and 28A.150.220(4). 99-04-008, § 180-82-204, filed 1/21/99, effective 2/21/99.]

**WAC 180-82-210 Primary and supporting endorsements.** (1) All endorsements obtained under the requirements in chapter 180-82 WAC shall be designated as either primary or supporting endorsements on teaching certificates.

(2) All candidates for teaching certificates shall be required to obtain a primary endorsement, except as otherwise provided in WAC 180-79A-257 (1)(d).

(3) Primary endorsements shall require a minimum of forty-five quarter credit hours (thirty semester credit hours) of academic study (or its equivalent) in the endorsement area: Provided, That primary endorsements for broad area endorsements (i.e., English/language arts, science, and social studies) shall require sixty quarter credit hours (forty semester credit hours) of academic study (or its equivalent) in the endorsement area.

(4) Supporting endorsements shall require a minimum of twenty-four quarter credit hours (sixteen semester credit hours) of academic study (or its equivalent) in the endorsement area.

(5) The state board of education or its designee may establish performance/competency criteria for obtaining an endorsement.

[Statutory Authority: RCW 28A.410.010. 01-13-108, § 180-82-210, filed 6/20/01, effective 7/21/01. Statutory Authority: RCW 28A.410.010 and 28A.305.130 (1) and (2). 99-23-023, § 180-82-210, filed 11/9/99, effective 12/10/99. Statutory Authority: RCW 28A.305.130 (1) and (2), 28A.410.010 and 28A.150.220(4). 99-04-008, § 180-82-210, filed 1/21/99, effective 2/21/99.]

## Chapter 180-85 WAC
## PROFESSIONAL CERTIFICATION—CONTINUING EDUCATION REQUIREMENT

WAC



**WAC 180-85-035 Lapse date—Definition.** As used in this chapter, the term "lapse date" shall mean the date upon which the professional certificate affected by this chapter will lapse if the holder fails to complete the continuing education requirement and the filing requirement of this chapter.

[Statutory Authority: RCW 28A.410.010. 01-13-111, § 180-85-035, filed 6/20/01, effective 7/21/01. Statutory Authority: RCW 28A.70.005. 86-13-018 (Order 8-86), § 180-85-035, filed 6/10/86.]

**WAC 180-85-075 Continuing education requirement.** Continuing education requirements are as follows:

(1) Each holder of a continuing or a standard certificate affected by this chapter shall be required to complete during a five-year period one hundred fifty continuing education credit hours, as defined in WAC 180-85-030, prior to his or her first lapse date and during each five-year period between subsequent lapse dates as calculated in WAC 180-85-100.

(2) Provided, That each holder of a continuing or a standard certificate affected by this chapter may present a copy of a valid certificate issued by the National Board for Professional Teaching standards in lieu of the completion of the continuing education credit hours required by subsection (1) of this section.

[Statutory Authority: RCW 28A.410.010. 01-09-004, § 180-85-075, filed 4/5/01, effective 5/6/01; 99-14-010, § 180-85-075, filed 6/24/99, effective 7/25/99. Statutory Authority: RCW 28A.305.130 (1) and (2), 28A.410.010 and 28A.150.220(4). 99-01-174, § 180-85-075, filed 12/23/98, effective 1/23/99. Statutory Authority: RCW 28A.70.005. 89-01-043 (Order 28-88), § 180-85-075, filed 12/14/88; 86-13-018 (Order 8-86), § 180-85-075, filed 6/10/86.]

# Title 182 WAC
# HEALTH CARE AUTHORITY

**Chapters**



## Chapter 182-08 WAC
## PROCEDURES

WAC



**WAC 182-08-095 Waiver of coverage.** Employees eligible for PEBB health care coverage have the option of waiving medical coverage for themselves and any or all dependents if they are covered by another medical plan. In order to waive medical coverage, the employee must complete an enrollment form that identifies the individuals for whom coverage is being waived. If an employee waives medical coverage for him/herself, coverage is automatically waived for all eligible dependents. An employee may choose to enroll only him/herself, and waive medical coverage for any or all dependents.

Employees whose medical coverage is waived will remain enrolled in a PEBB dental plan. Employees will also remain enrolled in PEBB life and long term disability coverage.

If PEBB medical coverage is waived, an otherwise eligible person may not enroll in a PEBB plan until the next open enrollment period, or within 31 days of loss of other medical coverage. Proof of other medical coverage is required to demonstrate that: 1) Coverage was continuous from the date PEBB coverage was waived; and 2) the period between loss of coverage and application for PEBB coverage is 31 days or less. The employee and dependents may have an additional opportunity to enroll in the event of acquisition of a new dependent as a result of marriage, birth, adoption, or placement for adoption, provided that enrollment is requested within 31 days of marriage or within 60 days of birth, adoption or placement for adoption.

