC.

NEW SECTION

WAC 182-513-1318 Income and resource criteria for home and community based (HCB) waiver programs and hospice. (1) This section provides an overview of the income and resource eligibility rules for a person to be eligible for a categorically needy (CN) home and community based (HCB) waiver program under chapter 182-515 WAC or the hospice program under WAC 182-513-1240 and 182-513-1245.

(2) To determine income eligibility for an SSI-related long-term care (LTC) HCB waiver, the agency or its designee:

(a) Determines income available under WAC 182-513-1325 and 182-513-1330;

(b) Excludes income under WAC 182-513-1340;

(c) Compares remaining gross nonexcluded income to:

(i) The special income level (SIL) defined under WAC 182-513-1100; or

(ii) For HCB service programs authorized by the aging and long-term supports administration (ALTSA), a higher standard is determined following the rules under WAC 182-515-1508 if a client's income is above the SIL but net income is below the medically needy income level (MNIL).

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

(4) To be resource eligible under the HCB waiver program, the person must:

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

(b) Not be in a period of ineligibility due to a transfer of asset penalty under WAC 182-513-1363;

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

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

(a) For people receiving HCS HCB waiver services, see WAC 182-515-1509;

(b) For people receiving DDA HCB waiver services, see WAC 182-515-1514.

(6) To be eligible for the CN hospice program, see WAC 182-513-1240.

(7) To be eligible for the MN hospice program in a medical institution, see WAC 182-513-1245.

NEW SECTION

WAC 182-513-1319 State-funded programs for noncitizens who are not eligible for a federally funded program. (1) This section describes the state-funded programs available to a person who does not meet the citizenship and immigration status criteria under WAC 182-513-1316 for federally funded coverage.

(2) If a person meets the eligibility and incapacity criteria of the medical care services (MCS) program under WAC 182-508-0005, the person may receive nursing facility care or state-funded residential services in an alternate living facility (ALF).

(3) Noncitizens age nineteen or older may be eligible for the state-funded long-term care services program under WAC 182-507-0125. A person must be preapproved by the aging and long-term support administration (ALTSA) for this program due to enrollment limits.

(4) Noncitizens under age nineteen who meet citizenship and immigration status under WAC 182-503-0535 (2)(e) are eligible for:

(a) Nursing facility services if the person meets nursing facility level of care; or

(b) State-funded personal care services if functionally eligible based on a department assessment under chapter 388-106 or 388-845 WAC.

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

WAC 182-513-1320 Determining institutional status for long-term care (LTC) services. ((~~(1) Institutional status is an eligibility requirement for long-term care services (LTC) and institutional medical programs. To attain institutional status, you must:~~

~~(a) Be approved for and receiving home and community based waiver services or hospice services; or~~

~~(b) Reside or based on a department assessment is likely to reside in a medical institution, institution for mental diseases (IMD) or inpatient psychiatric facility for a continuous period of:~~

~~(i) Thirty days if you are an adult eighteen and older;~~

~~(ii) Thirty days if you are a child seventeen years of age or younger admitted to a medical institution; or~~

~~(iii) Ninety days if you are a child seventeen years of age or younger receiving inpatient chemical dependency or inpatient psychiatric treatment.~~

~~(2) Once the department has determined that you meet institutional status, your status is not affected by:~~

~~(a) Transfers between medical facilities; or~~

~~(b) Changes from one kind of long-term care services (waiver, hospice or medical institutional services) to another.~~

~~(3) If you are absent from the medical institution or you do not receive waiver or hospice services for at least thirty consecutive days, you lose institutional status.~~)) (1) To attain institutional status outside a medical institution, a person must be approved for and receive:

(a) Home and community based (HCB) waiver services under chapter 182-515 WAC;

(b) Roads to community living (RCL) services under WAC 182-513-1235;

(c) Program of all-inclusive care for the elderly (PACE) under WAC 182-513-1230;

(d) Hospice services under WAC 182-513-1240(3); or

(e) State-funded long-term care service under WAC 182-507-0125.

(2) To attain institutional status in a medical institution, a person must reside in a medical institution thirty consecutive days or more, or based on a department assessment, be likely to reside in a medical institution thirty consecutive days or more.

(3) Once a person meets institutional status, the person's status is not affected if the person:

(a) Transfers between medical facilities; or

(b) Changes between any of the following programs: HCB waiver, RCL, PACE, hospice or services in a medical institution.

(4) A person loses institutional status if the person is absent from a medical institution, or does not receive HCB waiver, RCL, PACE, or hospice services, for more than twenty-nine consecutive days.

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

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

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

(2) The ((~~department must apply~~)) agency or its designee applies the following rules when determining income eligibility for SSI-related LTC services:

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

(b) WAC 182-512-0650 SSI-related medical—Available income;

(c) WAC 182-512-0700 SSI-related medical—Income eligibility;

(d) WAC 182-512-0750 SSI-related medical—Countable unearned income;

(e) WAC ((~~182-514-0840(3)~~)) 182-512-0840(3) self-employment income-allowable expenses((~~;~~

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

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

(3) In initial categorically needy income eligibility for LTC, the agency does not allow any deductions listed in 1612(b) of the Social Security Act, for example:

(a) Twenty dollars per month income exclusion under WAC 182-512-0800;

(b) The first $65 and the remaining one-half earned income work incentive under WAC 182-512-0840; and

(c) Impairment related work expense or blind work expense under WAC 182-512-0840.

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

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

(1) The ((~~department must apply~~)) agency or its designee applies the following rules when determining income eligibility for LTC services:

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

(b) WAC 182-512-0650 SSI-related medical—Available income;

(c) WAC 182-512-0700 SSI-related medical—Income eligibility;

(d) WAC 182-512-0750 SSI-related medical—Countable unearned income;

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

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

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

~~(2) For~~))—Allocating income—Determining eligibility for a spouse when the other spouse receives long-term services and supports (LTSS).

(2) In initial categorically needy income eligibility for LTC, the agency does not allow any deductions listed in 1612(b) of the Social Security Act, for example:

(a) Twenty dollars per month income exclusion under WAC 182-512-0800;

(b) The first $65 and the remaining one-half earned income work incentive under WAC 182-512-0840; and

(c) Impairment related work expense or blind work expense under WAC 182-512-0840.

(3) The following income is available to an institutionalized ((~~client married to a community spouse who is not applying or approved for LTC services, the department considers the following income available~~)) spouse, unless subsections ((~~(4) applies~~)) (5) and (6) apply:

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

(b) Income paid to a representative on the ((~~client's~~)) institutionalized spouse's behalf; and

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

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

((~~(3)~~)) (4) The ((~~department considers the~~)) following income is unavailable to an institutionalized ((~~client~~)) spouse:

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

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

((~~(4)~~)) (5) For the determination of eligibility only, if available income ((~~described in~~)) under subsection((~~s (2)~~)) (3)(a) through ((~~(d)~~)) (c) of this section, minus income exclusions ((~~described in WAC 388-513-1340~~)) under WAC 182-513-1340, exceeds the special income level (SIL), ((~~then~~)) defined under WAC 182-513-1100, the agency or its designee:

(a) ((~~The department~~)) Follows Washington state community property law when determining ownership of income;

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

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

((~~(d)~~)) (6) If the total of subsection ((~~(4)~~)) (5)(c) of this section plus the ((~~client's own~~)) institutionalized spouse's separate income is over the SIL, ((~~follow~~)) determine available income using subsection ((~~(2)~~)) (3) of this section.

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

~~(6) The department considers~~)) (7) A stream of income, not generated by a transferred resource, is available to the ((~~client not generated by a transferred resource available to the client~~)) institutionalized spouse, even ((~~when the client~~)) if the institutionalized spouse transfers or assigns the rights to the stream of income to one of the following:

(a) The community spouse; or

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

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

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

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

(1) When determining a person's eligibility and participation in the cost of care for LTC services, the agency excludes:

(a) Crime victim's compensation;

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

((~~(3) Native~~)) (c) American Indian/Alaskan native benefits excluded by federal statute (refer to WAC ((~~388-450-0040~~)) 182-512-0770);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

((~~(31)~~)) (2) The agency or its designee treats Department of Veterans Affairs (VA) benefits ((~~designated for~~)) as follows:

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

(b) ((~~Unusual medical expenses~~)) UME, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance((~~, with the exception described in subsection (32)~~)) are third-party resources;

((~~(32)~~)) (c) Benefits ((~~described in subsection (31)(b)~~)) in subsection (2)(b) of this section for a ((~~client~~)) person who receives long-term care services are excluded when determining eligibility, but are ((~~considered~~)) available as a third-party resource (TPR) as defined under WAC 182-513-1100 when determining the amount the ((~~client~~)) institutionalized individual contributes in the cost of care.

(3) Any other income excluded by federal law is excluded.

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

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

(1) The ((~~department~~)) agency or its designee disregards the following income amounts in the following order:

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

(i) Twenty dollars per month if unearned; or

(ii) Ten dollars per month if earned.

(b) The first ((~~twenty dollars~~)) $20 per month of earned or unearned income, unless the sole source of income paid to a ((~~client~~)) person is:

(i) Based on need; and

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

(2) For a ((~~client~~)) person who is related to the supplemental security income (SSI) program ((~~as described in~~)) under WAC 182-512-0050(1), the first ((~~sixty-five dollars~~)) $65 per month of earned income not excluded under WAC ((~~388-513-1340~~)) 182-513-1340, plus one-half of the remainder.

(3) Department of Veterans Affairs benefits designated for:

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

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

(4) Benefits ((~~described in~~)) under subsection (3)(b) of this section for a ((~~client~~)) person who receives long-term care services are excluded when determining eligibility, but are considered available as a third-party resource (TPR) defined under WAC 182-513-1100 when determining the amount the ((~~client~~)) person contributes in the cost of care.

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

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

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

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

~~(a) Two thousand dollars for:~~

~~(i) A single client; or~~

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

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

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

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

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

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

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

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

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

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

~~(c) WAC 388-470-0060, Resources of an alien's sponsor.~~

~~(8) For LTC services the department determines a client's countable resources as follows:~~

~~(a) The department determines countable resources for SSI-related clients as described in WAC 182-512-0350 through 182-512-0550 and resources excluded by federal law with the exception of:~~

~~(i) WAC 182-512-0550 pension funds owned by an:~~

~~(I) Ineligible spouse. Pension funds are defined as funds held in an individual retirement account (IRA) as described by the IRS code; or~~

~~(II) Work-related pension plan (including plans for self-employed individuals, known as Keogh plans).~~

~~(ii) WAC 182-512-0350 (1)(b) clients who have submitted an application for LTC services on or after May 1, 2006 and have an equity interest greater than five hundred thousand dollars in their primary residence are ineligible for LTC services. This exception does not apply if a spouse or blind, disabled or dependent child under age twenty-one is lawfully residing in the primary residence. Clients denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver described in WAC 388-513-1367. Effective January 1, 2011, the excess home equity limits increase to five hundred six thousand dollars. On January 1, 2012 and on January 1 of each year thereafter, this standard may be increased or decreased by the percentage increased or decreased in the consumer price index-urban (CPIU). For current excess home equity standard starting January 1, 2011 and each year thereafter, see http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.~~

~~(b) For an SSI-related client one automobile per household is excluded regardless of value if it is used for transportation of the eligible individual/couple.~~

~~(i) For an SSI-related client with a community spouse, the value of one automobile is excluded regardless of its use or value.~~

~~(ii) A vehicle not meeting the definition of automobile is a vehicle that has been junked or a vehicle that is used only as a recreational vehicle.~~

~~(c) For an SSI-related client, the department adds together the countable resources of both spouses if subsections (3), (6) and (9)(a) or (b) apply, but not if subsection (4) or (5) apply.~~

~~(d) For an SSI-related client, excess resources are reduced:~~

~~(i) In an amount equal to incurred medical expenses such as:~~

~~(A) Premiums, deductibles, and coinsurance/copayment charges for health insurance and medicare;~~

~~(B) Necessary medical care recognized under state law, but not covered under the state's medicaid plan;~~

~~(C) Necessary medical care covered under the state's medicaid plan incurred prior to medicaid eligibility. Expenses for nursing facility care are reduced at the state rate for the facility that the client owes the expense to.~~

~~(ii) As long as the incurred medical expenses:~~

~~(A) Were not incurred more than three months before the month of the medicaid application;~~

~~(B) Are not subject to third-party payment or reimbursement;~~

~~(C) Have not been used to satisfy a previous spend down liability;~~

~~(D) Have not previously been used to reduce excess resources;~~

~~(E) Have not been used to reduce client responsibility toward cost of care;~~

~~(F) Were not incurred during a transfer of asset penalty described in WAC 388-513-1363, 388-513-1364, and 388-513-1365; and~~

~~(G) Are amounts for which the client remains liable.~~

~~(e) Expenses not allowed to reduce excess resources or participation in personal care:~~

~~(i) Unpaid expense(s) prior to waiver eligibility to an adult family home (AFH) or assisted living facility is not a medical expense.~~

~~(ii) Personal care cost in excess of approved hours determined by the CARE assessment described in chapter 388-106 WAC is not a medical expense.~~

~~(f) The amount of excess resources is limited to the following amounts:~~

~~(i) For LTC services provided under the categorically needy (CN) program:~~

~~(A) Gross income must be at or below the special income level (SIL), 300% of the federal benefit rate (FBR).~~

~~(B) In a medical institution, excess resources and income must be under the state medicaid rate based on the number of days in the medical institution in the month.~~

~~(C) For CN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for CN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.~~

~~(ii) For LTC services provided under the medically needy (MN) program when excess resources are added to countable income, the combined total is less than the:~~

~~(A) State medical institution rate based on the number of days in the medical institution in the month, plus the amount of recurring medical expenses; or~~

~~(B) State hospice rate based on the number of days in the medical institution in the month plus the amount of recurring medical expenses, in a medical institution.~~

~~(C) For MN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for MN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.~~

~~(g) For a client not related to SSI, the department applies the resource rules of the program used to relate the client to medical eligibility.~~

~~(9) For legally married clients when only one spouse meets institutional status, the following rules apply. If the client's current period of institutional status began:~~

~~(a) Before October 1, 1989, the department adds together one-half the total amount of countable resources held in the name of:~~

~~(i) The institutionalized spouse; or~~

~~(ii) Both spouses.~~

~~(b) On or after October 1, 1989, the department adds together the total amount of nonexcluded resources held in the name of:~~

~~(i) Either spouse; or~~

~~(ii) Both spouses.~~

~~(10) If subsection (9)(b) of this section applies, the department determines the amount of resources that are allocated to the community spouse before determining countable resources used to establish eligibility for the institutionalized spouse, as follows:~~

~~(a) If the client's current period of institutional status began on or after October 1, 1989 and before August 1, 2003, the department allocates the maximum amount of resources ordinarily allowed by law. Effective January 1, 2009, the maximum allocation is one hundred and nine thousand five hundred and sixty dollars. This standard may change annually on January 1st based on the consumer price index. (For the current standard starting January 2009 and each year thereafter, see long-term care standards at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml); or~~

~~(b) If the client's current period of institutional status began on or after August 1, 2003, the department allocates the greater of:~~

~~(i) A spousal share equal to one-half of the couple's combined countable resources as of the first day of the month of the current period of institutional status, up to the amount described in subsection (10)(a) of this section; or~~

~~(ii) The state spousal resource standard of forty-eight thousand six hundred thirty-nine dollars (this standard may change every odd year on July 1st). This standard is based on the consumer price index published by the federal bureau of labor statistics. For the current standard starting July 2009 and each year thereafter, see long-term care standards at~~

~~http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.~~

~~(c) Resources are verified on the first moment of the first day of the month institutionalization began as described in WAC 182-512-0300(1).~~

~~(11) The amount of the spousal share described in (10)(b)(i) can be determined anytime between the date that the current period of institutional status began and the date that eligibility for LTC services is determined. The following rules apply to the determination of the spousal share:~~

~~(a) Prior to an application for LTC services, the couple's combined countable resources are evaluated from the date of the current period of institutional status at the request of either member of the couple. The determination of the spousal share is completed when necessary documentation and/or verification is provided; or~~

~~(b) The determination of the spousal share is completed as part of the application for LTC services if the client was institutionalized prior to the month of application, and declares the spousal share exceeds the state spousal resource standard. The client is required to provide verification of the couple's combined countable resources held at the beginning of the current period of institutional status.~~

~~(12) The amount of allocated resources described in subsection (10) of this section can be increased, only if:~~

~~(a) A court transfers additional resources to the community spouse; or~~

~~(b) An administrative law judge establishes in a fair hearing described in chapter 388-02 WAC, that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.~~

~~(13) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsection (6) or (14)(a), (b), or (c) of this section applies.~~

~~(14) A redetermination of the couple's resources as described in subsection (8) is required, if:~~

~~(a) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status; or~~

~~(b) The institutionalized spouse's countable resources exceed the standard described in subsection (1)(a), if subsection (9)(b) applies; or~~

~~(c) The institutionalized spouse does not transfer the amount described in subsections (10) or (12) to the community spouse by either:~~

~~(i) The end of the month of the first regularly scheduled eligibility review; or~~

~~(ii) The reasonable amount of additional time necessary to obtain a court order for the support of the community spouse.~~)) (1) General information.

(a) This section describes how the agency or its designee defines the resource standard and countable or excluded resources when determining a person's eligibility for SSI-related long-term care (LTC) services.