[Statutory Authority: RCW 41.05.160 and 41.05.065. 01-24-048 (Order 01-05), § 182-08-095, filed 11/29/01, effective 12/30/01. Statutory Authority: RCW 41.05.160. 99-19-029 (Order 99-03), § 182-08-095, filed 9/8/99,

effective 10/9/99; 97-21-126, § 182-08-095, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-095, filed 3/29/96, effective 4/29/96.]

**WAC 182-08-125 PEBB-sponsored medical and dental benefit is limited to one enrollment per individual member.** (1) Effective January 1, 2002, individuals that have more than one source of eligibility for enrollment in PEBB-sponsored medical and dental benefits (called "dual eligibility") are limited to one enrollment.

(2) The following three examples describe typical situations of dual eligibility. These are not the only situations where dual eligibility may arise and are provided as illustrations only.

(a) A husband and wife who are both employed by PEBB-participating employers, such as state agencies, may enroll only in medical or dental as an employee and not also as a dependent. That is, the husband may enroll only under his employing agency and the wife may enroll only under her employing agency.

(b) A dependent child that is eligible for coverage under two or more parents or stepparents who are employed by PEBB-participating employers, may be enrolled as a dependent under the coverage of one parent or stepparent, but not more than one.

(c) An employee employed in an insurance-eligible position by more than one PEBB-participating employer may enroll only under one employer. The employee may choose to enroll in insurance under the employer that:

(i) Offers the most favorable cost-sharing arrangement; or

(ii) Employed the employee for the longer period of time.

[Statutory Authority: RCW 41.05.160 and 41.05.065. 01-24-048 (Order 01-05), § 182-08-125, filed 11/29/01, effective 12/30/01.]

## Chapter 182-12 WAC
## ELIGIBLE AND NONELIGIBLE EMPLOYEES

WAC



**WAC 182-12-117 Eligible retirees.** (1) Eligible employees who terminate state service after becoming vested in a Washington state sponsored retirement system are eligible for retiree medical and dental coverages provided:

(a) The retiree and covered dependent(s) are eligible for Medicare, elects Medicare Parts A and B if the retiree retired after July 1, 1991; and

(b) The person submits an application form to enroll or waive PEBB medical and dental coverage within sixty days after active employer or continuous Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage ends and is eligible under one or more of the programs described in (c), (d), (e), (f), or (g) of this subsection;

(c) Except as provided in (e)(vii) of this subsection, the person immediately begins receiving a monthly retirement income benefit from one or more of the following retirement systems:

(i) Law enforcement officers' and fire fighters' retirement system plan 1 or 2;

(ii) Public employees' retirement system plan 1 or 2;

(iii) School employees' retirement system plan 2;

(iv) State judges/judicial retirement system;

(v) Teachers' retirement system plan 1 or 2; or

(vi) Washington state patrol retirement system.

(vii) Provided, however, that a lump-sum payment may be received in lieu of a monthly retiree income benefit payment under RCW 41.26.425(1), 41.32.762(1), 41.32.870(1), 41.35.410(1), 41.35.670(1), 41.40.625(1) or 41.40.815(1).

(d) The person is at least fifty-five years of age with at least ten years service credit and a member of one of the following retirement systems:

(i) Public employees' retirement system plan 3;

(ii) School employees' retirement system plan 3; and

(iii) Teachers' retirement system plan 3.

(e) The person is a member of state of Washington higher education retirement plan, and is:

(i) At least fifty-five years of age with at least ten years service; or

(ii) At least sixty-two years of age; or

(iii) Immediately begins receiving a monthly retirement income benefit.

(f) If not retiring under the public employees' retirement system, the person would have been eligible for a monthly retirement income benefit because of age and years of service had the person been employed under the provisions of public employees retirement system 1 or 2 for the same period of employment.

(g) The person is an elected official as defined under WAC 182-12-115(6) who has voluntarily or involuntarily left a public office, whether or not they receive a benefit from a state retirement system.

(2) Eligible employees who participate in the public employees' benefits board (PEBB) sponsored life insurance as an active employee and meet qualifications for retiree medical benefits as provided in subsection (1) of this section are eligible for PEBB sponsored retiree life insurance if they apply to the health care authority within sixty days after the date their active PEBB life insurance terminates and their premium is not being waived for any PEBB life insurance plan at the time of application for retiree life insurance.

(3) The following retired and disabled school district and educational service district employees are eligible to participate in PEBB medical and dental plans only, provided they meet the enrollment criteria stated below and if eligible for Medicare, are also enrolled in Medicare Parts A and B:

(a) Persons receiving a retirement allowance under chapter 41.32, 41.35 or 41.40 RCW as of September 30, 1993, and who enroll in PEBB plans not later than the end of the open enrollment period established by the authority for the plan year beginning January 1, 1995;

(b) Persons who separate from employment with a school district or educational service district due to a total and permanent disability, and are eligible to receive a deferred retirement allowance under chapter 41.32, 41.35 or 41.40 RCW. Such persons must enroll in PEBB plans not later than

the end of the open enrollment period established by the authority for the plan year beginning January 1, 1995, or sixty days following retirement, whichever is later.