(b) "Resource standard" means the maximum amount of resources a person can have and still be resource eligible for program benefits.

(c) For a person not SSI-related, the agency applies program specific resource rules to determine eligibility.

(2) Resource standards.

(a) The resource standard for the following people is $2000:

(i) A single person; or

(ii) An institutionalized spouse.

(b) The resource standard for a legally married couple is $3000, unless subsection (3)(b)(ii) of this section applies.

(c) The resource standard for a person with a qualified long-term care partnership policy under WAC 182-513-1400 may be higher based on the dollar amount paid out by a partnership policy.

(d) Determining the amount of resources that can be allocated to the community spouse when determining resource eligibility is under WAC 182-513-1355.

(3) Availability of resources.

(a) General. The agency or its designee applies the following rules when determining available resources for LTC services:

(i) WAC 182-512-0300 SSI-related medical—Resources eligibility;

(ii) WAC 182-512-0250 SSI-related medical—Ownership and availability of resources; and

(iii) WAC 182-512-0260 SSI-related medical—How to count a sponsor's resources.

(b) Married couples.

(i) When both spouses apply for LTC services, the resources of both spouses are available to each other through the month in which the spouses stopped living together.

(ii) When both spouses are institutionalized, the agency or its designee determines the eligibility of each spouse as a single person the month following the month of separation.

(iii) If the agency or its designee has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, but after eligibility has been established and services authorized for the institutionalized spouse, then the agency applies the standard under subsection (2)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the agency applies subsection (2)(b) of this section for the couple.

(iv) The resources of the community spouse are unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless (v) or (vi) of this subsection applies.

(v) When a single institutionalized individual marries, the agency or its designee redetermines eligibility applying the resource and income rules for a legally married couple.

(vi) A redetermination of the couple's resources under this section is required if:

(A) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status;

(B) The institutionalized spouse's countable resources exceed the standard under subsection (2)(a) of this section, and WAC 182-513-1355 (2)(b) applies; or

(C) The institutionalized spouse does not transfer the amount, under WAC 182-513-1355 (3) or (5), to the community spouse by either:

(I) The end of the month of the first regularly scheduled eligibility review; or

(II) A reasonable amount of time necessary to obtain a court order for the support of the community spouse.

(4) Countable resources.

(a) The agency or its designee determines countable resources using the following sections:

(i) WAC 182-512-0200 SSI-related medical—Definition of resources.

(ii) WAC 182-512-0250 SSI-related medical—Ownership and availability of resources.

(iii) WAC 182-512-0260 SSI-related medical—How to count a sponsor's resources.

(iv) WAC 182-512-0300 SSI-related medical—Resources eligibility.

(v) WAC 182-512-0350 SSI-related medical—Property and contracts excluded as resources;

(vi) WAC 182-512-0400 SSI-related medical—Vehicles excluded as resources;

(vii) WAC 182-512-0450 SSI-related medical—Life insurance excluded as a resource; and

(viii) WAC 182-512-0500 SSI-related medical—Burial funds, contracts and spaces excluded as resources.

(ix) Chapter 182-516 WAC, Trusts, annuities, life estates, and promissory notes—Effect on medical programs.

(b) The agency or its designee determines excluded resources based on federal law and WAC 182-512-0550, except:

(i) For institutional and HCB waiver programs, pension funds owned by a nonapplying spouse are counted toward the resource standard.

(ii) For long-term services and supports (LTSS), based on the need for either nursing facility level of care or intermediate care facility for the intellectually disabled level of care, one home is excluded only if it meets the home equity limits of subsection (8) of this section. See WAC 182-512-0350 (1)(b).

(c) The agency or its designee adds together the countable resources of both spouses if subsections (3)(b)(i) and (iv) apply, but not if subsection (3)(b)(ii) or (iii) apply. For a person with a community spouse, see WAC 182-513-1355.

(5) Excess resources.

(a) For LTC programs, a person may reduce excess resources by deducting incurred medical expenses under subsection (6) of this section;

(b) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program:

(A) In a medical institution, excess resources and available income must be under the state medicaid rate based on the number of days the person spent in the medical institution in the month.

(B) For HCB waiver eligibility, incurred medical expenses must reduce resources within allowable resource standards. The cost of care for the HCB waiver services cannot be allowed as a projected expense.

(ii) For LTC services provided under the medically needy (MN) program, see:

(A) WAC 182-513-1395 for LTC programs; and

(B) WAC 182-513-1245 for hospice.

(c) Excess resources not otherwise applied to medical expenses will be applied to the projected cost of care for services in a medical institution under WAC 182-513-1380.

(6) Allowable medical expenses.

(a) The following incurred medical expenses may be used to reduce excess resources:

(i) Premiums, deductibles, coinsurance, or copayment charges for health insurance and medicare;

(ii) Medically necessary care defined under WAC 182-500-0070, but not covered under the state's medicaid plan. Information regarding covered services is under chapter 182-501 WAC;

(iii) Medically necessary care defined under WAC 182-500-0070 incurred prior to medicaid eligibility. Expenses for nursing facility care are reduced at the state rate for the specific facility that provided the services.

(b) To be allowed, the medical expense must:

(i) Have been incurred more than three months before the month of the medicaid application;

(ii) Not be subject to third-party payment or reimbursement;

(iii) Not have been used to satisfy a previous spenddown liability;

(iv) Not have been previously used to reduce excess resources;

(v) Not have been used to reduce participation;

(vi) Not have been incurred during a transfer of asset penalty under WAC 182-513-1363; and

(vii) Be an amount for which the person remains liable.

(7) Nonallowable expenses. The following expenses are not allowed to reduce excess resources:

(a) Unpaid adult family home (AFH) or assisted living facility expenses incurred prior to medicaid eligibility;

(b) Personal care cost in excess of approved hours determined by the CARE assessment under chapter 388-106 WAC; and

(c) Expenses excluded by federal law.

(8) Excess home equity.

(a) A person with an equity interest in a primary residence in excess of the home equity limit is ineligible for long-term services and supports (LTSS) that are based on the need for either nursing facility level of care or intermediate care facility for the intellectually disabled level of care, unless one of the following persons lawfully resides in the home:

(i) That person's spouse; or

(ii) That person's dependent child under age twenty-one, blind child, or disabled child.

(b) The home equity provision applies to all applications for LTSS received on or after May 1, 2006.

(c) Effective January 1, 2016, the excess home equity limit is $552,000. On January 1, 2017, and on January 1st of each year thereafter, this standard may change by the percentage in the consumer price index-urban.

(d) A person who is denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver under WAC 182-513-1367.

(9) Institutional resource standards are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

NEW SECTION

WAC 182-513-1355 Allocating resources to a community spouse when determining resource eligibility for SSI-related long-term care services. (1) The agency or its designee uses this section to calculate the resource allocation from the institutionalized spouse to the community spouse for the determination of the institutionalized spouse's resource eligibility under WAC 182-513-1350 (2)(a)(ii).

(2) If the institutionalized spouse's most recent continuous period of institutionalization (MRCPI) began:

(a) Before October 1, 1989, the agency adds together one-half the total amount of countable resources, as determined under WAC 182-513-1350(4), held in the name of:

(i) The institutionalized spouse; and

(ii) Both spouses.

(b) On or after October 1, 1989, the agency or its designee adds together the total amount of countable resources, as determined under WAC 182-513-1350(4), held in the name of:

(i) Either spouse; and

(ii) Both spouses.

(3) If subsection (2)(b) of this section applies, the agency or its designee determines the amount of resources allocated to the community spouse, before determining the amount of countable resources used to establish eligibility for the institutionalized spouse under WAC 182-513-1350:

(a) If the institutionalized spouse's MRCPI began on or after October 1, 1989, and before August 1, 2003, the agency or its designee allocates the federal spousal resource maximum;

(b) If the institutionalized spouse's MRCPI began on or after August 1, 2003, the agency or its designee allocates the greater of:

(i) A spousal share equal to one-half of the couple's combined countable resources, up to the federal spousal resource maximum; or

(ii) The state spousal resource standard.

(4) Countable resources under subsection (3)(b) of this section determined as of the first day of the month in which MRCPI began.

(5) The agency or its designee uses a community spouse evaluation to determine the amount of the spousal share under subsection (3)(b)(i) of this section.

(6) The agency or its designee completes a community spouse resource evaluation:

(a) Upon request by the institutionalized spouse, or the institutionalized spouse's community spouse;

(b) At any time between the date that the MRCPI began and the date that eligibility for long-term care (LTC) is determined; and

(c) Upon receipt of any verification required to establish the amount of the couple's resources in the month of MRCPI.

(7) The community spouse resource evaluation can be completed prior to an application for LTC or as part of the LTC application if:

(a) The beginning of the MRCPI was prior to the month of application; and

(b) The spousal share exceeds the state spousal resource standard.

(8) The amount of allocated resources under subsection (3) of this section can be increased, but only if:

(a) A court has entered an order against the institutionalized spouse for the support of the community spouse or a dependent of either spouse; or

(b) A final order is entered under chapter 182-526 WAC, ruling that the institutionalized spouse or community spouse established that the income generated by the resources allocated under subsection (3) of this section is insufficient to raise the community spouse's income to the monthly maintenance needs allowance (MMNA) determined under WAC 182-513-1385, but only after the application of the income-first rule under 42 U.S.C. 1396r-5 (d)(6).

(9) If a final order establishes that the conditions identified in subsection (8)(b) of this section have been met, then an amount of allocated resources under subsection (3) of this section will be substituted by an amount adequate to provide such an MMNA.

(10) The institutionalized spouse has until the end of the month of the first regularly scheduled eligibility review to transfer countable resources in excess of $2000 to the community spouse.

(11) Standards in this section are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

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

WAC 182-513-1363 Evaluating ((~~the~~)) an asset transfer ((~~of assets on or after May 1, 2006 for persons~~)) for people applying for or receiving long-term care (LTC) services. ((~~This section describes how the department evaluates asset transfers made on or after May 1, 2006 and their affect on LTC services. This applies to transfers by the client, spouse, a guardian or through an attorney in fact. Clients subject to asset transfer penalty periods are not eligible for LTC services. LTC services for the purpose of this rule include nursing facility services, services offered in any medical institution equivalent to nursing facility services, and home and community-based services furnished under a waiver program. Program of all-inclusive care of the elderly (PACE) and hospice services are not subject to transfer of asset rules. The department must consider whether a transfer made within a specified time before the month of application, or while the client is receiving LTC services, requires a penalty period.~~

~~• Refer to WAC 388-513-1364 for rules used to evaluate asset transfers made on or after April 1, 2003 and before May 1, 2006.~~

~~• Refer to WAC 388-513-1365 for rules used to evaluate asset transfer made prior to April 1, 2003.~~

~~(1) When evaluating the effect of the transfer of asset made on or after May 1, 2006 on the client's eligibility for LTC services the department counts sixty months before the month of application to establish what is referred to as the "look-back" period.~~

~~(2) The department does not apply a penalty period to transfers meeting the following conditions:~~

~~(a) The total of all gifts or donations transferred do not exceed the average daily private nursing facility rate in any month;~~

~~(b) The transfer is an excluded resource described in WAC 388-513-1350 with the exception of the client's home, unless the transfer of the home meets the conditions described in subsection (2)(d);~~

~~(c) The asset is transferred for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:~~

~~(i) An intent to transfer the asset at FMV or other adequate compensation. To establish such an intent, the department must be provided with written evidence of attempts to dispose of the asset for fair market value as well as evidence to support the value (if any) of the disposed asset.~~

~~(ii) The transfer is not made to qualify for LTC services, continue to qualify, or avoid Estate Recovery. Convincing evidence must be presented regarding the specific purpose of the transfer.~~

~~(iii) All assets transferred for less than fair market value have been returned to the client.~~

~~(iv) The denial of eligibility would result in an undue hardship as described in WAC 388-513-1367.~~

~~(d) The transfer of ownership of the client's home, if it is transferred to the client's:~~

~~(i) Spouse; or~~

~~(ii) Child, who:~~

~~(A) Meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or~~

~~(B) Is less than twenty-one years old; or~~

~~(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided verifiable care that enabled the individual to remain in the home. A physician's statement of needed care is required; or~~

~~(iii) Brother or sister, who has:~~

~~(A) Equity in the home, and~~

~~(B) Lived in the home for at least one year immediately before the client's current period of institutional status.~~

~~(e) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);~~

~~(f) The transfer meets the conditions described in subsection (3), and the asset is transferred:~~

~~(i) To another person for the sole benefit of the spouse;~~

~~(ii) From the client's spouse to another person for the sole benefit of the spouse;~~

~~(iii) To trust established for the sole benefit of the individual's child who meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);~~

~~(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or~~

~~(3) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (2)(f), if the transfer or trust:~~

~~(a) Is established by a legal document that makes the transfer irrevocable;~~

~~(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and~~

~~(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term of the trust, whichever is less; and~~

~~(d) The requirements in subsection (2)(c) of this section do not apply to trusts described in WAC 388-561-0100 (6)(a) and (b) and (7)(a) and (b).~~

~~(4) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of long-term care service if:~~

~~(a) The transfer is in exchange for care services the family member provided the client;~~

~~(b) The client has a documented need for the care services provided by the family member;~~

~~(c) The care services provided by the family member are allowed under the medicaid state plan or the department's waiver services;~~

~~(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;~~

~~(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;~~

~~(f) The time for which care services are claimed is reasonable based on the kind of services provided; and~~

~~(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.~~

~~(5) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (4) as the transfer of an asset without adequate consideration.~~

~~(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the individual is not eligible for LTC services.~~

~~(7) If a client or the client's spouse transfers an asset on or after May 1, 2006, the department must establish a penalty period by adding together the total uncompensated value of all transfers made on or after May 1, 2006. The penalty period:~~

~~(a) For a LTC services applicant, begins on the date the client would be otherwise eligible for LTC services based on an approved application for LTC services or the first day after any previous penalty period has ended; or~~

~~(b) For a LTC services recipient, begins the first of the month following ten-day advance notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous penalty period has ended; and~~

~~(c) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later.~~

~~(8) If an asset is sold, transferred, or exchanged, the portion of the proceeds:~~

~~(a) That is used within the same month to acquire an excluded resource described in WAC 388-513-1350 does not affect the client's eligibility;~~

~~(b) That remain after an acquisition described in subsection (8)(a) becomes an available resource as of the first day of the following month.~~

~~(9) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC 388-513-1330 (5) through (7).~~

~~(10) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:~~

~~(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;~~

~~(b) The amount described in subsection (10)(a) is divided by the statewide average daily private cost for nursing facilities at the time of application; and~~

~~(c) A penalty period equal to the number of whole days found by following subsections (7)(a), (b), and (c).~~

~~(11) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses are receiving LTC services. When both spouses are receiving LTC services;~~

~~(a) We divide the penalty between the two spouses.~~

~~(b) If one spouse is no longer subject to a penalty (e.g. the spouse is no longer receiving institutional services or is deceased) any remaining penalty that applies to both spouses must be served by the remaining spouse.~~

~~(12) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter 388-02 WAC.~~

~~(13) Additional statutes which apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:~~

~~(a) RCW 74.08.331 Unlawful practices—Obtaining assistance—Disposal of realty;~~

~~(b) RCW 74.08.338 Real property transfers for inadequate consideration;~~

~~(c) RCW 74.08.335 Transfers of property to qualify for assistance; and~~

~~(d) RCW 74.39A.160 Transfer of assets—Penalties.~~))

(1) When determining a person's eligibility for long-term care (LTC) services, the agency or its designee evaluates the effect of an asset transfer made within the sixty-month period before the month that the person:

(a) Attained institutional status, or would have attained institutional status but for a period of ineligibility; and

(b) Applied for LTC services.

(2) The agency or its designee evaluates all transfers for recipients of LTC services made on or after the month the recipient attained institutional status.

(3) The agency or its designee establishes a period of ineligibility during which the person is not eligible for LTC services if the person, the person's spouse, or someone acting on behalf of either:

(a) Transfers an asset within the time period under subsection (1) or (2) of this section; and

(b) Does not receive adequate consideration for the asset, unless the transfer meets one of the conditions in subsection (4)(a) through (g) of this section.

(4) The agency or its designee does not apply a period of ineligibility for uncompensated value if:

(a) The total of all transfers in a month does not exceed the average daily private nursing facility rate in that month;

(b) The transferred resource was an excluded resource under WAC 182-513-1350 except a home, unless the transfer of the home meets the conditions under (d) of this subsection;

(c) The asset was transferred for less than fair market value (FMV), and the person can establish one of the following:

(i) An intent to transfer the asset at FMV. To establish such an intent, the agency or its designee must be provided with convincing evidence of the attempt to dispose the asset for FMV;

(ii) The transfer was not made to qualify for medicaid, continue to qualify for medicaid, or avoid estate recovery. Convincing evidence must be presented regarding the specific purpose of the transfer;

(iii) All assets transferred for less than FMV have been returned to the person or the person's spouse; or

(iv) The denial of eligibility would result in an undue hardship under WAC 182-513-1367;

(d) The transferred asset was a home, if the home was transferred to the person's:

(i) Spouse;

(ii) Child who meets the disability criteria under WAC 182-512-0050 (1)(b) or (c);

(iii) Child who was under age twenty-one; or

(iv) Child who lived in the home and provided care, but only if:

(A) The child lived in the person's home for at least two years;

(B) The child provided verifiable care during the time period in (d)(iv)(A) of this subsection for at least two years;

(C) The period of care under (d)(iv)(B) of this subsection was immediately before the person's current period of institutional status;

(D) The care was not paid for by medicaid;

(E) The care enabled the person to remain at home; and

(F) The person provided physician's documentation that the in-home care was necessary to prevent the person's current period of institutional status; or

(v) Sibling, who has lived in and has had an equity interest in the home for at least one year immediately before the date the person attained institutional status;

(e) The asset was transferred to the person's spouse; or to the person's child, if the child meets the disability criteria under WAC 182-512-0050 (1)(b) or (c);

(f) The transfer was to a family member before the current period of institutional status, and all the following conditions are met. If all the following conditions are not met, the transfer is an uncompensated transfer, regardless of consideration received:

(i) The transfer is in exchange for care services the family member provided to the person;

(ii) The person had a documented need for the care services provided by the family member;

(iii) The care services provided by the family member are allowed under the medicaid state plan or the department's home and community based waiver services;

(iv) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(v) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(vi) The time for which care services are claimed is reasonable based on the kind of services provided; and

(vii) The assets were transferred as the care services were performed, or with no more time delay than one calendar month between the provision of the service and the transfer.

(g) The transfer meets the conditions under subsection (5) of this section, and the asset is transferred; or

(i) To another party for the sole benefit of the person's spouse;

(ii) From the person's spouse to another party for the sole benefit of the spouse;

(iii) To a trust established for the sole benefit of the person's child who meets the disability criteria under WAC 182-512-0050 (1)(b) or (c); or

(iv) To a trust established for the sole benefit of a person who is under age sixty-five who meets the disability criteria under WAC 182-512-0050 (1)(b) or (c).

(5) An asset transfer or establishment of a trust is for the sole benefit of a person under subsection (4)(g) of this section if the document transferring the asset:

(a) Was made in writing;

(b) Is irrevocable;

(c) States that the person's spouse, blind or disabled child, or another disabled person can benefit from the transferred assets; and

(d) States that all assets involved must be spent for the sole benefit of the person over an actuarially sound period, based on the life expectancy of that person or the term of the document, whichever is less, unless the document is a trust that meets the conditions of a trust established under Section 42 U.S.C. 1396p (d)(4)(A) or Section 42 U.S.C. 1396 (d)(4)(C) as described under chapter 182-516 WAC.

(6) To calculate the period of ineligibility under subsection (3) of this section:

(a) Add together the total uncompensated value of all transfers under subsection (3) of this section; and

(b) Divide the total in (a) of this subsection by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later. The result is the length, in days rounded down to the nearest whole day, of the period of ineligibility;

(7) The period of ineligibility under subsection (6) of this section begins:

(a) For an LTC services applicant: The date the person would be otherwise eligible for LTC services, but for the transfer, based on an approved application for LTC services or the first day after any previous period of ineligibility has ended; or

(b) For an LTC services recipient: The first of the month following ten-day advance notice of the period of ineligibility, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous period of ineligibility has ended.

(8) The period of ineligibility ends after the number of whole days, calculated in subsection (6) of this section, pass from the date the period of ineligibility began in subsection (7) of this section.

(9) If the transfer was to the person's spouse, and it includes the right to receive an income stream, the agency or its designee determines availability of the income stream under WAC 182-513-1330.

(10) If the transferred asset for which adequate consideration was not received was made to someone other than the person's spouse and included the right to receive a stream of income not generated by the transferred asset, the length of the period of ineligibility is calculated and applied in the following way:

(a) The amount of reasonably anticipated future monthly income, after the transfer, is multiplied by the actuarial life expectancy in months of the person who owned the income. The actuarial life expectancy is based on age of the person in the month the transfer occurs;

(b) The amount in (a) of this subsection is divided by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later. The result is the length, in days rounded down to the nearest whole day, of the period of ineligibility; and

(c) The period of ineligibility begins under subsection (7) of this section and ends under subsection (8) of this section.

(11) A period of ineligibility for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses have attained institutional status. When both spouses are institutionalized, the agency or its designee divides the penalty equally between the two spouses. If one spouse is no longer subject to a period of ineligibility, the remaining period of ineligibility that applied to both spouses will be applied to the other spouse.

(12) Throughout this section, the date of an asset transfer is:

(a) For real property:

(i) The day the deed is signed by the grantor if the deed is recorded; or

(ii) The day the signed deed is delivered to the grantee;

(b) For all other assets, the day the intentional act or the failure to act resulted in the change of ownership or title.

(13) If a person or the person's spouse disagrees with the determination or application of a period of ineligibility, a hearing may be requested under chapter 182-526 WAC.

(14) Additional statutes that apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:

(a) RCW 74.08.331 Unlawful practices—Obtaining assistance—Disposal of realty—Penalties;

(b) RCW 74.08.338 Real property transfers for inadequate consideration;

(c) RCW 74.08.335 Transfers of property to qualify for assistance; and

(d) RCW 74.39A.160 Transfer of assets—Penalties.

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

WAC 182-513-1367 Hardship waivers ((~~for long-term care (LTC) services~~)). ((~~Clients~~)) (1) People who are denied or terminated from ((~~LTC~~)) long-term services and supports (LTSS) due to a transfer of asset penalty ((~~(described in WAC 388-513-1363, 388-513-1364 and 388-513-1365)~~)) under WAC 182-513-1363, or having excess home equity ((~~(described in WAC 388-513-1350)~~)) under WAC 182-513-1350 may apply for an undue hardship waiver. The agency or its designee gives notice of the right to apply for an undue hardship waiver ((~~will be given~~)) whenever there is a denial or termination based on an asset transfer or excess home equity. This section:

((~~•~~)) (a) Defines undue hardship;

((~~•~~)) (b) Specifies the approval criteria for an undue hardship request;

((~~•~~)) (c) Establishes the process the ((~~department~~)) agency or its designee follows for determining undue hardship; and

((~~•~~)) (d) Establishes the appeal process for a client whose request for an undue hardship is denied.

((~~(1) When does undue hardship exist?~~

~~(a)~~)) (2) Undue hardship ((~~may exist~~)) exists:

((~~(i) When a transfer of an asset occurs between:~~

~~(A) Registered domestic partners as described in chapter 26.60 RCW; or~~

~~(B) Same-sex couples who were married in states and the District of Columbia where same-sex marriages are legal; and~~

~~(C) The transfer would not have caused a period of ineligibility if made between an opposite sex married couple under WAC 388-513-1363.~~

~~(ii)~~)) (a) When a ((~~client~~)) person who transferred the assets or income, or on whose behalf the assets or income were transferred, either personally or through a spouse, guardian, or another person authorized to act on behalf of the person through a power of attorney document (attorney-in-fact), has exhausted all reasonable means including legal remedies to recover the assets or income or the value of the transferred assets or income that have caused a penalty period((~~; and~~

~~(iii) The client~~)) the person provides sufficient documentation to support ((~~their~~)) the efforts to recover the assets or income; or

((~~(iv) The client~~)) (b) The person is unable to access home equity in excess of the standard ((~~described in WAC 388-513-1350~~)) under WAC 182-513-1350; and

((~~(v)~~)) (c) When, without ((~~LTC~~)) LTSS benefits, the ((~~client~~)) person is unable to obtain:

((~~(A)~~)) (i) Medical care to the extent that ((~~his or her~~)) health or life is endangered; or

((~~(B)~~)) (ii) Food, clothing, shelter or other basic necessities of life.

((~~(b)~~)) (3) Undue hardship can be approved for an interim period while the client is pursuing recovery of the assets or income.

((~~(2)~~)) (4) Undue hardship does not exist:

(a) When the transfer of asset penalty period or excess home equity provision inconveniences a ((~~client~~)) person or restricts ((~~their~~)) the person's lifestyle but does not seriously deprive ((~~him or her~~)) the person as defined in subsection ((~~(1)(a)(iii)~~)) (2)(c)(i) and (ii) of this section;

(b) When the resource is transferred to a person who is handling the financial affairs of the ((~~client~~)) person; or

(c) When the resource is transferred to another person by the individual that handles the financial affairs of the ((~~client~~)) person.

((~~(d)~~)) (5) Undue hardship may exist under subsection (4)(b) and (c) of this section if ((~~DSHS~~)) the department has found evidence of financial exploitation.

((~~(3) How is an undue hardship waiver requested?~~

~~(a)~~)) (6) An undue hardship waiver may be requested by:

((~~(i)~~)) (a) The ((~~client~~)) person;

((~~(ii)~~)) (b) The ((~~client's~~)) person's spouse;

((~~(iii)~~)) (c) The ((~~client's~~)) person's authorized representative((~~;~~

~~(iv) The client's power of attorney~~)); or

((~~(v)~~)) (d) With the consent of the ((~~client or their~~)) person, the person's guardian, or a medical institution, as defined in WAC ((~~182-500-0005~~)) 182-500-0050, in which an institutionalized ((~~client~~)) person resides.

((~~(b)~~)) (7) The hardship waiver request must:

((~~(i)~~)) (a) Be in writing;

((~~(ii)~~)) (b) State the reason for requesting the hardship waiver;

((~~(iii)~~)) (c) Be signed by the requestor and include the requestor's name, address and telephone number. If the request is being made on behalf of a ((~~client~~)) person, then the ((~~client's~~)) person's name, address and telephone number must be included;

((~~(iv)~~)) (d) Be made within thirty days of the date of denial or termination of ((~~LTC services~~)) LTSS; and

((~~(v)~~)) (e) Returned to the originating address on the denial/termination letter.

((~~(4) What if additional information is needed to determine a hardship waiver?~~

~~(a)~~)) (8) If additional information is needed to determine a hardship waiver, the agency or its designee sends a written notice to the ((~~client is sent~~)) person requesting additional information within fifteen days of the request for an undue hardship waiver. The person may request additional time to provide the information ((~~can be requested by the client.~~

~~(5) What happens if my hardship waiver is approved?~~)).

(9) If the hardship is approved:

(a) The ((~~department~~)) agency sends a notice within fifteen days of receiving all information needed to determine a hardship waiver. The approval notice specifies a time period the undue hardship waiver is approved.

(b) Any changes in a ((~~client's~~)) person's situation that led to the approval of a hardship must be reported to the ((~~department by the tenth of the month following~~)) agency or its designee within thirty days of the change per WAC ((~~388-418-0007~~)) 182-504-0110.

(((~~6) What happens if my~~)) (10) If the hardship waiver is denied((~~?~~)):

(a) The ((~~department~~)) agency or its designee sends a denial notice within fifteen days of receiving the requested information. The letter will state the reason it was not approved.

(b) The denial notice ((~~will have~~)) has instructions on how to request an administrative hearing. The ((~~department~~)) agency or its designee must receive an administrative hearing request within ninety days of the date of the adverse action or denial.

(((~~7) What statute or rules govern administrative hearings?~~

~~(a) An administrative hearing held under this section is governed by chapters 34.05 RCW and chapter 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.~~

~~(8) Can the department revoke an approved undue hardship waiver?~~

~~(a) The department~~)) (11) If there is a conflict between this section and chapter 182-526 WAC, this section prevails.

(12) The agency or its designee may revoke approval of an undue hardship waiver if any of the following occur:

(((~~i~~))) (a) A ((~~client~~)) person, or ((~~his or her~~)) the person's authorized representative, fails to provide timely information ((~~and/or~~)) or resource verifications as it applies to the hardship waiver when requested by the ((~~department~~)) agency or its designee per WAC ((~~388-490-0005 and 388-418-0007 or 182-504-0125~~)) 182-503-0050 and 182-504-0105;

(((~~ii~~))) (b) The lien or legal impediment that restricted access to home equity in excess of ((~~five hundred thousand dollars~~)) the home equity limit is removed; or

(((~~iii~~))) (c) Circumstances for which the undue hardship was approved have changed.

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

WAC 182-513-1380 Determining a ((~~client's~~)) person's financial participation in the cost of care for long-term care (((~~LTC) services~~)) in a medical institution. This rule describes how the ((~~department~~)) agency or its designee allocates income and excess resources when determining participation in the cost of care (((~~the post-eligibility process). The department applies rules described in WAC 388-513-1315 to define which income and resources must be used in this process.~~

~~(1) For a client receiving institutional or hospice services in a medical institution, the department applies all subsections of this rule.~~

~~(2) For a client receiving waiver services at home or in an alternate living facility, the department applies only those subsections of this rule that are cited in the rules for those programs.~~

~~(3) For a client receiving hospice services at home, or in an alternate living facility, the department applies rules used for the community options program entry system (COPES) for hospice applicants with gross income under the medicaid special income level (SIL) (three hundred percent of the federal benefit rate (FBR)), if the client is not otherwise eligible for another noninstitutional categorically needy medicaid program. (Note: For hospice applicants with income over the medicaid SIL, medically needy medicaid rules apply.)~~

~~(4) The department~~)) in a medical institution.

(1) The agency or its designee defines which income and resources must be used in this process under WAC 182-513-1315.

(2) The agency or its designee allocates nonexcluded income in the following order, and the combined total of (((~~4~~))) (a), (b), (c), and (d) of this subsection cannot exceed the effective one-person medically needy income level (MNIL):

(a) A personal needs allowance (PNA) of:

(i) ((~~Seventy dollars~~)) For the following ((~~clients~~)) people who receive a needs-based veteran's pension in excess of $90 and live in a state veteran's home ((~~and receive a needs-based veteran's pension in excess of ninety dollars~~)), $70:

(A) A veteran without a spouse or dependent child((~~.~~)); or

(B) A veteran's surviving spouse with no dependent children((~~.~~));

(ii) For people who live in a state veteran's home and receive a pension of less than $90, the difference between ((~~one hundred sixty dollars~~)) $160 and the needs-based veteran's pension amount ((~~for persons specified in subsection (4)(a)(i) of this section who receive a veteran's pension less than ninety dollars.~~));

(iii) ((~~One hundred sixty dollars~~)) For a ((~~client~~)) person living in a state veterans' home who does not receive a needs-based veteran's pension, $160;

(iv) ((~~Forty-one dollars and sixty-two cents~~)) For all ((~~clients~~)) people in a medical institution receiving aged, blind, disabled, (ABD) or temporary assistance for needy families (TANF) cash assistance((~~.~~)), $41.62; or

(v) For all other ((~~clients~~)) people in a medical institution ((~~the PNA is fifty-seven dollars and twenty-eight cents.~~

~~(vi) Current PNA and long-term care standards can be found at http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)), $57.28.

(b) Mandatory federal, state, or local income taxes owed by the ((~~client~~)) person.

(c) Wages for a ((~~client~~)) person who:

(i) Is related to the supplemental security income (SSI) program ((~~as described in~~)) under WAC 182-512-0050(1); and

(ii) Receives the wages as part of ((~~a~~)) an agency-approved or department-approved training or rehabilitative program designed to prepare the ((~~client~~)) person for a less restrictive placement. When determining this deduction, employment expenses are not deducted.

(d) Guardianship fees and administrative costs, including any attorney fees paid by the guardian, ((~~after June 15, 1998, only~~)) as allowed ((~~by chapter 388-79 WAC~~)) under WAC 182-513-1505 through 182-513-1525 .

(((~~5) The department~~)) (3) The agency or its designee allocates nonexcluded income after deducting amounts

((~~described in~~)) under subsection ((~~(4)~~)) (2) of this section in the following order:

(a) Current or back child support garnished or withheld from income according to a child support order in the month of the garnishment if it is:

(i) For the current month((~~;~~

~~(i)~~));

(ii) For the time period covered by the PNA; and

((~~(ii) Is~~)) (iii) Not counted as the dependent member's income when determining the ((~~family~~)) dependent allocation amount under WAC 182-513-1385.

(b) A monthly maintenance needs allowance for the community spouse ((~~not to exceed, effective January 1, 2008, two thousand six hundred ten dollars, unless a greater amount is allocated as described in subsection (7) of this section. The community spouse maintenance allowance may change each January based on the consumer price index. Starting January 1, 2008 and each year thereafter the community spouse maintenance allocation can be found in the long-term care standards chart at http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml. The monthly maintenance needs allowance:~~

~~(i) Consists of a combined total of both:~~

~~(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st; and~~

~~(B) Excess shelter expenses as described under subsection (6) of this section.~~

~~(ii) Is reduced by the community spouse's gross countable income; and~~

~~(iii) Is allowed only to the extent the client's income is made available to the community spouse.~~

~~(c) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of the community spouse or institutionalized person who:~~

~~(i) Resides with the community spouse:~~

~~(A) For each child, one hundred and fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income). This standard is called the community spouse (CS) and family maintenance standard and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.~~

~~(ii) Does not reside with the community spouse or institutionalized person, in an amount equal to the effective one-person MNIL for the number of dependent family members in the home less the dependent family member's income.~~

~~(iii) Child support received from a noncustodial parent is the child's income.~~)) as determined using the calculation under WAC 182-513-1385. If the community spouse is also receiving long-term care services, the allocation is limited to an amount that brings the community spouse's income to the PNA.

(c) A dependent allowance for each dependent of the institutionalized person or the person's spouse, as determined using the calculation under WAC 182-513-1385.