(4) Employees who are permanently and totally disabled and eligible for a deferred monthly retirement income benefit are eligible for medical, dental and life insurance benefits as provided in subsection (2) of this section, provided they apply for retiree coverage before their PEBB active employee coverage ends.

(5) With the exception of the Washington state patrol, retirees and disabled employees are not eligible for an employer premium contribution.

(6) The Federal Civil Service Retirement System shall be considered a Washington state sponsored retirement system for Washington State University cooperative extension service employees who hold a federal civil service appointment and who are covered under the PEBB program at the time of retirement or disability.

[Statutory Authority: RCW 41.05.160. 01-17-042 (Order 01-01), § 182-12-117, filed 8/9/01, effective 9/9/01; 97-21-127, § 182-12-117, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-117, filed 3/29/96, effective 4/29/96.]

**WAC 182-12-118 Insurance eligibility for surviving dependents of emergency service personnel killed in the line of duty.** Surviving dependents of emergency service personnel who were killed in the line of duty on or after January 1, 1998, are eligible to participate in medical and dental coverage administered by the health care authority and sponsored by the public employee's benefits board.

(1) This rule applies to the dependents of emergency service personnel "killed in the line of duty" as determined consistent with Title 51 RCW by the department of labor and industries.

(2) "Emergency service personnel" is defined as law enforcement officers, fire fighters and reserve officers, fire fighters as defined in RCW 41.26.030 and 41.24.010.

(3) "Surviving dependent" is defined as:

(a) A lawful spouse or ex-spouse as defined in RCW 41.26.162; and

(b) Dependent children. The term "children" includes unmarried natural children, stepchildren and legally adopted children under the age of twenty or under the age of twenty-four for a dependent student attending high school or an accredited secondary school full-time. Disabled dependents as defined in RCW 41.26.020(7) are eligible at any age.

(4) Premium rates will be subsidized consistent with rates established by the health care authority for non-Medicare retirees under RCW 41.05.022 and for Medicare-eligible retirees under RCW 41.05.085.

(5) Surviving dependents that are Medicare-eligible must enroll in both parts A and B of Medicare.

(6) The surviving dependent must send a completed enrollment application to the health care authority no later than sixty days after:

(a) The last day of any coverage extended by the employing agency of the emergency service employee who died in the line of duty; or

(b) The last day of coverage extended through the Consolidated Omnibus Budget Reconciliation Act (COBRA) from any employing agency.

(7) Surviving dependents must choose one of the following two options for maintaining eligibility for participation under public employee's benefits board sponsored medical and dental coverage:

(a) Enroll in coverage:

(i) Enrollment in a medical plan is required.

(ii) Enrollment in dental coverage is optional. Once enrolled in dental the member must maintain enrollment in a dental plan for a minimum of two years before dental can be dropped.

(iii) Dental only coverage is not available.

(b) Waive enrollment:

(i) Surviving dependents may waive enrollment in public employee's benefits board sponsored medical and dental coverage if they are enrolled in employer sponsored medical through their employment.

(ii) Surviving dependents may enroll in public employee's benefits board sponsored medical and dental when their employer sponsored coverage ends. Proof of their continuous enrollment in employer sponsored coverage must be submitted with their application for enrollment to the health care authority within sixty days of the date that their coverage ended.

(8) Enrollees may change their medical or dental plan selection during the annual open enrollment period held by the health care authority. In addition to the annual open enrollment period, enrollees may change plans if they move out of their plan's service area or into a service area where a plan that was not previously offered is now available.

(9) Surviving dependents will forfeit their right to enroll in public employee's benefits board sponsored medical and dental coverage if they:

(a) Do not make application to the health care authority before the date specified in subsection (6) of this section; or

(b) Do not maintain continuous medical coverage during the waiver period enrollment for public employee's benefits board sponsored medical, as provided in subsection (7)(a)(ii) of this section.

[Statutory Authority: RCW 41.05.160 and 41.05.065. 01-24-047 (Order 01-04), § 182-12-118, filed 11/29/01, effective 12/30/01.]

**WAC 182-12-200 Retirees may change enrollment in approved PEBB health plans.** A retiree, whose spouse is enrolled as an eligible employee in a PEBB or Washington state school district-sponsored health plan, may defer enrollment in PEBB retiree medical and dental plans and enroll in the spouse's PEBB or school district-sponsored health plan. If a retiree defers enrollment in a PEBB retiree medical plan, enrollment must also be deferred for dental coverage. The retiree and eligible dependents may subsequently enroll in a PEBB retiree medical, or medical and dental, plan(s) if the retiree was continuously enrolled under the spouse's PEBB or school district-sponsored health coverage from the date the retiree was initially eligible for retiree coverage:

(1) During any open enrollment period determined by the HCA; or

(2) Within sixty days of the date the spouse ceases to be enrolled in a PEBB or school district-sponsored health plan as an eligible employee; or

(3) Within sixty days of the date of the retiree's loss of eligibility as a dependent under the spouse's PEBB or school district-sponsored health plan.