(d) Medical expenses incurred by the ((~~institutional client~~)) institutionalized individual and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(e) Maintenance of the home of a single institutionalized ((~~client~~)) person or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the ((~~client~~)) person is likely to return to the home within the six-month period; and

(iv) When social services staff documents the need for the income ((~~exemption~~)) deduction.

((~~(6) For the purposes of this section, "excess shelter expenses" means the actual expenses under subsection (6)(b) less the standard shelter allocation under subsection (6)(a). For the purposes of this rule:~~

~~(a) The standard shelter allocation is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and is found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; and~~

~~(b) Shelter expenses are the actual required maintenance expenses for the community spouse's principal residence for:~~

~~(i) Rent;~~

~~(ii) Mortgage;~~

~~(iii) Taxes and insurance;~~

~~(iv) Any maintenance care for a condominium or cooperative; and~~

~~(v) The food stamp standard utility allowance described in WAC 388-450-0195, provided the utilities are not included in the maintenance charges for a condominium or cooperative.~~

~~(7) The amount allocated to the community spouse may be greater than the amount in subsection (6)(b) only when:~~

~~(a) A court enters an order against the client for the support of the community spouse; or~~

~~(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.~~

~~(8) A client who is admitted to a medical facility for ninety days or less and continues to receive full SSI benefits is not required to use the SSI income in the cost of care for medical services. Income allocations are allowed as described in this section from non-SSI income.~~

~~(9)~~)) (4) A person may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the participation.

(5) A person is responsible to pay only up to the state rate for the cost of care. If long-term care insurance pays a portion of the state rate cost of care, a person pays only the difference up to the state rate cost of care.

(6) When a person lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the person has in a month.

(7) Standards ((~~described in~~)) under this section for long-term care ((~~can be~~)) are found at((~~: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/standards-ltc.

NEW SECTION

WAC 182-513-1385 Determining the community spouse monthly maintenance needs allowance and dependent allowance in post-eligibility treatment of income for long-term care (LTC) programs. (1) This section describes how to calculate the monthly maintenance needs allowance (MMNA) in post-eligibility treatment of income for long-term care (LTC) programs for a community spouse or dependent of the institutionalized individual.

(2) The community spouse MMNA standards are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/standards-ltc, unless a greater amount is calculated under subsection (5) of this section. The MMNA standards may change each January and July based on the consumer price index.

(3) The community spouse MMNA is allowed only to the extent that the institutionalized spouse's income is made available to the community spouse, and is calculated as follows:

(a) The minimum MMNA as calculated in subsection (4)(a) of this section plus excess shelter expenses as calculated in subsection (4)(b) of this section;

(i) The total under (a) of this subsection cannot be less than the minimum MMNA; and

(ii) If the total under subsection (4)(a) of this section exceeds the maximum MMNA, the maximum MMNA is the result under subsection (4)(a) of this section; and

(b) The total under subsection (4)(a) of this section is reduced by the community spouse's gross income. The result is the MMNA.

(4) The minimum MMNA and excess shelter expense values are calculated as follows:

(a) The minimum MMNA is one hundred fifty percent of the two-person federal poverty level (FPL); and

(b) If excess shelter expenses are less than zero, the result is zero. Excess shelter expenses are calculated as follows:

(i) Add:

(A) Mortgage or rent, which includes space rent for mobile homes;

(B) Real property taxes;

(C) Homeowner's insurance;

(D) Required maintenance fees for a condominium, cooperative, or homeowner's association that are recorded in a covenant; and

(E) The food assistance standard utility allowance (SUA) under WAC 388-450-0195 minus the cost of any utilities that are included in (b)(i)(D) of this subsection.

(ii) Subtract the standard shelter allocation from the total in (b)(i) of this subsection. The standard shelter allocation is thirty percent of one hundred fifty percent of the two-person FPL. The result is the value of excess shelter expenses.

(5) The amount allocated to the community spouse may be greater than the amount determined in subsection (3) of this section, but only if:

(a) A court order has been entered against the institutionalized spouse approving a higher MMNA for the support of the community spouse; or

(b) A final order has been entered after an administrative hearing has been held under chapter 182-526 WAC ruling the institutionalized spouse or the community spouse established the community spouse needs income, above the level otherwise provided by the MMNA, due to exceptional circumstances causing significant financial duress.

(6) If a final order establishes that the conditions identified in subsection (5)(b) of this section have been met, then an amount of allocated resources under subsection (3) of this section will be substituted by an amount adequate to provide such an MMNA.

(7) The agency or its designee determines the dependent allowance for dependents of the institutionalized individual or the institutionalized individual's spouse. The amount the agency allows depends on whether the dependent resides with the community spouse.

(a) For each dependent who resides with the community spouse:

(i) Subtract the dependent's income from one hundred fifty percent of the two-person FPL;

(ii) Divide the amount determined in (a)(i) of this subsection by three;

(iii) The result is the dependent allowance for that dependent.

(b) For each dependent who does not reside with the community spouse:

(i) The agency determines the effective MNIL standard based on the number of dependent family members in the home;

(ii) Subtracts each dependent's separate income;

(iii) The result is the dependent allowance for the dependents.

(c) Child support received from a noncustodial parent is the child's income.

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

WAC 182-513-1395 Determining eligibility for institutional ((~~or hospice~~)) services for ((~~individuals~~)) people living in a medical institution under the SSI-related medically needy ((~~(MN)~~)) program. ((~~This section describes how the department determines a client's eligibility for institutional or hospice services in a medical institution and for facility care only under the MN program. In addition, this section describes rules used by the department to determine whether a client approved for these benefits is also eligible for noninstitutional medical assistance in a medical institution under the MN program.~~

~~(1) To be eligible for institutional or hospice services under the MN program for individuals living in a medical institution, a client must meet the financial requirements described in subsection (5). In addition, a client must meet program requirements described in WAC 388-513-1315; and~~

~~(a) Be an SSI-related client with countable income as described in subsection (4)(a) that is more than the special income level (SIL); or~~

~~(b) Be a child not described in subsection (1)(a) with countable income as described in subsection (4)(b) that exceeds the categorically needy (CN) standard for the children's medical program.~~

~~(2) For an SSI-related client, excess resources are reduced by medical expenses as described in WAC 388-513-1350 to the resource standard for a single or married individual.~~

~~(3) The department determines a client's countable resources for institutional and hospice services under the MN programs as follows:~~

~~(a) For an SSI-related client, the department determines countable resources per WAC 388-513-1350.~~

~~(b) For a child not described in subsection (3)(a), no determination of resource eligibility is required.~~

~~(4) The department determines a client's countable income for institutional and hospice services under the MN program as follows:~~

~~(a) For an SSI-related client, the department reduces available income as described in WAC 388-513-1325 and 388-513-1330 by:~~

~~(i) Excluding income described in WAC 388-513-1340;~~

~~(ii) Disregarding income described in WAC 388-513-1345; and~~

~~(iii) Subtracting previously incurred medical expenses incurred by the client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC 388-513-1350.~~

~~(b) For a child not described in subsection (4)(a), the department:~~

~~(i) Follows the income rules described in WAC 182-505-0210 for the children's medical program; and~~

~~(ii) Subtracts the medical expenses described in subsection (4).~~

~~(5) If the income remaining after the allowed deductions described in WAC 388-513-1380, plus countable resources in excess of the standard described in WAC 388-513-1350(1), is less than the department-contracted rate times the number of days residing in the facility the client:~~

~~(a) Is eligible for institutional or hospice services in a medical institution, and medical assistance;~~

~~(b) Is approved for twelve months; and~~

~~(c) Participates income and excess resources toward the cost of care as described in WAC 388-513-1380.~~

~~(6) If the income remaining after the allowed deductions described in WAC 388-513-1380 plus countable resources in excess of the standard described in WAC 388-513-1350(1) is more than the department-contracted rate times the number of days residing in the facility the client:~~

~~(a) Is not eligible for payment of institutional services; and~~

~~(b) Eligibility is determined for medical assistance only as described in chapter 182-519 WAC.~~

~~(7) If the income remaining after the allowed deductions described in WAC 388-513-1380 is more than the department contracted nursing facility rate based on the number of days the client is in the facility, but less than the private nursing rate plus the amount of medical expenses not used to reduce excess resources the client:~~

~~(a) Is eligible for nursing facility care only and is approved for a three or six month based period as described in chapter 182-519 WAC. This does not include hospice in a nursing facility; and~~

~~(i) Pays the nursing home at the current state rate;~~

~~(ii) Participates in the cost of care as described in WAC 388-513-1380; and~~

~~(iii) Is not eligible for medical assistance or hospice services unless the requirements in (6)(b) is met.~~

~~(b) Is approved for medical assistance for a three or six month base period as described in chapter 182-519 WAC, if:~~

~~(i) No income and resources remain after the post eligibility treatment of income process described in WAC 388-513-1380.~~

~~(ii) Medicaid certification is approved beginning with the first day of the base period.~~

~~(c) Is approved for medical assistance for up to three or six months when they incur additional medical expenses that are equal to or more than excess income remaining after the post eligibility treatment of income process described in WAC 388-513-1380.~~

~~(i) This process is known as spenddown and is described in WAC 182-519-0100.~~

~~(ii) Medicaid certification is approved on the day the spenddown is met.~~

~~(8) If the income remaining after the allowed deductions described in WAC 388-513-1380, plus countable resources in excess of the standard described in WAC 388-513-1350 is more than the private nursing facility rate times the number of days in a month residing in the facility, the client:~~

~~(a) Is not eligible for payment of institutional services.~~

~~(b) Eligibility is determined for medical assistance only as described in chapter 182-519 WAC.~~)) (1) For the purposes of this section only, "remaining income" means all gross nonexcluded income remaining after the post-eligibility calculation under WAC 182-513-1380.

(2) General information. To be eligible for institutional services when living in a medical institution under the SSI-related medically needy (MN) program, a person must:

(a) Meet program requirements under WAC 182-513-1315;

(b) Have gross nonexcluded income in excess of the special income level (SIL) defined under WAC 182-513-1100; and

(c) Meet the financial requirements of subsection (3) or (4) of this section.

(3) Financial eligibility.

(a) The agency or its designee determines a person's resource eligibility, excess resources, and medical expense deductions using WAC 182-513-1350.

(b) The agency or its designee determines a person's countable income by:

(i) Excluding income under WAC 182-513-1340;

(ii) Determining available income under WAC 182-513-1325 or 182-513-1330;

(iii) Disregarding income under WAC 182-513-1345; and

(iv) Deducting medical expenses that were not used to reduce excess resources under WAC 182-513-1350.

(4) Eligibility for agency payment to the facility for institutional services and the MN program.

(a) If a person's remaining income plus excess resources is less than, or equal to, the state-contracted daily rate times the number of days the person has resided in the facility, the person:

(i) Is eligible for agency payment to the facility for institutional services and the MN program; and

(ii) Is approved for a twelve-month certification period.

(b) The person must pay income and excess resources towards the cost of care under WAC 182-513-1380.

(5) Eligibility for agency payment to the facility for institutional services and MN spenddown. If a person's remaining income is more than the state-contracted daily rate times the number of days the person has resided in the facility, but less than the private nursing facility rate for the same period, the person:

(a) Is eligible to receive institutional services at the state-contracted rate; and

(i) Is approved for a three-month or six-month base period;

(ii) Pays income and excess resources towards the state-contracted cost of care under WAC 182-513-1380; and

(b) Is eligible for the MN program for the same three-month or six-month base period when the total of additional medical expenses incurred during the base period exceeds:

(i) The total remaining income for all months of the base period;

(ii) Minus the total state-contracted rate for all months of the base period.

(6) If a person has excess resources and the person's remaining income is more than the state-contracted daily rate times the number of days the person has resided in the facility, the person is not eligible to receive institutional services and the MN program.

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

WAC 182-513-1396 ((~~Clients~~)) People living in a fraternal, religious, or benevolent nursing facility. ((~~This section describes how the department determines eligibility for institutional services and noninstitutional medical assistance for a client living in a fraternal, religious, or benevolent nursing facility.~~

~~(1) For a client living in a licensed nursing facility operated by a fraternal, religious, or benevolent organization who meets all other eligibility requirements, the department approves institutional services and noninstitutional medical assistance, if:~~

~~(a) Any contract between the client and the facility excludes such benefits on a free or prepaid basis for life; or~~

~~(b) The facility is unable to fulfill the terms of the contract and has:~~

~~(i) Voided the contract; and~~

~~(ii) Refunded any of the client's existing assets to the client.~~

~~(2) For a client described in subsection (1), the department denies institutional services and noninstitutional medical assistance, if the client:~~

~~(a) Signs a contract with the organization that includes such benefits on a free or prepaid basis for life; and~~

~~(b) Surrenders income and/or resources to the organization in exchange for such benefits.~~)) (1) The agency or its designee determines apple health coverage under noninstitutional rules for a person who meets all other eligibility requirements and lives in a licensed, but nonmedicaid-contracted facility operated by a fraternal, religious, or benevolent organization.

(2) Nothing in subsection (1) of this section prevents the agency or its designee from evaluating contracts with facilities not described in subsection (1) of this section.

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

WAC 182-513-1397 Treatment of entrance fees ((~~of individuals~~)) for people residing in a continuing care retirement ((~~communities~~)) community or a life care community. ((~~The following rule applies to long-term care medicaid applicants who reside in a continuing care retirement communities or life care communities that collect an entrance fee on admission from residents:~~

~~(1) Treatment of entrance fee. An individual's~~)) (1) A person's entrance fee in a continuing care retirement community or life care community is ((~~considered a~~)) an available resource ((~~available~~)) to the ((~~individual~~)) person, to the extent that:

(a) The ((~~individual~~)) person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the ((~~individual~~)) person be insufficient to pay for care((~~.~~));

(b) The ((~~individual~~)) person is eligible for a refund of any remaining entrance ((~~free~~)) fee when the ((~~individual~~)) person dies or when the person terminates the continuing care retirement community or life care community contract and leaves the community; and

(c) The entrance ((~~free~~)) fee does not confer an ownership interest in the continuing care retirement community or life care community.

(2) Nothing in subsection (1) of this section prevents the agency or its designee from evaluating contracts with facilities not described in subsection (1) of this section.

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

WAC 182-513-1400 Long-term care (LTC) partnership program (index). Under the long-term care (LTC) partnership program, ((~~individuals~~)) people who purchase qualified long-term care partnership insurance policies can apply for long-term care medicaid under special rules for determining financial eligibility. These special rules generally allow the ((~~individual~~)) person to protect assets up to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for long-term care medicaid and will not subsequently be subject to estate recovery for medicaid and long-term care services paid. The Washington long-term care partnership program is effective on December 1, 2011.

The following rules govern long-term care eligibility under the long-term care partnership program:

(1) WAC ((~~388-513-1405~~)) 182-513-1405 Definitions.

(2) WAC ((~~388-513-1410 What qualifies as a~~)) 182-513-1410 LTC partnership policy((~~?~~)) qualifications.

(3) WAC ((~~388-513-1415 What~~)) 182-513-1415 Assets that can't be protected under the LTC partnership provisions((~~?~~)).

(4) WAC ((~~388-513-1420 Who is eligible~~)) 182-513-1420 Eligibility for asset protection under a ((~~LTC~~)) partnership policy((~~?~~)).

(5) WAC ((~~388-513-1425 When would I not qualify~~)) 182-513-1425 Not qualifying for LTC medicaid if ((~~I have a~~)) an LTC partnership policy ((~~that does not have exhausted benefits?~~)) is in pay status.

(6) WAC ((~~388-513-1430 What~~)) 182-513-1430 Change of circumstances that must ((~~I report when I have a~~)) be reported when there is an LTC partnership policy paying a portion of ((~~my~~)) care((~~?~~)).

(7) WAC ((~~388-513-1435 Will~~)) 182-513-1435 When Washington recognizes ((~~a~~)) an LTC partnership policy purchased in another state((~~?~~)).

(8) WAC ((~~388-513-1440~~)) 182-513-1440 Determining how many ((~~of my~~)) assets can be protected((~~?~~)).

(9) WAC ((~~388-513-1445 How do I designate~~)) 182-513-1445 Designating a protected asset and ((~~what~~)) required proof ((~~is required?~~)).

(10) WAC ((~~388-513-1450~~)) 182-513-1450 How ((~~does~~)) the transfer of assets affects LTC partnership and medicaid eligibility((~~?~~)).

(11) WAC ((~~388-513-1455 If I have~~)) 182-513-1455 Protected assets under ((~~a~~)) an LTC partnership policy((~~, what happens~~)) after ((~~my~~)) death((~~?~~)).

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

WAC 182-513-1405 Definitions. For purposes of ((~~this section~~)) WAC 182-513-1400 through 182-513-1455, the following terms have the meanings ((~~given them. Additional definitions can be found at~~)) stated. See chapter ((~~388-500~~)) 182-500 WAC and WAC ((~~388-513-1301~~)) 182-513-1100 for additional definitions.

"Issuer" means any entity that delivers, issues for delivery, or provides coverage to, a resident of Washington, any policy that claims to provide asset protection under the Washington long-term care partnership act, chapter 48.85 RCW. ((~~Issuer~~)) As used in this chapter, issuer specifically includes insurance companies, fraternal benefit societies, health care service contractors, and health maintenance organizations.

"Long-term care (LTC) insurance" means a policy ((~~described in~~)) under chapter 284-83 WAC.