[Statutory Authority: RCW 41.05.160. 01-17-041 (Order 01-00), § 182-12-200, filed 8/9/01, effective 9/9/01; 97-21-127, § 182-12-200, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-200, filed 3/29/96, effective 4/29/96; Order 4-77, § 182-12-200, filed 11/17/77.]

## Chapter 182-20 WAC
## STANDARDS FOR COMMUNITY HEALTH CLINICS

WAC



**WAC 182-20-001 Purpose.** The purpose of this chapter is to establish procedures at the Washington state health care authority for determining eligibility and distribution of funds for medical, dental, and migrant services to community health clinics under section 214(3), chapter 19, Laws of 1989 1st ex. sess., including other state general fund appropriations for medical, dental, and migrant services in community health clinics since 1985.

[Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-001, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-001, filed 5/26/95, effective 6/26/95.]

**WAC 182-20-010 Definitions.** For the purposes of these rules, the following words and phrases shall have these meanings unless the context clearly indicates otherwise.

(1) "Community health clinic" means a public or private nonprofit tax exempt corporation with the mission of providing primary health care to low income individuals at a charge based upon ability to pay.

(2) "Authority" means the Washington state health care authority.

(3) "Encounter" means a face-to-face contact between a patient and a health care provider exercising independent judgment, providing primary health care, and documenting the care in the individual's health record.

(4) "Health care provider" means any person having direct or supervisory responsibility for the delivery of health care including:

(a) Physicians under chapters 18.57 and 18.71 RCW;

(b) Dentists under chapter 18.32 RCW;

(c) Advanced registered nurse practitioner under chapter 18.79 RCW;

(d) Physician's assistant under chapters 18.71A and 18.57A RCW;

(e) Dental hygienist under chapter 18.29 RCW;

(f) Licensed midwife under chapter 18.50 RCW;

(g) Federal uniformed service personnel lawfully providing health care within Washington state.

(5) "Low-income individual" means a person with income at or below two hundred percent of federal poverty level. The poverty level has been established by Public Law 97-35 § 652 (codified at 42 USC 9847), § 673(2) (codified at 42 USC 9902 (2)) as amended; and the *Poverty Income Guideline* updated annually in the *Federal Register*.

(6) "Primary health care" means comprehensive care that includes a basic level of preventive and therapeutic medical and/or dental care, usually delivered in an outpatient setting, and focused on improving and maintaining the individual's general health.

(7) "Relative value unit" means a standard measure of performance based upon time to complete a clinical procedure. The formula is one unit equals ten minutes. A table is available from the authority stating the actual values.

(8) "Administrator" means the administrator of the health care authority or the administrator's designee.

(9) "User" means an individual having one or more primary health care encounters and counted only once during a calendar year.

(10) "Contractor" means the community health clinic or other entity performing services funded by chapter 182-20 WAC, and shall include all employees of the contractor.

[Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-010, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-010, filed 5/26/95, effective 6/26/95.]

**WAC 182-20-100 Administration.** The authority shall contract with community health clinics to provide primary health care in the state of Washington by:

(1) Developing criteria for the selection of community health clinics to receive funding;

(2) Establishing statewide standards governing the granting of awards and assistance to community health clinics;

(3) Disbursing funds appropriated for community health clinics only to those clinics meeting the criteria in WAC 182-20-160;

(4) Distributing available state funds to community health clinics according to the following priority in the order listed:

(a) First, to community health clinics that are private, nonprofit corporations classified exempt under Internal Revenue Service Rule 501 (c)(3) and governed by a board of directors including representatives from the populations served;

(b) Second, to local health jurisdictions with an organized primary health clinic or division;

(c) Third, to private nonprofit or public hospitals with an organized primary health clinic or department.

(5) Reviewing records and conducting on-site visits of contractors or applicants as necessary to assure compliance with these rules; and

(6) Withholding funding from a contractor or applicant until such time as satisfactory evidence of corrective action is received and approved by the authority, if the authority determines:

(a) Noncompliance with applicable state law or rule; or

(b) Noncompliance with the contract; or

(c) Failure to provide such records and data required by the authority to establish compliance with section 214(3),

chapter 19, Laws of 1989 1st ex. sess., this chapter, and the contract; or

(d) The contractor or applicant provided inaccurate information in the application.

[Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-100, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-100, filed 5/26/95, effective 6/26/95.]