((~~**"Long-term care services"** means services received in a medical institution, or under a home and community based waiver authorized by home and community services or division of developmental disabilities. Hospice services are considered long-term care services for the purposes of the long-term care partnership when medicaid eligibility is determined under chapter 388-513 or 388-515 WAC.~~))

"Protected assets" means assets that are designated as excluded or not taken into account upon determination of long-term care medicaid eligibility ((~~described in WAC 388-513-1315~~)) under WAC 182-513-1315. The protected or excluded amount is up to the dollar amount of benefits that have been paid for long-term care services by the qualifying long-term care partnership policy on the medicaid applicant's or client's behalf. The assets are also protected or excluded for the purposes of estate recovery ((~~described in chapter 388-527~~)) under chapter 182-527 WAC, ((~~in~~)) up to the amount of benefits paid by the qualifying policy for medical and long-term care services.

"Qualified long-term care insurance partnership" means an agreement between the Centers for Medicare and Medicaid Services (CMS), and the health care authority (HCA) which allows for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of ((~~an individual~~)) a person who is a beneficiary under a long-term care insurance policy that has been determined by the Washington state insurance commission to meet the requirements of section 1917 (b)(1)(c)(iii) of the act. These policies are described in chapter 284-83 WAC.

"Reciprocity Agreement" means an agreement between states approved under section 6021(b) of the Deficit Reduction Act of 2005, Public Law 109-171 (DRA) under which the states agree to provide the same asset protections for qualified partnership policies purchased by ((~~an individual~~)) a person while residing in another state and that state has a reciprocity agreement with the state of Washington.

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

WAC 182-513-1410 ((~~What qualifies as a~~)) LTC partnership policy((~~?~~)) qualifications. A LTC partnership policy is a LTC policy that has been approved by the office of insurance commissioner as a LTC partnership policy described in chapter 284-83 WAC.

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

WAC 182-513-1415 ((~~What~~)) Assets that can't be protected under the LTC partnership provisions((~~?~~)). The following assets cannot be protected under a LTC partnership policy.

(1) Resources in a trust ((~~described in WAC 388-561-0100~~)) under WAC 182-516-0100 (6) and (7).

(2) Annuity interests in which Washington must be named as a preferred remainder beneficiary as ((~~described in WAC 388-561-0201~~)) under WAC 182-516-0201.

(3) Home equity in excess of the standard ((~~described in WAC 388-513-1350~~)) under WAC 182-513-1350. Individuals who have excess home equity interest are not eligible for long-term care medicaid services.

(4) Any portion of the value of an asset that exceeds the dollar amount paid out by the LTC partnership policy.

(5) The unprotected value of any partially protected asset (((~~an example would be the home~~))) is subject to estate recovery described in chapter ((~~388-527~~)) 182-527 WAC.

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

WAC 182-513-1420 ((~~Who is eligible~~)) Eligibility for asset protection under a partnership policy((~~?~~)). (1) The LTC partnership policy must meet all the requirements in chapter 284-83 WAC. For existing LTC policies which are converted to a LTC partnership policy via an exchange or through the addition of a policy rider or endorsement, the conversion must take place on or after December 1, 2011 unless the policy is paying out benefits at the time the policy is exchanged.

(2) You meet all applicable eligible requirements for LTC medicaid and:

(a) Your LTC partnership policy benefits have been exhausted and you are in need of LTC services.

(b) Your LTC partnership policy is not exhausted and is:

(i) Covering all costs in a medical institution and you are still in need for medicaid; or

(ii) Covering a portion of the LTC costs under your LTC partnership policy but does not meet all of your LTC needs.

(c) At the time of your LTC partnership policy has paid out more benefits than you have designated as protected. In this situation your estate can designate additional assets to be excluded from the estate recovery process up to the dollar amount the LTC partnership policy has paid out.

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

WAC 182-513-1425 ((~~When would I not qualify~~)) Not qualifying for LTC medicaid if ((~~I have a~~)) an LTC partnership policy is in pay status((~~?~~)). You are not eligible for long-term care (LTC) medicaid when the following applies:

(1) The income you have available to pay toward your cost of care ((~~described in WAC 388-513-1380~~)) under WAC 182-513-1380, combined with the amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate at the institution.

(2) The income you have available to pay toward your cost of care on a home and community based (HCB) waiver ((~~described in chapter 388-515~~)) under chapter 182-515 WAC, combined with the amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate in a home or residential setting.

(3) You fail to meet another applicable eligibility requirement for LTC medicaid.

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

WAC 182-513-1430 ((~~What~~)) Change of circumstances that must ((~~I report~~)) be reported when ((~~I have a~~)) there is an LTC partnership policy paying a portion of ((~~my~~)) care((~~?~~)). You must report changes described in WAC ((~~388-418-0005~~)) 182-504-0105 plus the following:

(1) You must report and verify the value of the benefits that your issuer has paid on your behalf under the long-term care (LTC) partnership policy upon request by the ((~~department~~)) agency, and at each annual eligibility review.

(2) You must provide proof when you have exhausted the benefits under your LTC partnership policy.

(3) You must provide proof if you have given away or transferred assets that you have previously designated as protected. Although, there is no penalty for the transfer of protected assets once you have been approved for LTC medicaid, the value of transferred assets reduces the total dollar amount that is designated as protected and must be verified.

(4) You must provide proof if you have sold an asset or converted a protected asset into cash or another type of asset. You will need to make changes in the asset designation and verify the type of transaction and new value of the asset.

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

WAC 182-513-1435 ((~~Will~~)) When Washington recognizes ((~~a~~)) an LTC partnership policy purchased in another state((~~?~~)). The Washington long term care partnership program provides reciprocity with respect to qualifying long-term care insurance policies covered under other state long-term care insurance partnerships. This allows you to purchase a partnership policy in one state and move to Washington without losing your asset protection. If your LTC policy is in pay status at the time you move to Washington and you are otherwise eligible for LTC medicaid, Washington will recognize the amount of protection you accumulated in the other state.

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

WAC 182-513-1440 Determining how many of my assets can be protected((~~?~~)). You can protect assets based on the amount paid by your LTC partnership policy. Assets are protected in both LTC eligibility and estate recovery. If the partnership for long-term care program is discontinued, an individual who purchased an approved plan before the date the program is discontinued remains eligible to receive dollar-for-dollar asset disregard and asset protection under the long-term care (LTC) medicaid program.

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

WAC 182-513-1445 ((~~How do I designate~~)) Designating a protected asset and ((~~what~~)) required proof ((~~is required?~~)). (1) Complete a ((~~DSHS~~)) department of social and health services (DSHS) 10-438 long-term care partnership (LTCP) asset designation form listing assets and the full fair market value that are earmarked as protected at the time of initial application for ((~~LTC~~)) long-term services and supports under medicaid.

(a) The full fair market value (FMV) of real property or interests in real property will be based on the current assessed value for property tax purposes for real property. A professional appraisal by a licensed appraiser can establish the current value if the assessed value is disputed.

(b) The value of a life estate in real property is determined using the life estate tables found ((~~in: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCO~~

~~appendix2.shtml~~)) at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/determining-value-life-estates.

(c) If you own an asset with others, you can designate the value of your ((~~pro-rata~~)) pro rata equity share.

(d) If the dollar amount of the benefits paid under a LTCP policy is greater than the fair market value of all assets protected at the time of the application for long-term care medicaid, you may designate additional assets for protection under this section. The DSHS LTCP asset designation form must be submitted with the updated assets indicated along with proof of the current value of designated assets.

(e) The value of your assets protected for you under your LTC partnership policy do not carry over to your spouse should ((~~they~~)) the spouse need medicaid ((~~long-term care~~)) LTC services during or after your lifetime ((~~or after your death~~)). If your surviving spouse has ((~~their own~~)) an LTC partnership policy ((~~he or she~~)) the spouse may designate assets based on the dollar amount paid under ((~~his or her~~)) the spouse's own policy.

(f) Assets designated as protected under this subsection will not be subject to transfer penalties ((~~described in WAC 388-513-1363~~)) under WAC 182-513-1363.

(2) Proof of the current fair market value of all protected assets is required at the initial application and each annual review.

(3) Submit current verification from the issuer of the LTCP policy of the current dollar value paid toward ((~~long-term care~~)) LTC benefits. This verification is required at application and each annual eligibility review.

(4) Any ((~~individual~~)) person or the personal representative of the ((~~individual's~~)) person's estate who asserts that an asset is protected has the initial burden of:

(a) Documenting and proving by ((~~clear and~~)) convincing evidence that the asset or source of funds for the asset in question was designated as protected;

(b) Demonstrating the value of the asset and the proceeds of the asset beginning from the time period the LTC partnership has paid out benefits to the present; and

(c) Documenting that the asset or proceeds of the asset remained protected at all times.

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

WAC 182-513-1450 How ((~~does~~)) the transfer of assets affects LTC partnership and medicaid eligibility((~~?~~)). (1) If you transfer an asset within the sixty months prior to the medicaid application or after medicaid eligibility has been established, ((~~we~~)) the agency will evaluate the transfer based on WAC ((~~388-513-1363~~)) 182-513-1363 and determine if a penalty period applies unless:

(a) You have already been receiving institutional services;

(b) Your LTC partnership policy has paid toward institutional services for you; and

(c) The value of the transferred assets has been protected under the LTC partnership policy.

(2) The value of the transferred assets that exceed your LTC partnership protection will be evaluated for a transfer penalty.

(3) If you transfer assets ((~~whose~~)) with values that are protected, you lose that value as future protection unless all the transferred assets are returned.

(4) The value of your protected assets less the value of transferred assets equals the adjusted value of the assets you are able to protect.

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

WAC 182-513-1455 ((~~If I have~~)) What happens to protected assets under a LTC partnership policy((~~, what happens~~)) after ((~~my~~)) death((~~?~~)). Assets designated as protected prior to death are not subject to estate recovery for medical or long-term care (LTC) services paid on your behalf ((~~as described in chapter 388-527~~)) under chapter 182-527 WAC as long as the following requirements are met:

(1) A personal representative who asserts an asset is protected under this section has the initial burden of providing proof ((~~as described in chapter 388-527~~)) under chapter 182-527 WAC.

(2) A personal representative must provide verification from the LTC insurance company of the dollar amount paid out by the LTC partnership policy.

(3) If the LTC partnership policy paid out more than was previously designated, the personal representative has the right to assert that additional assets should be protected based on the increased protection. The personal representative must use the DSHS LTCP asset designation form and send it to the office of financial recovery.

(4) The amount of protection available to you at death through the estate recovery process is decreased by the FMV of any protected assets that were transferred prior to death.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-513-1300	Payment standard for persons in medical institutions.
WAC 182-513-1301	Definitions related to long-term care (LTC) services.
WAC 182-513-1305	Determining eligibility for noninstitutional medical assistance in an alternate living facility (ALF).
WAC 182-513-1364	Evaluating the transfer of an asset made on or after April 1, 2003 for long-term care (LTC) services.
WAC 182-513-1365	Evaluating the transfer of an asset made on or after March 1, 1997 and before April 1, 2003 for long-term care (LTC) services.

WAC 182-513-1366 Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services.

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

WAC 182-515-1505 ((~~Long-term care~~)) Home and community based (HCB) waiver services authorized by home and community services (HCS) ((~~and hospice~~)). ((~~(1)~~)) This chapter describes the general and financial eligibility requirements for categorically needy (CN) home and community based (HCB) waiver services ((~~administered~~)) authorized by home and community services (HCS) ((~~and hospice services administered by the health care authority (HCA)~~)). The definitions in WAC 182-513-1100 and chapter 182-500 WAC apply throughout this chapter.

((~~(2)~~)) (1) The ((~~HCB service programs~~)) HCS waivers are:

(a) Community options program entry system (COPES);

(b) ((~~Program of all-inclusive care for the elderly (PACE);~~

~~(c) Washington medicaid integration partnership (WMIP); or~~

~~(d)~~)) New Freedom consumer-directed services (New Freedom)((~~.~~

~~(3) Roads to community living (RCL) services. For RCL services this chapter is used only to determine your cost of care. Medicaid eligibility is guaranteed for three hundred sixty-five days upon discharge from a medical institution.~~

~~(4) Hospice services if you don't reside in a medical institution and:~~

~~(a) Have gross income at or below the special income level (SIL); and~~

~~(b) Aren't eligible for another CN or medically needy (MN) medicaid program.~~

~~(5) WAC 388-515-1506 describes the general eligibility requirements for HCS CN waivers.~~

~~(6) WAC 388-515-1507 describes eligibility for waiver services when you are eligible for medicaid using noninstitutional CN rules.~~

~~(7) WAC 388-515-1508 describes the initial financial eligibility requirements for waiver services when you are not eligible for noninstitutional CN medicaid described in WAC 388-515-1507(1).~~

~~(8) WAC 388-515-1509 describes the rules used to determine your responsibility in the cost of care for waiver services if you are not eligible for medicaid under a CN program listed in WAC 388-515-1507(1). This is also called client participation or post eligibility~~)); and

(c) Residential support waiver (RSW).

(2) WAC 182-515-1506 describes the general eligibility requirements for HCB waiver services authorized by HCS.

(3) WAC 182-515-1507 describes financial requirements for eligibility for HCB waiver services authorized by HCS when a person is eligible for a noninstitutional SSI-related categorically needy (CN) medicaid program.

(4) WAC 182-515-1508 describes the financial eligibility requirements for HCB waiver services authorized by HCS when a person is not eligible for SSI-related noninstitutional CN medicaid under WAC 182-515-1507.

(5) WAC 182-515-1509 describes the rules used to determine a person's responsibility for the cost of care and room and board for HCB waiver services if the person is eligible under WAC 182-515-1508.

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

WAC 182-515-1506 ((~~What are the general eligibility requirements for~~)) Home and community based (HCB) waiver services authorized by home and community services (HCS) ((~~and hospice?~~))—General eligibility. (1) To be eligible for home and community based (HCB) waiver services ((~~and hospice you~~)) a person must:

(a) Meet the program and age requirements for the specific program:

(i) Community options program entry system (COPES), ((~~per~~)) under WAC 388-106-0310;

(ii) ((~~PACE, per WAC 388-106-0705;~~

~~(iii) WMIP waiver services, per WAC 388-106-0750;~~

~~(iv)~~)) Residential support waiver (RSW), under WAC 388-106-0310; or

(iii) New Freedom, ((~~per~~)) under WAC ((~~388-106-1410;~~

~~(v) Hospice, per chapter 182-551 WAC; or~~

~~(vi) Roads to community living (RCL), per WAC 388-106-0250, 388-106-0255 and 388-106-0260~~)) 388-106-0338.

(b) Meet the disability criteria for the supplemental security income (SSI) program ((~~as described in~~)) under WAC 182-512-0050;

(c) Require the level of care provided in a nursing facility ((~~described in~~)) under WAC 388-106-0355;

(d) ((~~Be residing~~)) Reside in a medical institution as defined in WAC 182-500-0050, or be likely to be placed in one within the next thirty days without HCB waiver services provided under one of the programs listed in ((~~subsection (1)~~)) (a) of this subsection;

(e) ((~~Have attained~~)) Attain institutional status ((~~as described in WAC 388-513-1320~~)) under WAC 182-513-1320;

(f) ((~~Be determined in need of~~)) Assessed for HCB waiver services ((~~and~~)), be approved for a plan of care ((~~as described in subsection (1)(a)~~)), and receiving an HCB waiver service under (a) of this subsection;

(g) Be able to live at home with community support services and choose to remain at home, or live in a department-contracted((~~:~~

~~(i) Enhanced adult residential care (EARC) facility;~~

~~(ii) Licensed adult family home (AFH); or~~

~~(iii) Assisted living (AL) facility.~~

~~(h) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363 through 388-513-1365;~~

~~(i) Not have a home with equity in excess of the requirements described in WAC 388-513-1350.~~

~~(2) Refer to WAC 388-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care services~~)) alternate living facility under WAC 182-513-1100.

(2) A person is not eligible for home and community based (HCB) waiver services if the person:

(a) Is subject to a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; or

(b) Has a home with equity in excess of the requirements under WAC 182-513-1350.

(3) See WAC 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care (LTC) services.