**WAC 182-20-160 Eligibility.** Applicants shall:

(1) Demonstrate private, nonprofit, tax exempt status incorporated in Washington state or public agency status under the jurisdiction of a local or county government;

(2) Receive other funds from at least one of the following sources:

(a) Section 329 of the Public Health Services Act;

(b) Section 330 of the Public Health Services Act;

(c) Community development block grant funds;

(d) Title V Urban Indian Health Service funds; or

(e) Other public or private funds providing the clinic demonstrates:

(i) Fifty-one percent of total clinic population are low income;

(ii) Fifty-one percent or greater of funds come from sources other than programs under WAC 182-20-160;

(3) Operate as a community health clinic providing primary health care for at least eighteen months prior to applying for funding;

(4) Provide primary health care services with:

(a) Twenty-four-hour coverage of the clinic including provision or arrangement for medical and/or dental services after clinic hours;

(b) Direct clinical services provided by one or more of the following:

(i) Physician licensed under chapters 18.57 and 18.71 RCW;

(ii) Physician's assistant licensed under chapters 18.71A and 18.57A RCW;

(iii) Advanced registered nurse practitioner under chapter 18.79 RCW;

(iv) Dentist under chapter 18.32 RCW;

(v) Dental hygienist under chapter 18.29 RCW;

(c) Provision or arrangement for services as follows:

(i) Preventive health services on-site or elsewhere including:

(A) Eye and ear examinations for children;

(B) Perinatal services;

(C) Well-child services; and

(D) Family planning services;

(ii) Diagnostic and treatment services of physicians and where feasible a physician's assistant and/or advanced registered nurse practitioner, on-site;

(iii) Services of a dental professional licensed under Title 18 RCW on-site or elsewhere;

(iv) Diagnostic laboratory and radiological services on-site or elsewhere;

(v) Emergency medical services on-site or elsewhere;

(vi) Arrangements for transportation services;

(vii) Preventive dental services on-site or elsewhere; and

(viii) Pharmaceutical services, as appropriate, on-site or elsewhere;

(5) Demonstrate eligibility to receive and receipt of reimbursement from:

(a) Public insurance programs; and

(b) Public assistant programs, where feasible and possible;

(6) Have established for at least eighteen months an operating sliding scale fee schedule for adjustment of charges, based upon the individual's ability to pay for low-income individuals;

(7) Provide health care regardless of the individual's ability to pay; and

(8) Establish policies and procedures reflecting sensitivity to cultural and linguistic differences of individuals served and provide sufficient staff with the ability to communicate with the individuals.

[Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-160, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-160, filed 5/26/95, effective 6/26/95.]

**WAC 182-20-200 Allocation of state funds.** The authority shall allocate available funds to medical, dental and migrant contractors providing primary health care based on the following criteria:

(1) **Medical.**

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;

(B) Prorated according to the percentage of total medical contract funds distributed to each contractor;

(ii) Up to ten percent for administration.

(b) The remainder of the appropriated funds is referred to as the "medical base." The medical base means the total amount of money appropriated by the legislature for the medical program minus the amounts specified in (a)(i) and (ii) of this subsection. The medical base is distributed to medical contractors based upon the following formulas:

(i) Starting July 1, 1996, the medical base is distributed to medical contractors based upon the following formula:

(A) Forty percent of the medical base is distributed equally among all medical contractors;

(B) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical sliding fee users divided by the total medical sliding fee users of all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's medical sliding fee users}}{\text{total of all contractors' medical sliding fee users}} \times 30\% \text{ medical base}$$

(C) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical sliding fee encounters by the total number of medical sliding fee encounters reported by all contractors as reported in the prior calendar year annual reports.

individual contractor's medical sliding fee encounters
——————————— X 30% medical base
total of all contractors' medical sliding fee encounters

(2) **Dental.**

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent of appropriated funds to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;

(B) Prorated according to the percentage of total dental contract funds distributed to each contractor.

(ii) Up to ten percent for administration.

(b) The remainder of the funds is referred to as the dental base. The dental base means the total amounts appropriated by the legislature for dental programs minus the amounts specified in (a)(i) and (ii) of this subsection and as follows:

(i) Starting July 1, 1996, the dental base is distributed to dental contractors based upon the following formula:

(A) Forty percent of the dental base is distributed equally among all dental contractors;

(B) Thirty percent of the dental base is distributed by the ratio of the contractor's primary health care (PHC) dental sliding fee users divided by the total dental sliding fee users of all contractors as reported in the prior calendar year annual reports.

individual contractor's dental sliding fee users
——————————— X 30% dental base
total of all contractors' dental sliding fee users

(C) Thirty percent of the dental base is distributed by the ratio of the contractor's primary health care (PHC) dental sliding fee relative value units (RVU) divided by the total number of dental sliding fee relative value units (RVU) reported by all contractors as reported in the prior calendar year annual reports.

individual contractor's dental sliding fee RVUs
——————————— X 30% dental base
total of all contractors' dental sliding fee RVUs

(3) **Migrant.**

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by the end of each funding year;

(B) Prorated according to the percentage of total migrant contract funds distributed to each contractor.

(ii) Up to ten percent for administration.

(b) The remainder of the appropriated funds is referred to as the "migrant base." The migrant base means the total amount of money appropriated by the legislature for the migrant program minus the amounts specified in (a)(i) and (ii) of this subsection. The migrant base is distributed to migrant contractors based upon the following formula:

The migrant base is distributed to migrant contractors based upon the following formula starting July 1, 1995: One hundred percent of the migrant base is distributed by the ratio of the contractor's primary health care (PHC) migrant users divided by the total migrant users of all contractors as reported in the prior calendar year annual reports.

individual contractor's migrant users
——————————— X 100% migrant base
total of all contractors' migrant users

[Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-200, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-200, filed 5/26/95, effective 6/26/95.]

**WAC 182-20-400 Limitations on awards.** Specific to the medical, dental, and migrant base as referenced in WAC 182-20-200 (1)(b), (2)(b), and (3)(b):

Starting July 1, 1997:

(1) Any approved contractor shall initially receive no more than one hundred twenty-five percent of that contractor's previous year's initial allotment.

(2) Any approved contractor shall initially receive no less than seventy-five percent of that contractor's previous year's initial allotment. In the event that funding is inadequate to provide seventy-five percent, criteria shall be established to equitably allocate the available funds.

(3) Funds in excess of the initial allocation shall be distributed in a supplemental allotment pursuant to WAC 182-20-200.

[Statutory Authority: RCW 41.05.160. 01-04-080 (Order 00-06), § 182-20-400, filed 2/7/01, effective 3/10/01. Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-400, filed 5/26/95, effective 6/26/95.]

## Chapter 182-25 WAC
## WASHINGTON BASIC HEALTH PLAN

WAC



**WAC 182-25-010 Definitions.** The following definitions apply throughout these rules.

(1) "Administrator" means the administrator of the Washington state health care authority (HCA) or designee.

(2) "Appeal procedure" means a formal written procedure for resolution of problems or concerns raised by enrollees which cannot be resolved in an informal manner to the enrollee's satisfaction.

(3) "Basic health plan" (or BHP) means the system of enrollment and payment for basic health care services administered by the administrator through managed health care systems.

(4) "BHP plus" means the program of expanded benefits available to children through coordination between the department of social and health services (DSHS) and basic health plan. Eligibility for BHP Plus is determined by the

department of social and health services, based on Medicaid eligibility criteria. To be eligible for the program children must be under age nineteen, with a family income at or below two hundred percent of federal poverty level, as defined by the United States Department of Health and Human Services. They must be Washington state residents, not eligible for Medicare, and may be required to meet additional DSHS eligibility requirements.

(5) "Co-payment" means a payment indicated in the schedule of benefits which is made by an enrollee to a health care provider or to the MHCS.

(6) "Covered services" means those services and benefits in the BHP schedule of benefits (as outlined in the member handbook issued to the enrollee, or to a subscriber on behalf of the enrollee), which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable co-payments.

(7) "Disenrollment" means the termination of covered services in BHP for a subscriber and dependents, if any.

(8) "Effective date of enrollment" means the first date, as established by BHP, on which an enrollee is entitled to receive covered services from the enrollee's respective managed health care system.

(9) "Dependent" means:

(a) The subscriber's lawful spouse, not legally separated, who resides with the subscriber; or

(b) The unmarried child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, who is:

(i) Younger than age nineteen, and who has not been relinquished for adoption by the subscriber or the subscriber's dependent spouse; or

(ii) Younger than age twenty-three, and a registered student at an accredited secondary school, college, university, technical college, or school of nursing, attending full time, other than during holidays, summer and scheduled breaks; or

(c) A person of any age who is under legal guardianship of the subscriber or the subscriber's dependent spouse, and who is incapable of self-support due to disability.

(10) "Eligible full-time employee" means an employee who meets all eligibility requirements in WAC 182-25-030 and who is regularly scheduled to work thirty or more hours per week for an employer. The term includes a self-employed individual (including a sole proprietor or a partner of a partnership, and may include an independent contractor) if the individual:

(a) Is regularly scheduled to work thirty hours or more per week; and

(b) Derives at least seventy-five percent of his or her income from a trade or business that is licensed to do business in Washington.

Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements.

(11) "Eligible part-time employee" means an employee who meets all the criteria in subsection (10) of this section, but who is regularly scheduled to work fewer than thirty hours per week for an employer.

(12) "Employee" means one who is in the employment of an employer, as defined by RCW 50.04.080.

(13) "Employer" means an enterprise licensed to do business in Washington state, as defined by RCW 50.04.080, with employees in addition to the employer, whose wages or salaries are paid by the employer.

(14) "Enrollee" means a person who meets all eligibility requirements, who is enrolled in BHP, and for whom applicable premium payments have been made.

(15) "Family" means an individual or an individual and spouse, if not legally separated, and dependents. For purposes of eligibility determination and enrollment in the plan, an individual cannot be a member of more than one family.

(16) "Financial sponsor" means a person, organization or other entity, approved by the administrator, that is responsible for payment of all or a designated portion of the monthly premiums on behalf of a subscriber and any dependents.