(((~~3~~))) (4) Current income and resource standards ((~~charts~~)) are ((~~located~~)) found at((~~: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.html~~)) http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

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

WAC 182-515-1507 ((~~What are the financial requirements for~~)) Home and community based (HCB) waiver services authorized by home and community services (HCS) ((~~when you are~~))—Financial eligibility if a person is eligible for ((~~a~~)) an SSI-related noninstitutional categorically needy (CN) medicaid program((~~?~~)). (((~~(1) You are eligible for medicaid under one of the following programs:~~

~~(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001. This includes SSI clients under 1619B status;~~

~~(b) SSI-related CN medicaid described in WAC 182-512-0100 (2)(a) and (b);~~

~~(c) SSI-related health care for workers with disabilities program (HWD) described in WAC 182-511-1000. If you are receiving HWD, you are responsible to pay your HWD premium as described in WAC 182-511-1250;~~

~~(d) Aged, blind, or disabled (ABD) cash assistance described in WAC 388-400-0060 and are receiving CN medicaid.~~

~~(2) You do not have a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363 through 388-513-1365. This does not apply to PACE or hospice services.~~

~~(3) You do not have a home with equity in excess of the requirements described in WAC 388-513-1350.~~

~~(4) You do not have to meet the initial eligibility income test of having gross income at or below the special income level (SIL).~~

~~(5) You do not pay (participate) toward the cost of your personal care services.~~

~~(6) If you live in a department contracted facility listed in WAC 388-515-1506 (1)(g), you pay room and board up to the ADSA room and board standard. The ADSA room and board standard is based on the federal benefit rate (FBR) minus the current personal needs allowance (PNA) for HCS CN waivers in an alternate living facility.~~

~~(a) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH) you keep a PNA of sixty-two dollars and seventy-nine cents and use your income to pay up to the room and board standard.~~

~~(b) If subsection (6)(a) applies and you are receiving HWD described in WAC 182-511-1000, you are responsible to pay your HWD premium as described in WAC 182-511-1250, in addition to the ADSA room and board standard.~~

~~(7) If you are eligible for aged, blind or disabled (ABD) cash assistance program described in WAC 388-400-0060 you do not participate in the cost of personal care and you may keep the following:~~

~~(a) When you live at home, you keep the cash grant amount authorized under WAC 388-478-0033;~~

~~(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ADSA room and board standard; or~~

~~(c) When you live in an assisted living facility or enhanced adult residential center, you are only eligible to receive an ABD cash grant of thirty-eight dollars and eighty-four cents as described in WAC 388-478-0045, which you keep for your PNA.~~

~~(8) Current resource and income standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.~~

~~(9)~~))) (1) A person is financially eligible for home and community based (HCB) waiver services if:

(a) The person is receiving coverage under one of the following supplemental security income (SSI)-related categorically needy (CN) medicaid programs:

(i) SSI program under WAC 182-510-0001. This includes SSI clients under Section 1619(b) of the Social Security Act;

(ii) SSI-related noninstitutional CN program under chapter 182-512 WAC; or

(iii) Health care for workers with disabilities program (HWD) under chapter 182-511 WAC.

(b) The person does not have a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; and

(c) The person does not own a home with equity in excess of the requirements under WAC 182-513-1350.

(2) A person eligible under this section does not pay toward the cost of care, but must pay room and board if living in an alternate living facility (ALF) under WAC 182-513-1100.

(3) A person eligible under this section who lives in a department-contracted ALF described under WAC 182-513-1100 and does not receive a cash grant from the department of social and health services under WAC 388-400-0060:

(a) Keeps a personal needs allowance (PNA) of $62.79; and

(b) Pays towards room and board up to the room and board standard with the remaining income. The room and board standard is the federal benefit rate (FBR) minus $62.79.

(4) A person who is eligible under the HWD program must pay the HWD premium under WAC 182-511-1250, in addition to room and board, if residing in an ALF.

(5) A person who is eligible for the aged, blind, disabled (ABD) cash assistance program under WAC 388-400-0060 does not pay toward the cost of care and keeps:

(a) The cash grant amount authorized under WAC 388-478-0033 if living at home;

(b) A PNA of $38.84, but must pay towards room and board with the remaining income and ABD cash grant up to the room and board standard if living in an adult family home (AFH). The room and board standard is the federal benefit rate (FBR) minus $62.79; or

(c) The cash grant of $38.84 under WAC 388-478-0006 if living in an assisted living facility.

(6) Current resource, income, PNA, and ((~~ADSA~~)) room and board standards are ((~~located~~)) found at((~~: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml~~)) http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

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

WAC 182-515-1508 ((~~How does the department determine if you are financially eligible for~~)) Home and community based (HCB) waiver services authorized by home and community services (HCS) ((~~and hospice if you are not eligible for medicaid under a categorically needy (CN) program listed in WAC 388-515-1507(1)?~~))—Financial eligibility using SSI-related institutional rules. (1) If ((~~you are~~)) a person is not eligible for ((~~medicaid under~~)) a categorically needy (CN) program ((~~listed in~~)) under WAC ((~~388-515-1507(1)~~)) 182-515-1507, the ((~~department must~~)) agency determines ((~~your~~)) eligibility for home and community based (HCB) waiver services authorized by home and community services (HCS) using institutional medicaid rules. This section explains how ((~~you~~)) a person may qualify using institutional ((~~medicaid~~)) rules.

(2) ((~~You~~)) A person must meet ((~~the~~)):

(a) General eligibility requirements ((~~described in WAC 388-513-1315 and 388-515-1506.~~

~~(3) You must meet the following resource requirements:~~

~~(a) Resource limits described in WAC 388-513-1350.~~

~~(b) If you have resources over the standard allowed in WAC 388-513-1350, the department reduces resources over the standard by your unpaid medical expenses described in WAC 388-513-1350 if you verify these expenses.~~

~~(4) You must meet~~)) under WAC 182-513-1315 and 182-515-1506;

(b) The resource requirements under WAC 182-513-1350;

(c) The following income requirements:

(((~~(a) Your gross nonexcluded~~)) (i) Available income must be at or below the special income level (SIL) ((~~which is three hundred percent of the federal benefit rate (FBR)~~)), defined under WAC 182-513-1100; or

(((~~(b) For home and community based (HCB) service programs authorized by HCS your gross nonexcluded income is:~~

~~(i) Above the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); and~~))

(ii) ((~~Net~~)) If available income is above the SIL, net available income is no greater than the effective one-person medically needy income level (MNIL). Net income is calculated by reducing ((~~gross nonexcluded~~)) available income by:

(A) Medically needy (MN) disregards found ((~~in WAC 388-513-1345~~)) under WAC 182-513-1345; ((~~and~~))

(B) The average monthly nursing facility state rate ((~~is five thousand six hundred and twenty six dollars. This rate will be updated annually starting October 1, 2012 and each year thereafter on October 1. This standard will be updated annually in the long-term care standard section of the EAZ manual described at http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.~~

~~(5) The department follows the rules in WAC 388-515-1325, 388-513-1330, and 388-513-1340 to determine available income and income exclusions.~~

~~(6)~~));

(C) Health insurance premiums, other than medicare; and

(D) Outstanding medical bills, prorated monthly over a twelve-month certification period, that meet the requirements of WAC 182-513-1350.

(3) The agency determines available income and income exclusions under WAC 182-513-1325, 182-513-1330, and 182-513-1340.

(4) A person eligible under this section is responsible to pay toward the cost of care and room and board, as described under WAC 182-515-1509.

(5) Current resource ((~~and~~)), income standards ((~~(including the SIL, MNIL and FBR)~~)), and the average state nursing facility rate for long-term care are found at((~~: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

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

WAC 182-515-1509 ((~~How does the department determine how much of my income I must pay towards the cost of my care if I am only eligible for home and community based (HCB) services under WAC 388-515-1508?~~)) Home and community based (HCB) waiver services authorized by home and community services (HCS)—Client financial responsibility. ((~~If you are only eligible for medicaid under WAC 388-515-1508, the department determines how much you must pay based upon the following:~~

~~(1) If you are~~)) (1) A person eligible for home and community based (HCB) waiver services authorized by home and community services (HCS) under WAC 182-515-1508 must pay toward the cost of care and room and board under this section.

(a) Post-eligibility treatment of income, participation, and participate are all terms that refer to a person's responsibility towards cost of care.

(b) Room and board is a term that refers to a person's responsibility toward food and shelter in an alternate living facility (ALF).

(2) The agency determines how much a person must pay toward the cost of care for HCB waiver services authorized by HCS when living at home:

(a) A single ((~~and living~~)) person who lives at home (as defined in WAC 388-106-0010)((~~, you~~)) keeps ((~~all your income up to the federal poverty level (FPL) for your personal needs allowance (PNA)~~)) a personal needs allowance (PNA) of up to the federal poverty level (FPL) and must pay the remaining available income toward cost of care after allowable deductions described in subsection (4) of this section.

((~~(2) If you are~~)) (b) A married ((~~living~~)) person who lives with the person's spouse at home ((~~as defined in WAC 388-106-0010, you keep all your income up to the effective one-person medically needy income level (MNIL) for your PNA if your spouse lives at home with you. If you are married and living apart from your spouse, you're allowed to keep your income up to the FPL for your PNA.~~

~~(3) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH), you:~~

~~(a) Keep a PNA from your gross nonexcluded income. The PNA is sixty-two dollars and seventy-nine cents effective July 1, 2008; and~~

~~(b) Pay for your room and board up to the ADSA room and board standard.~~

~~(4) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and any room and board deduction~~)) (as defined in WAC 388-106-0010) keeps a PNA of up to the effective one-person medically needy income level (MNIL) and pays the remainder of the person's available income toward cost of care after allowable deductions under subsection (4) of this section.

(c) A married person who lives at home and apart from the person's spouse keeps a PNA of up to the FPL but must pay the remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(d) A married couple living at home where each person receives HCB waiver services is each allowed to keep a PNA of up to the FPL but must pay remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(e) A married couple living at home where each person receives HCB waiver services, one person authorized by the developmental disabilities administration (DDA) and the other authorized by HCS, is allowed the following:

(i) The person authorized by DDA pays toward the cost of care under WAC 182-515-1512 or 182-515-1514; and

(ii) The person authorized by HCS retains the federal poverty level (FPL) and pays the remainder of the available income toward cost of care after allowable deductions under subsection (4) of this section.

(3) The agency determines how much a person must pay toward the cost of care for HCB waiver services authorized by HCS and room and board when living in a department contracted alternate living facility (ALF) defined under WAC 182-513-1100 a person:

(a) Keeps a PNA of $62.79;

(b) Pays room and board up to the room and board standard. The room and board standard is the federal benefit rate (FBR) minus $62.79; and

(c) Pays the remainder of available income toward the cost of care after allowable deductions under subsection (4) of this section.

(4) If income remains after the PNA and room and board liability under subsection (2) or (3) of this section, the remaining available income must be paid toward the cost of care after it is reduced by ((~~allowable~~)) deductions in the following order:

(a) ((~~If you are working, the department allows~~)) An earned income deduction of the first ((~~sixty-five dollars~~)) $65 plus one-half of the remaining earned income((~~.~~));

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed ((~~by chapter 388-79 WAC~~)) under WAC 182-513-1505 through 182-513-1525;

(c) Current or back child support garnished or withheld from ((~~your~~)) the person's income according to a child support order in the month of the garnishment if it is for the current month. If the ((~~department~~)) agency allows this as a deduction from ((~~your~~)) income, the ((~~department will~~)) agency does not count it as ((~~your~~)) the child's income when determining the family allocation amount in WAC 182-513-1385;

(d) A monthly maintenance-needs allowance for ((~~your~~)) the community spouse ((~~not to exceed that in WAC 388-513-1380 (5)(b) unless a greater amount is allocated as described in subsection (e) of this section. This amount:~~

~~(i) Is allowed only to the extent that your income is made available to your community spouse; and~~

~~(ii) Consists of a combined total of both:~~

~~(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; and~~

~~(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:~~

~~(I) Rent, including space rent for mobile homes, plus;~~

~~(II) Mortgage, plus;~~

~~(III) Taxes and insurance, plus;~~

~~(IV) Any required payments for maintenance care for a condominium or cooperative, plus;~~

~~(V) The food assistance standard utility allowance (SUA) described in WAC 388-450-0195 provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;~~

~~(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; and~~

~~(VII) Is reduced by your community spouse's gross countable income.~~

~~(iii) The amount allocated to the community spouse may be greater than the amount in subsection (d)(ii) only when:~~

~~(A) There is a court order approving a higher amount for the support of your community spouse; or~~

~~(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.~~)) as determined under WAC 182-513-1385. If the community spouse is also receiving long-term care services, the allocation is limited to an amount that brings the person's income to the person's PNA, as calculated under WAC 182-513-1385;

(e) A monthly maintenance-needs ((~~amount~~)) allowance for each ((~~minor or dependent child, dependent parent, or dependent sibling of your community or institutionalized spouse. The amount the department allows is based on the living arrangement of the dependent. If the dependent:~~

~~(i) Resides with your community spouse, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);~~

~~(ii) Does not reside with the community spouse, the amount is equal to the effective one-person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).~~)) dependent of the institutionalized person, or the person's spouse, as calculated under WAC 182-513-1385;

(f) ((~~Your unpaid~~)) Incurred medical expenses which have not been used to reduce excess resources. Allowable medical expenses are ((~~described in WAC 388-513-1350~~)) under WAC 182-513-1350.

((~~(g)~~)) (5) The total of the following deductions cannot exceed the ((~~SIL (three hundred percent of the FBR)~~)) special income level (SIL) defined under WAC 182-513-1100:

((~~(i) Personal needs allowance~~)) (a) The PNA allowed in subsection((~~s (1), (2) and (3)(a) and (b)~~)) (2) or (3) of this section, including room and board; ((~~and~~

~~(ii)~~))

(b) The earned income deduction ((~~of the first sixty-five dollars plus one-half of the remaining earned income~~)) in subsection (4)(a) of this section; and

((~~(iii)~~)) (c) The guardianship fees and administrative costs in subsection (4)(b) of this section.

(6) A person may have to pay third-party resources defined under WAC 182-513-1100 in addition to the room and board and participation.

((~~(5) You~~)) (7) A person must pay ((~~your provider the combination~~)) the person's provider the sum of the room and board amount, and the cost of ((~~personal~~)) care ((~~services~~)) after all allowable deductions, and any third-party resources defined under WAC 182-513-1100.

((~~(6) You may have to pay third party resources described in WAC 182-501-0200 in addition to the room and board and participation. The combination of room and board, participation, and third party resources is the total amount you must pay.~~

~~(7) Current income and resource standards for long-term care (including SIL, MNIL, FPL, FBR) are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.~~))

(8) ((~~If you are~~)) A person on HCB waiver services does not pay more than the state rate for cost of care.

(9) When a person lives in multiple living arrangements in a month (((~~an example is a move from an adult family home to a home setting on HCB services)~~)), the ((~~department~~)) agency allows ((~~you~~)) the highest PNA available based on all the living arrangements and services ((~~you have~~)) the person has received in a month.

(((~~9) Current PNA and ADSA room and board~~)) (10) Standards described in this section are ((~~located~~)) found at((~~: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml~~)) http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

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

WAC 182-515-1510 ((~~Division of~~)) Home and community based (HCB) waiver services authorized by the developmental disabilities (((~~DDD) home and community based services waivers~~)) administration (DDA). ((~~The four sections that follow~~)) This chapter describes the general and financial eligibility requirements for categorically needy (CN) home and community based (HCB) waivers authorized by the ((~~division of~~)) developmental disabilities (((~~DDD) home and community based services (HCBS) waivers~~)) administration (DDA). The definitions in WAC 182-513-1100 and chapter 182-500 WAC apply throughout this chapter.

(1) The DDA waiver programs are:

(a) Basic Plus;

(b) Core;

(c) Community protection;

(d) Children's intensive in-home behavioral support (CIIBS); and

(e) Individual and family services (IFS).

(((~~1) WAC 388-515-1511~~)) (2) WAC 182-515-1511 describes the general eligibility requirements ((~~under the DDD HCBS~~)) for HCB waiver((~~s~~)) services authorized by DDA.

(((~~2) WAC 388-515-1512~~)) (3) WAC 182-515-1512 describes the financial requirements for ((~~the DDD waivers if you are~~)) eligibility for HCB waiver services authorized by DDA if a person is eligible for ((~~medicaid under the noninstitutional categorically needy~~)) a noninstitutional SSI-related CN program (((~~CN)~~)).

(((~~3) WAC 388-515-1513~~)) (4) WAC 182-515-1513 describes the ((~~initial~~)) financial eligibility requirements for ((~~the DDD~~)) HCB waiver((~~s if you are~~)) services authorized by DDA when a person is not eligible for ((~~medicaid under a categorically needy~~)) an SSI-related noninstitutional CN program (((~~CN) listed in~~)) under WAC ((~~388-515-1512(1)~~)) 182-515-1512.

(((~~4) WAC 388-515-1514~~)) (5) WAC 182-515-1514 describes the ((~~post eligibility financial requirements for the DDD waivers if you are not eligible for medicaid under a categorically needy program CN listed in~~)) rules used to determine a person's responsibility in the cost of care and room and board for HCB waiver services authorized by DDA if the person is eligible under WAC ((~~388-515-1512(1)~~)) 182-515-1512.

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

WAC 182-515-1511 ((~~What are the general eligibility requirements for~~)) Home and community based (HCB) waiver services ((~~under the division of~~)) authorized by the developmental disabilities ((~~(DDD) home and community based services (HCBS) waivers?~~)) administration (DDA)—General eligibility. ((~~(1) This section describes the general eligibility requirements for waiver services under the DDD home and community based services (HCBS) waivers.~~

~~(2) The requirements for services for DDD HCBS waivers are described in chapter 388-845 WAC. The department establishes eligibility for DDD HCBS waivers.~~)) (1) To be eligible((~~, you~~)) for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA), a person must:

(a) Meet specific program requirements under chapter 388-845 WAC;

(b) Be an eligible client of the ((~~division of developmental disabilities (DDD)~~)) DDA;

((~~(b)~~)) (c) Meet the disability criteria for the supplemental security income (SSI) program ((~~as described in~~)) under WAC 182-512-0050;

((~~(c) Require~~)) (d) Need the level of care provided in an intermediate care facility for the intellectually disabled (ICF/ID);

((~~(d)~~)) (e) Have attained institutional status ((~~as described in WAC 388-513-1320~~)) under WAC 182-513-1320;

((~~(e)~~)) (f) Be able to reside in the community and choose to do so as an alternative to living in an ICF/ID;

((~~(f) Need waiver services as determined by your plan of care or individual support plan~~)) (g) Be assessed for HCB waiver services, be approved for a plan of care, and receive HCB waiver services under (a) of this subsection, and:

(i) Be able to live at home with HCB waiver services; or

(ii) Live in a department-contracted facility((~~, which includes~~)) with HCB waiver services, such as:

(A) A group home;

(B) A group training home;

(C) A child foster home, group home, or staffed residential facility;

(D) An adult family home (AFH); or

(E) An adult residential care (ARC) facility.