(17) "Gross family income" means total cash receipts, as defined in (a) of this subsection, before taxes, from all sources, for subscriber and dependents whether or not they are enrolled in BHP, with the exceptions noted in (b) of this subsection.

(a) Income includes:

(i) Money wages, tips and salaries before any deductions;

(ii) Net receipts from nonfarm self-employment (receipts from a person's own unincorporated business, professional enterprise, or partnership, after deductions for business expenses);

(iii) Net receipts from farm self-employment (receipts from a farm which one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses);

(iv) Regular payments from Social Security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance, alimony, child support, military family allotments, private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments;

(v) Work study or training stipends;

(vi) Dividends and interest accessible to the enrollee without a penalty;

(vii) Net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings.

(b) Income does not include the following types of money received:

(i) Capital gains;

(ii) Any assets drawn down as withdrawals from a bank, the sale of property, a house or a car;

(iii) Tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for injury (except workers' compensation);

(iv) Noncash benefits, such as the employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied nonfarm or farm housing, and such noncash benefit programs as Medicare, Medicaid, food stamps, school lunches, and housing assistance;

(v) Income earned by dependent children;

(vi) Income of a family member who resides in another household when such income is not available to the subscriber or dependents seeking enrollment in BHP;

(vii) College or university scholarships, grants, fellowships and assistantships;

(viii) Payments from the department of social and health services adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145;

(ix) Documented child care expenses for the care of a dependent child of a subscriber may be deducted (at a rate set by the administrator and consistent with Internal Revenue Service requirements) when calculating gross family income. To qualify for this deduction, the subscriber must be employed during the time the child care expenses were paid, and payment may not be paid to a parent or step parent of the child or to a dependent child of the subscriber or his/her spouse.

(18) "Home care agency" means a private or public agency or organization that administers or provides home care services directly or through a contract arrangement to ill, disabled, or infirm persons in places of temporary or permanent residence, and is licensed by the department of social and health services (DSHS) as a home care agency. In order to qualify, the agency must be under contract with one of the following DSHS programs: Chore, Medicaid Personal Care, Community Options Program Entry System (COPES) or Respite Care (up to level three).

(19) "Institution" means a federal, state, county, city or other government correctional or detention facility or government-funded facility where health care historically has been provided and funded through the budget of the operating agency, and includes, but is not limited to: Washington state department of corrections institutions; federal, county and municipal government jail and detention institutions; Washington state department of veterans affairs soldiers' and veterans' homes; department of social and health services state hospitals and facilities and juvenile rehabilitation institutions and group homes. An institution does not include: Educational institutions; government-funded acute health care or mental health facilities except as provided above; chemical dependency facilities; and nursing homes.

(20) "Institutionalized" means to be confined, voluntarily or involuntarily, by court order or health status, in an institution, as defined in subsection (19) of this section. This does not include persons on work release or who are residents of higher education institutions, acute health care facilities, alcohol and chemical dependency facilities, or nursing homes.

(21) "Insurance broker" or "agent" means a person who is currently licensed as a disability insurance broker or agent, according to the laws administered by the office of the insurance commissioner under chapter 48.17 RCW.

(22) "Managed health care system" (or "MHCS") means:

(a) Any health care organization (including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof) which has entered into a contract with the HCA to provide basic health care services; or

(b) A self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(7).

(23) "Maternity benefits through medical assistance," also known as S-Medical, means the coordinated program between BHP and DSHS for eligible pregnant women. This program includes all Medicaid benefits, including maternity coverage. Eligible members must be at or below one hundred eighty-five percent of the federal poverty level. Eligibility for this program is determined by DSHS, based on Medicaid eligibility criteria.

(24) "Medicaid" means the Title XIX Medicaid program administered by the department of social and health services, and includes the medical care programs provided to the "categorically needy" and the "medically needy" as defined in chapter 388-503 WAC.

(25) "Medicare" means programs established by Title XVIII of Public Law 89-97, as amended, "Health Insurance for the Aged and Disabled."

(26) "Nonsubsidized enrollee" or "full premium enrollee" means an individual who enrolls in BHP, as the subscriber or dependent, and who pays or on whose behalf is paid the full costs for participation in BHP, without subsidy from the HCA.

(27) "Open enrollment" means a time period designated by the administrator during which enrollees may enroll additional dependents or apply to transfer their enrollment from one managed health care system to another.

(28) "Participating employee" means an employee of a participating employer or home care agency who has met all the eligibility requirements and has been enrolled for coverage under BHP.

(29) "Participating employer" means an employer who has been approved for enrollment in BHP as an employer group.

(30) "Preexisting condition" means any illness, injury or condition for which, in the six months immediately preceding an enrollee's effective date of enrollment in BHP:

(a) Treatment, consultation or a diagnostic test was recommended for or received by the enrollee; or

(b) Medication was prescribed or recommended for the enrollee; or

(c) Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care or treatment.