(iii) Live in ((~~your~~)) the person's own home with supported living services from a certified residential provider; or

(iv) Live in the home of a contracted companion home provider((~~; and~~

~~(g) Be both medicaid eligible under the categorically needy program (CN) and be approved for services by the division of developmental disabilities~~)).

(2) A person is not eligible for home and community based (HCB) waiver services if the person:

(a) Is subject to a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; or

(b) Has a home with equity in excess of the requirements under WAC 182-513-1350.

(3) See WAC 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care (LTC) services.

(4) Current income and resource standard charts are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

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

WAC 182-515-1512 ((~~What are the financial requirements for the DDD waiver services if I am eligible for medicaid under the noninstitutional categorically needy program (CN)?~~)) Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility if a person is eligible for a noninstitutional SSI-related categorically needy (CN) program. ((~~(1) You automatically meet income and resource eligibility for DDD waiver services if you are eligible for medicaid under a categorically needy program (CN) under one of the following programs:~~

~~(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001. This includes SSI clients under 1619B status. These clients have medicaid eligibility determined and maintained by the Social Security Administration;~~

~~(b) Health care for workers with disabilities (HWD) described in WAC 182-511-1000 through 182-511-1250;~~

~~(c) SSI-related (CN) medicaid described in WAC 182-512-0100 (2)(a) and (b) or meets the requirements in WAC 182-512-0880 and is (CN) eligible after the income disregards have been applied;~~

~~(d) CN medicaid for a child as described in WAC 182-505-0210 (1), (2), (7) or (8); or~~

~~(e) Aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060.~~

~~(2) If you are eligible for a CN medicaid program listed in subsection (1) above, you do not have to pay (participate) toward the cost of your personal care and/or habilitation services.~~

~~(3) If you are eligible for a CN medicaid program listed in subsection (1) above, you do not need to meet the initial eligibility income test of gross income at or below the special income level (SIL), which is three hundred percent of the federal benefit rate (FBR).~~

~~(4) If you are eligible for a CN medicaid program listed in subsection (1), you pay up to the ADSA room and board standard described in WAC 388-515-1507. Room and board and long-term care standards are located at http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.~~

~~(a) If you live in an ARC, AFH or DDD group home, you keep a personal needs allowance (PNA) and use your income to pay up to the ADSA room and board standard. Effective January 1, 2009 the PNA is sixty-two dollars and seventy-nine cents.~~

~~(5) If you are eligible for a premium based medicaid program such as health care for workers with disabilities (HWD), you must continue to pay the medicaid premium to remain eligible for that CN-P program.~~)) (1) A person is financially eligible for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) if:

(a) The person is receiving coverage under one of the following SSI-related categorically needy (CN) medicaid programs:

(i) Supplemental security income (SSI) program under WAC 182-510-0001. This includes SSI clients under 1619(b) status; or

(ii) Health care for workers with disabilities (HWD) under chapter 182-511 WAC; or

(iii) SSI-related noninstitutional (CN) program under chapter 182-512 WAC; or

(iv) The foster care program under WAC 182-505-0211 and the person meets disability requirements under WAC 182-512-0050.

(b) The person does not have a penalty period of ineligibility for the transfer of an asset as under WAC 182-513-1363; and

(c) The person does not own a home with equity in excess of the requirements under WAC 182-513-1350.

(2) A person eligible under this section does not pay toward the cost of care, but must pay room and board if living in an alternate living facility (ALF) under WAC 182-513-1100.

(3) A person eligible under this section who lives in a department-contracted ALF described under WAC 182-513-1100:

(a) Keeps a personal needs allowance (PNA) of $62.79; and

(b) Pays towards room and board up to the room and board standard with remaining income. The room and board standard is the federal benefit rate (FBR) minus $62.79.

(4) A person who is eligible under the HWD program must pay the HWD premium under WAC 182-511-1250, in addition to room and board if residing in an ALF.

(5) A person who is eligible for the aged, blind, disabled (ABD) cash assistance program under WAC 388-400-0060 does not pay participation toward the cost of care and keeps the following:

(a) The cash grant amount authorized under WAC 388-478-0033 if living at home;

(b) A PNA of $38.84, but must pay towards room and board with the remaining income and ABD cash grant for the cost of room and board up to the room and board standard if living in an adult family home (AFH). The room and board standard is the federal benefit rate (FBR) minus $62.79; or

(c) The cash grant of $38.84 authorized under WAC 388-478-0006 when living in an assisted living or DDA group home.

(6) Current resource, income, PNA and room and board standards are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

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

WAC 182-515-1513 ((~~How does the department determine if I am financially eligible for DDD waiver service medical coverage if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1)?~~)) Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility using SSI-related institutional rules. ((~~If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1), we must determine your eligibility using institutional medicaid rules. This section explains how you may qualify under this program. You may be required to pay towards the cost of your care if you are eligible under this program. The rules explaining how much you have to pay are listed in WAC 388-515-1514. To qualify, you must meet both the resource and income requirements.~~

~~(1) Resource limits are described in WAC 388-513-1350. If you have resources which are higher than the standard allowed, we may be able to reduce resources by your unpaid medical expenses described in WAC 388-513-1350.~~

~~(2) You are not subject to a transfer of asset penalty described in WAC 388-513-1363 through 388-513-1365.~~

~~(d) Not have a home with equity in excess of the requirements described in WAC 388-513-1350.~~

~~(3) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit level. The department follows the rules in WAC 388-515-1325, 388-513-1330 and 388-513-1340 to determine available income and income exclusions.~~

~~(4) Refer to WAC 388-513-1315 for rules used to determine countable resources, income and eligibility standards for long-term care services.~~

~~(5) Current income and resources standards are located at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.~~)) (1) If a person is not eligible for a categorically needy (CN) program under WAC 182-515-1512, the agency determines eligibility for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) using institutional medicaid rules. This section explains how a person may qualify using institutional rules.

(2) A person must meet:

(a) General eligibility requirements under WAC 182-513-1315 and 182-515-1511;

(b) Resource requirements under WAC 182-513-1350; and

(c) Have available income at or below the special income level (SIL) defined under WAC 182-513-1100.

(3) The agency determines available income and income exclusions according to WAC 182-513-1325, 182-513-1330, and 182-513-1340.

(4) A person eligible under this section is responsible to pay income toward the cost of care and room and board, as described under WAC 182-515-1514.

(5) Current resource, income standards are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

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

WAC 182-515-1514 ((~~How does the department determine how much of my income I must pay towards the cost of my DDD waiver services if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1)?~~)) Home and community based (HCB) services authorized by the developmental disabilities administration (DDA)—Client financial responsibility. ((~~If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1), the department determines how much you must pay based upon the following:~~

~~(1) If you are an SSI-related client living at home as defined in WAC 388-106-0010, you keep all your income up to the SIL (three hundred percent of the FBR) for your personal needs allowance (PNA).~~

~~(2) If you are an SSI-related client and you live in an ARC, AFH or DDD group home, you:~~

~~(a) Keep a personal needs allowance (PNA) from your gross nonexcluded income. Effective January 1, 2009 the PNA is sixty-two dollars and seventy-nine cents; and~~

~~(b) Pay for your room and board up to the ADSA room and board rate described in http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml.~~

~~(3) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and any room and board deduction described in (2) above, is reduced by allowable deductions in the following order:~~

~~(a) If you are working, we allow an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;~~

~~(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed by chapter 388-79 WAC;~~

~~(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If we allow this as deduction from your income, we will not count it as your child's income when determining the family allocation amount;~~

~~(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC 388-513-1380 (5)(b) unless a greater amount is allocated as described in subsection (e) of this section. This amount:~~

~~(i) Is allowed only to the extent that your income is made available to your community spouse; and~~

~~(ii) Consists of a combined total of both:~~

~~(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; and~~

~~(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:~~

~~(I) Rent, including space rent for mobile homes, plus;~~

~~(II) Mortgage, plus;~~

~~(III) Taxes and insurance, plus;~~

~~(IV) Any required payments for maintenance care for a condominium or cooperative plus;~~

~~(V) The food assistance standard utility allowance (SUA) provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;~~

~~(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml; and~~

~~(VII) Is reduced by your community spouse's gross countable income.~~

~~(iii) May be greater than the amount in subsection (d)(ii) only when:~~

~~(A) There is a court order approving a higher amount for the support of your community spouse; or~~

~~(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.~~

~~(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of your community or institutionalized spouse. The amount we allow is based on the living arrangement of the dependent. If the dependent:~~

~~(i) Resides with your community spouse, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);~~

~~(ii) Does not reside with the community spouse, the amount is equal to the effective one-person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).~~

~~(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC 388-513-1350.~~

~~(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):~~

~~(i) Personal needs allowances in subsection (1) for in home or subsection (2)(a) in a residential setting; and~~

~~(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in subsection (3)(a); and~~

~~(iii) Guardianship fees and administrative costs in subsection (3)(b).~~

~~(4) If you are eligible for aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060 you do not participate in the cost of personal care and you may keep the following:~~

~~(a) When you live at home, you keep the cash grant amount authorized under the ABD cash program;~~

~~(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ADSA room and board standard described in http://www.dshs.wa.gov/manuals/eaz/ sections/LongTermCare/LTCstandardspna.shtml; or~~

~~(c) When you live in an ARC or DDD group home, you are only eligible to receive a cash grant of thirty-eight dollars and eighty-four cents which you keep for your PNA.~~

~~(5) You may have to pay third party resources (TPR) described in WAC 182-501-0200 in addition to room and board and the cost of personal care and/or habilitation services (participation) after all allowable deductions have been considered is called your total responsibility. You pay this amount to the ARC, AFH or DDD group home provider.~~)) (1) A person eligible for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) under WAC 182-515-1513 must pay toward the cost of care and room and board under this section.

(a) Post-eligibility treatment of income, participation, and participate are all terms that refer to a person's responsibility towards cost of care.

(b) Room and board is a term that refers to a person's responsibility toward food and shelter in an alternate living facility (ALF).

(2) The agency determines how much a person must pay toward the cost of care for home and community based (HCB) waiver services authorized by the DDA when the person is living at home, as follows:

(a) A single person who lives at home (as defined in WAC 388-106-0010) keeps a personal needs allowance (PNA) of up to the special income level (SIL) defined under WAC 182-513-1100.

(b) A single person who lives at home on the roads to community living program authorized by DDA keeps a PNA up to the SIL but must pay any remaining available income toward cost of care after allowable deductions described in subsection (4) of this section.

(c) A married person who lives with the person's spouse at home (as defined in WAC 388-106-0010) keeps a PNA of up to the SIL but must pay any remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(d) A married couple living at home where each person receives HCB waiver services, one authorized by DDA and the other authorized by home and community services (HCS) is allowed the following:

(i) The person authorized by DDA keeps a PNA of up to the SIL but must pay any remaining available income toward the person's cost of care after allowable deductions in subsection (4) of this section; and

(ii) The person authorized by HCS pays toward the cost of care under WAC 182-515-1507 or 182-515-1509.

(3) The agency determines how much a person must pay toward the cost of care for HCB wavier services authorized by DDA and room and board when the person is living in a department-contracted ALF defined under WAC 182-513-1100. A person:

(a) Keeps a PNA of $62.79;

(b) Pays room and board up to the room and board standard. The room and board standard is the federal benefit rate (FBR) minus $62.79; and

(c) Pays the remainder of available income toward the cost of care after allowable deductions under subsection (4) of this section.

(4) If income remains after the PNA and room and board liability under subsection (2) or (3) of this section, the remaining available income must be paid toward the cost of care after it is reduced by allowable deductions in the following order:

(a) An earned income deduction of the first $65, plus one-half of the remaining earned income;

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed under WAC 182-513-1505 through 182-513-1525;

(c) Current or back child support garnished or withheld from the person's income according to a child support order in the month of the garnishment if it is for the current month. If the agency allows this as a deduction from income, the agency does not count it as the child's income when determining the family allocation amount in WAC 182-513-1385;

(d) A monthly maintenance-needs allowance for the community spouse under WAC 182-513-1385. If the community spouse is on long-term care services, the allocation is limited to an amount that brings the person's income to the person's PNA;

(e) A monthly maintenance-needs allowance for each dependent of the institutionalized person, or the person's spouse, as calculated under WAC 182-513-1385; and

(f) Incurred medical expenses which have not been used to reduce excess resources. Allowable medical expenses are under WAC 182-513-1350.

(5) The total of the following deductions cannot exceed the SIL defined under WAC 182-513-1100:

(a) The PNA described in subsection (2) or (3) of this section, including room and board;

(b) The earned income deduction in subsection (4)(a) of this section; and

(c) The guardianship fees and administrative costs in subsection (4)(b) of this section.

(6) A person may have to pay third-party resources defined under WAC 182-513-1100 in addition to the room and board and participation.

(7) A person must pay the person's provider the sum of the room and board amount, the cost of care after all allowable deductions, and any third-party resources defined under WAC 182-513-1100.

(8) A person on HCB waiver services does not pay more than the state rate for cost of care.

(9) When a person lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the person has received in a month.

(10) Standards described in this section are found at http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-515-1500 Payment standard for persons in certain group living facilities.

WSR 17-03-123
PERMANENT RULES
BUILDING CODE COUNCIL

[Filed January 18, 2017, 11:04 a.m., effective February 18, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: Amendment of chapter 51-04 WAC, Policies and procedures for consideration of statewide and local amendments to the state building code.

Citation of Existing Rules Affected by this Order: Amending WAC 51-04-010, 51-04-015, 51-54-020, 51-04-025, 51-04-030, and 51-04-040.

Statutory Authority for Adoption: RCW 19.27.031, 19.27.074.

Other Authority: RCW 19.27.035.

Adopted under notice filed as WSR 16-21-101 on October 19, 2016.

Changes Other than Editing from Proposed to Adopted Version: In WAC 51-04-020, subsection (1)(a)(i) was amended to include the International Existing Building Code in the Group 1 codes and the title of the Energy Code was amended to include the clarification that only the commercial portion is included in Group 1.

Subsection (1)(a)(ii) was amended to include the International Fuel Gas Code, NFPA 54 and 48 in the list of the Group 2 codes.

Subsection (3) was modified to clarify there would be two hearings for each code group.

Subsection (4) was modified to state the final changes to both Group 1 and 2 codes would be filed with the code reviser at the same time. In addition, it was clarified that limited amendments to Group 1 codes would be considered while the Group 2 codes are reviewed.

Subsection (6) was removed. It was deemed this language was unnecessary or should be relocated to a more appropriate section.

In WAC 51-04-025, subsection (1) the criteria for state amendments was expanded to include existing model code language rather than just changes in the model code language. Portions of the language from WAC 51-54-020(6) were also added here as being a more logical location.

In subsection (2), clarification was added on how incomplete submissions will be handled.

Subsection (5) was removed. The council felt this language was confusing as it did not specify the origins of the material and not all items would be applicable to all proposals.

In WAC 51-04-030, subsection (3) was modified to strike the word "proposed."

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 6, 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 6, 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: January 13, 2017.

Steve K. Simpson
Council Chair

AMENDATORY SECTION (Amending WSR 07-15-043, filed 7/13/07, effective 8/13/07)

WAC 51-04-010 Declaration of purpose. The Washington state building code council, hereinafter called the council, is required by chapter 266, Laws of 1988, to adopt and maintain the state building code, hereinafter referred to as the building code, as provided in chapters 19.27, 19.27A, and 70.92 RCW, and the state legislature.

(1) The primary objective of the council is to encourage consistency in the building code throughout the state of Washington and to maintain the building code consistent with the state's interest as provided in RCW 19.27.020. An objective of statewide adoption is to minimize state amendments to the model codes.

The building code shall be as defined in WAC 51-04-015(8).

(2) The council is also required by RCW 19.27.074 to approve or deny all city and county amendments to the building code that apply to single family or multifamily buildings as defined in RCW 19.27.015.

(3) The council may issue opinions relating to the codes at the request of a local official charged with the duty to enforce the enumerated codes as specified in RCW 19.27.031.

(4) The purpose of this chapter is to establish policies and procedures for:

(a) Submittal and council review and consideration of proposed statewide ((~~and~~)) amendments to the building code;

(b) Submittal and council review and consideration of proposed city and county amendments ((~~respectively,~~)) to the building code;

(c) Reconsideration of council actions; and

(d) Issuing opinions to local officials.

AMENDATORY SECTION (Amending WSR 05-23-104, filed 11/17/05, effective 1/1/06)

WAC 51-04-015 Definitions. (1) ((~~"Supplements and accumulative supplements" mean the publications between editions of the model codes and standards which include changes to the current edition of the model codes and standards.~~

~~(2)~~)) "Council" means the Washington state building code council.

((~~(3)~~)) (2) "Emergency statewide amendment" means any proposed statewide amendment, the adoption of which is necessary immediately in order to protect life, safety or health of building occupants; preserve the structural integrity of buildings built to the state building code; to correct errors and omissions; or by the direction of the Washington state legislature or federal legislation. Emergency statewide amendments to the state building code must be adopted in accordance with the Administrative Procedure Act, chapter 34.05 RCW.

((~~(4)~~)) (3) "Local government amendment" means any amendment to the state building code, as adopted by cities or counties for implementation and enforcement in their respective jurisdictions.

((~~(5)~~)) (4) "Local government residential amendment" means any amendment to the state building code, as adopted by cities or counties for implementation and enforcement in their respective jurisdictions, that applies to single and multi-family buildings as defined by RCW 19.27.015.

((~~(6)~~)) (5) "Model codes" means the codes developed by the model code organizations and adopted by and referenced in chapter 19.27 RCW.

((~~(7)~~)) (6) "Model code organization(s)" means the national code-promulgating organizations that develop the model codes (as defined herein), such as the International Code Council, International Association of Plumbing and Mechanical Officials, and National Fire Protection Association.

((~~(8)~~)) (7) "State building code" means the codes adopted by and referenced in chapter 19.27 RCW; the state energy code; and any other codes so designated by the Washington state legislature as adopted and amended by the council.

((~~(9)~~)) (8) "Statewide amendment" means any amendment to the building code, initiated through council action or by petition to the council from any agency, city or county, or interested individual or organization, that would have the effect of amending the building code for the entire state of Washington. Statewide amendments to the state building code must be adopted in accordance with the Administrative Procedure Act, chapter 34.05 RCW.

((~~(10)~~)) (9) "State building code update cycle" means that period during which the model code and standards referenced in chapter 19.27 RCW are updated and amended by the council in accordance with the Administrative Procedure Act, chapter 34.05 RCW hereinafter referred to as the "adoption period" and those additional periods when code changes are received for review as proposed amendments to the model codes, hereinafter referred to as "submission periods."

AMENDATORY SECTION (Amending WSR 07-15-043, filed 7/13/07, effective 8/13/07)

WAC 51-04-020 Policies for the consideration of proposed statewide amendments. ((~~Statewide and emergency statewide amendments to the state building code shall be based on one of the following criteria:~~

~~(1) The amendment is needed to address a critical life/safety need.~~

~~(2) The amendment is needed to address a specific state policy or statute.~~

~~(3) The amendment is needed for consistency with state or federal regulations.~~

~~(4) The amendment is needed to address a unique character of the state.~~

~~(5) The amendment corrects errors and omissions.~~

~~Statewide and emergency statewide amendments to the state building code shall conform to the purposes, objectives, and standards prescribed in RCW 19.27.020.~~

~~The council will accept and consider petitions for emergency statewide amendments to the building code at any time, in accordance with RCW 19.27.074 and chapter 34.05 RCW.~~)) (1) The council will accept and consider petitions for emergency statewide amendments to the building code at any time, in accordance with RCW 19.27.074 and chapter 34.05 RCW. The council will accept and consider all ((~~other~~)) petitions for statewide amendments in conjunction with the state building code update cycle, in accordance with RCW 19.27.-074 and chapter 34.05 RCW, and WAC 51-04-015 and 51-04-020 as follows:

((~~The state building code council shall publicize the state building code amendment process in January of each year. Proposed state amendments must be received by March 1 to be considered for adoption by December 1. The state building code council shall review all proposed statewide amendments and file for future rule making those proposals approved as submitted or as amended by the council.~~))

(a) For the purpose of review and adoption of new model code editions and statewide amendment submission, the state building code shall be divided into two groups:

(i) Group 1: International Building Code (IBC); International Existing Building Code (IEBC); International Fire Code (IFC) Washington state energy code-commercial (WSEC-C).

(ii) Group 2: International Residential Code (IRC); International Mechanical Code (IMC); International Fuel Gas Code (IFGC); standards liquefied petroleum gas are National Fire Protection Association (NFPA) standards 58 and 54; Uniform Plumbing Code (UPC); Washington state energy code-residential (WSEC-R).

(b) The adoption period of new model codes commences when new editions of the model codes are available to the public. Within sixty days, the council shall publish a timeline to include a report of significant model code amendments and applicability of existing state amendments, followed by a submission period for new proposed statewide amendments.

(i) The council shall review Group 1 codes and approve a report on significant changes and applicability of existing state amendments. The Group 1 report shall be posted on the council web site and a submission period of at least two months shall be allowed for new proposed statewide amendments.

(ii) Upon completion and posting of the Group 1 report, and provided new editions of Group 2 model codes are available to the public, the council shall review the Group 2 codes and approve a report on significant changes and applicability of existing state amendments. The Group 2 report shall be posted on the council web site and a submission period of at least two months shall be allowed for new proposed statewide amendments

(2) The council shall review proposed new statewide amendments, and approve those meeting the appropriate criteria to file as proposed rules in accordance with chapter 34.05 RCW. The proposed rules filing shall include a small business economic impact statement in accordance with chapter 19.85 RCW.

(3) The council shall conduct at least two public hearings for each group.

(4) The code adoption period shall conclude with formal adoption of the state building code as amended by the council. As required by RCW 19.27.074, all decisions to adopt or amend the state building code shall be made prior to December 1st and shall not take effect before the end of the regular legislative session in the next year. Group 1 and 2 codes shall be filed with the code reviser at the same time. Amendments to Group 1 codes during the Group 2 adoption shall be limited to code correlation, errors, language clarification and updated section references.

(5) State amendments as approved by the council shall be submitted to the appropriate model code organization, at the direction of the council, except those adopted for consistency with state statutes or regulation and held for further review during the adoption period of those model codes by the council. The effective date of any statewide amendments shall be the same as the effective date of the new edition of the model codes, except for emergency amendments adopted in accordance with chapter 34.05 RCW and deemed appropriate by the council.

((~~The adoption period of new model codes commences upon availability of the publication of the new edition of the model codes and concludes with formal adoption of the building code as amended by the council and final review by the state legislature. For the purposes of this section, the publication of supplements shall not be considered a new edition.~~

~~The council will consider state amendments to: The model codes provided that the proposed amendments shall be limited to address changes in the model codes since the previous edition; or, address existing statewide amendments to the model codes; or, address portions of the state building code other than the model codes. The state building code council shall consider the action of the model code organizations in their consideration of these proposals.~~

~~Within sixty days of the receipt of the new edition of the model codes the council shall enter rule making to update the state building code.~~))

AMENDATORY SECTION (Amending WSR 07-15-043, filed 7/13/07, effective 8/13/07)

WAC 51-04-025 Procedure for submittal of proposed statewide amendments. (1) Statewide and emergency statewide amendments to the state building code shall conform to the purposes, objectives, and standards prescribed in RCW 19.27.020.

All proposed statewide amendments shall be submitted in writing to the council, on the form provided by the council. The amendment must address existing model code language; a change in the model codes since a previous edition; or an existing state or local amendment to the model code; or a portion of the state code other than the model code. The state building code council shall consider the action of the model code organizations in their consideration of these proposals.

Statewide and emergency statewide amendments to the state building code shall be based on one of the following criteria:

(a) The amendment is needed to address a critical life/safety need.

(b) The amendment clarifies the intent or application of the code.

(c) The amendment is necessary for consistency with state or federal regulations.

(d) The amendment corrects errors and omissions.

(e) The amendment eliminates an obsolete, conflicting, duplicating or unnecessary regulation.

(2) Petitions for statewide amendments to the building code shall be submitted to the council during the submission period and the adoption period in accordance with WAC 51-04-020. Minimum requirements specified on the form for submittals must be included. Incomplete submittals will be held for thirty days and the proponent will be notified with a request for more information. If after thirty days, the applicant has not provided requested information for a complete application, the proponent's proposal will be deemed incomplete and shall not move forward.

(3) Petitions for emergency statewide amendments to the building code may be submitted at any time, in accordance with RCW 19.27.074 and chapter 34.05 RCW, and WAC 51-04-015 and 51-04-020.

The council may refer a proposed statewide amendment to one of the council standing committees for review and comment prior to council action in accordance with chapter 34.05 RCW.

(4) The council shall ((~~deal with~~)) consider and take action on all proposed statewide amendments within the time frames required by chapter 19.27 RCW, RCW 34.05.330, and all other deadlines established by statute.

AMENDATORY SECTION (Amending WSR 07-15-043, filed 7/13/07, effective 8/13/07)

WAC 51-04-030 Policies for consideration of proposed local government residential amendments. (1) All amendments to the building code, as adopted by cities and counties for implementation and enforcement in their respective jurisdictions, that apply to single and multifamily buildings as defined by RCW 19.27.015, shall be submitted to the council for approval.

(2) The council shall consider and approve or deny all proposed local government residential amendments to the state building code as presented to the council within ninety calendar days of receipt of a proposal, unless alternative scheduling is agreed to by the council and the proposing entity. Where a proposed local government residential amendment is modified upon adoption by the city or county legislative body, it shall be resubmitted to the council. Local government residential amendments shall not be effective until approved by the council and the local governing authority.

(3) All local government residential amendments to the building code that require council approval shall be submitted in writing to the council, ((~~after the city or county legislative body has adopted the amendment and~~)) by the authorized local code or elected official, prior to implementation and enforcement of the amendment by the local jurisdiction. All local amendments submitted for review shall be accompanied

by findings of fact ((~~adopted by the governing body of the local jurisdiction~~)) justifying the adoption of the local amendment in accordance with the five criteria noted below in this section.

(4) It is the policy of the council to encourage joint proposals for local government residential amendments from more than one jurisdiction. Local government residential amendments submitted to the council for approval shall be based on:

((~~(1)~~)) (a) Climatic conditions that are unique to the jurisdiction.

((~~(2)~~)) (b) Geologic or seismic conditions that are unique to the jurisdiction.

((~~(3)~~)) (c) Environmental impacts such as noise, dust, etc., that are unique to the jurisdiction.

((~~(4)~~)) (d) Life, health, or safety conditions that are unique to the local jurisdiction.

((~~(5)~~)) (e) Other special conditions that are unique to the jurisdiction.

EXCEPTION: Local government residential amendments to administrative provisions (departmental operational procedures) contained within the state building code need not be submitted to the council for review and approval provided that such amendments do not alter the construction requirements of those chapters.

((~~Those portions of the supplement or accumulative supplements~~)) (5) Appendices to the codes that affect single and multifamily residential buildings as defined by RCW 19.27.015 that are not adopted by the council shall be submitted to the council for consideration as local government residential amendments to the building code.

Local government residential amendments shall conform to the limitations provided in RCW 19.27.040.

AMENDATORY SECTION (Amending WSR 16-01-042, filed 12/9/15, effective 1/9/16)

WAC 51-04-040 Reconsideration. (1) When the council approves, denies or modifies a statewide or local amendment to the building code, ((~~the party proposing the amendment~~)) any party with written or oral testimony to the council related to the amendment on the record may file a petition for reconsideration. The petition must be received by the Washington State Building Code Council, 1500 Jefferson Avenue S.E., P.O. Box 41449, Olympia, Washington 98504-1449, within ((~~ten~~)) twenty calendar days of the date of the ((~~denial~~)) council action on the amendment. The petition must give specific reasons for why the council should reconsider the amendment for approval or denial.

(2) Within sixty calendar days of receipt of a timely petition for reconsideration, the council shall in writing:

(a) Grant the petition for reconsideration and ((~~approve~~)) enter rule making to revise the amendment;

(b) Deny the petition for reconsideration, giving reasons for the denial; or

(c) Request additional information and extend the time period for not more than thirty calendar days to either grant or deny the petition for reconsideration.

(3) The council's denial of a proposed statewide or local government amendment, or the council denial of a petition for reconsideration under this section, is subject to judicial review under chapter 34.05 RCW.

WSR 17-03-127
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed January 18, 2017, 11:36 a.m., effective February 18, 2017]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The department is amending WAC 388-106-0270 What services are available under community first choice (CFC)? and 388-106-0274 Are there limits to the assistive technology I may receive?, to clarify language related to service descriptions and limits.

Citation of Existing Rules Affected by this Order: Amending WAC 388-106-0270 and 388-106-0274.

Statutory Authority for Adoption: RCW 74.08.090.

Adopted under notice filed as WSR 16-23-169 on November 23, 2016.

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 2, 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: January 17, 2017.

Katherine I. Vasquez
Rules Coordinator

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

WAC 388-106-0270 What services are available under community first choice (CFC)? The services you may receive under the community first choice program include:

(1) Personal care services((~~,~~)) as defined in WAC 388-106-0010.

(2) Relief care, which is personal care services by a second individual or agency provider as a back-up to your primary paid personal care provider.

(3) Skills acquisition training, which is training that allows you to acquire, maintain, and enhance skills necessary to accomplish ADLs, IADLs, or health related tasks more independently. Health related tasks are specific tasks related to the needs of an individual((~~, which~~)) that under state law

licensed health professionals can delegate or assign to a qualified health care practitioner.

(4) Personal emergency response systems (PERS), which ((~~is a~~)) are basic electronic ((~~device~~)) devices that ((~~enables~~)) enable you to secure help in an emergency when:

(a) You live alone in your own home; ((~~or~~))

(b) You are alone in your own home for significant parts of the day and have no provider for extended periods of time; or

(c) No one in your home, including you, is able to secure help in an emergency.

(5) Assistive technology, including assistive equipment, which are items that increase your independence or substitute for human assistance specifically with ADL, IADL, or health related tasks, including but not limited to:

(a) Additions to the standard PERS unit, such as fall detection, GPS, or medication delivery with or without reminder systems((~~. For cost allocation purposes, the cost of additions to the standard PERS unit will be considered assistive technology; or~~));

(b) Department approved devices, ((~~which include~~)) including but ((~~are~~)) not limited to((~~:~~)) visual alert systems, voice activated systems, switches and eyegazes, and timers or electronic devices that monitor or sense movement and react in a prescribed manner such as turning on or off an appliance;

(c) Repair or replacing items as limited by WAC 388-106-0274; and

(d) Training of participants and caregivers on the maintenance or upkeep of equipment purchased under assistive technology.

(6) Nurse delegation services((~~,~~)) as defined in WAC 246-840-910 through 246-840-970.

(7) Nursing services((~~,~~)) when you are not already receiving ((~~this type of service~~)) nursing services from another source. A registered nurse may visit you and perform any of the following activities:

(a) Nursing assessment/reassessment;

(b) Instruction to you and your providers;

(c) Care coordination and referral to other health care providers;

(d) Skilled treatment, which is care that ((~~would require~~)) requires authorization, prescription, and supervision by an authorized practitioner prior to its provision by a nurse, including but not limited to((~~,~~)) medication administration or wound care such as debridement((~~.~~)); nursing services will only provide skilled treatment in the event of an emergency((~~.~~)) and in nonemergency situations, the nurse will refer the need for any skilled medical or nursing treatments to a health care provider, home health agency, or other appropriate resource((~~.~~));

(e) File review; and

(f) Evaluation of health-related care needs ((~~affecting~~)) that affect service plan and delivery.

(8) Community transition services, which are ((~~non-recurring~~)) nonrecurring, ((~~set-up~~)) setup items or services to assist you with ((~~being discharged~~)) discharge from a nursing facility, institution for mental diseases, or intermediate care facility for individuals with intellectual disabilities, when these items or services are necessary for you to set up your own home((~~. Community transition services may include~~)), including but not limited to:

(a) Security deposits that are required to lease an apartment or home, including first month's rent;

(b) Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bath and linen supplies;

(c) ((~~Set-up~~)) Setup fees or deposits for utilities, including telephone, electricity, heating, water, and garbage;

(d) Services necessary for your health and safety such as pest eradication and one-time cleaning prior to occupancy;

(e) Moving expenses; and

(f) Activities to assess need, arrange for, and procure necessary resources.

(9) Caregiver management training on how to select, manage and dismiss personal care providers((~~. Training is provided in written, DVD, and web-based formats~~)).

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

WAC 388-106-0274 Are there limits to the assistive technology I may receive? (1) There are limits to the assistive technology you may receive. Assistive technology excludes:

(a) Any purchase ((~~that is~~)) solely for recreational purposes;

(b) ((~~Applications for devices that are sold separately from the device,~~)) Subscriptions((~~,~~)) and data plan charges, ((~~or items that require a~~)) and monthly recurring ((~~fee~~)) fees;

(c) Medical supplies and medical equipment;

(d) Home modifications; and

(e) Any item that would otherwise be covered under any other payment source, including but not limited to((~~,~~)) medicare, medicaid, and private insurance.

(2) In combination with skills acquisition training, assistive technology purchases are limited to a yearly amount determined by the department per fiscal year.

(3) To help decide whether to authorize ((~~this service,~~)) assistive technology the department may require a treating professional's written recommendation regarding the need for ((~~the~~)) an assistive technology evaluation. The treating professional ((~~making~~)) who makes this recommendation must:

(a) Have personal knowledge of or experience with the requested assistive technology; and

(b) Have examined you, reviewed your medical records, and have knowledge of your level of functioning, and ability to use the technology.

(4) Your choice of ((~~services~~)) assistive technology is limited to the most cost effective option that meets your health and welfare needs.

(5) Replacement of an assistive technology item or piece of equipment is limited to once every two years.