(31) "Premium" means a periodic payment, based upon gross family income and determined under RCW 70.47.060(2), which an individual, their employer or a financial sponsor makes to BHP for subsidized or nonsubsidized enrollment in BHP.

(32) "Program" means subsidized BHP, nonsubsidized BHP, BHP Plus, or maternity benefits through medical assistance.

(33) "Provider" or "health care provider" means a health care professional or institution duly licensed and accredited to provide covered services in the state of Washington.

(34) "Rate" means the amount, including administrative charges and any applicable premium and prepayment tax imposed under RCW 48.14.020, negotiated by the adminis-

trator with and paid to a managed health care system, to provide BHP health care benefits to enrollees.

(35) "Schedule of benefits" means the basic health care services adopted and from time to time amended by the administrator, which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable co-payments, as described in the member handbook.

(36) "Service area" means the geographic area served by a managed health care system as defined in its contract with HCA.

(37) "Subscriber" is a person who applies to BHP on his/her own behalf and/or on behalf of his/her dependents, if any, who meets all applicable eligibility requirements, is enrolled in BHP, and for whom the monthly premium has been paid. Notices to a subscriber and, if applicable, a financial sponsor or employer shall be considered notice to the subscriber and his/her enrolled dependents.

(38) "Subsidized enrollee" or "reduced premium enrollee" means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA. To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, "subsidized enrollee" also means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

(39) "Subsidy" means the difference between the amount of periodic payment the HCA makes to a managed health care system on behalf of a subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

[Statutory Authority: RCW 70.47.050. 01-09-001 (Order 00-08), § 182-25-010, filed 4/4/01, effective 5/5/01. Statutory Authority: RCW 70.47.050 and 70.47.020 as revised by E2SSB 6067. 01-01-134 (Order 00-04), § 182-25-010, filed 12/20/00, effective 1/20/01. Statutory Authority: RCW 70.47.050, 70.47.060 and 70.47.100. 99-24-005 (Order 99-06), § 182-25-010, filed 11/18/99, effective 12/19/99. Statutory Authority: RCW 70.47.050, 70.47.060(9) and SHB 2556. 98-15-018, § 182-25-010, filed 7/6/98, effective 8/6/98. Statutory Authority: RCW 70.47.050. 98-07-002, § 182-25-010, filed 3/5/98, effective 4/5/98; 97-15-003, § 182-25-010, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-010, filed 7/9/96, effective 8/9/96.]

**WAC 182-25-105 How to appeal health care authority (HCA) decisions.** (1) Health care authority decisions regarding the following may be appealed under this section:

(a) Eligibility;

(b) Premiums;

(c) Premium adjustments or penalties;

(d) Enrollment;

(e) Suspension;

(f) Disenrollment; or

(g) Selection of managed health care system (MHCS).

(2) To appeal a health care authority decision, enrollees or applicants must send a letter of appeal to the HCA. The letter of appeal must be signed by the appealing party and received by the HCA within thirty calendar days of the date of the decision. The letter of appeal must include:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The enrollee:

(i) Remains otherwise eligible;

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

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

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

(10) If the appealing party disagrees with a review decision under subsection (6) of this section, the appealing party may request judicial review of the decision, as provided for in RCW 34.05.542. Request for judicial review must be filed with the court within thirty days of service of the final agency decision.

[Statutory Authority: RCW 70.47.050. 01-23-095 (Order 00-01), § 182-25-105, filed 11/21/01, effective 1/1/02; 99-07-078, § 182-25-105, filed 3/18/99, effective 4/18/99; 98-07-002, § 182-25-105, filed 3/5/98, effective 4/5/98; 96-15-024, § 182-25-105, filed 7/9/96, effective 8/9/96.]

**WAC 182-25-110 How to appeal a managed health care system (MHCS) decision.** (1) Enrollees who are appealing a MHCS decision, including decisions related to coverage disputes; denial of claims; benefits interpretation; or resolution of complaints must follow their MHCS's complaint/appeals process.

(2) Each MHCS must maintain a complaint/appeals process for enrollees and must provide enrollees with instructions for filing a complaint and/or appeal. This complaint/appeals process must comply with the requirements of chapter 48.43 RCW and chapter 284-43 WAC.

(3) On the request of the enrollee, the HCA may assist an enrollee by:

(a) Attempting to informally resolve complaints against the enrollee's MHCS;

(b) Investigating and resolving MHCS contractual issues; and

(c) Providing information and assistance to facilitate review of the decision by an independent review organization.

[Statutory Authority: RCW 70.47.050. 01-23-095 (Order 00-01), § 182-25-110, filed 11/21/01, effective 1/1/02; 99-07-078, § 182-25-110, filed 3/18/99, effective 4/18/99; 96-15-024, § 182-25-110, filed 7/9/96, effective 8/9/96.]

# Title 183 WAC

# WASHINGTON CITIZENS' COMMISSION ON SALARIES FOR ELECTED OFFICIALS

**Chapters**



## Chapter 183-04 WAC
## PUBLIC RECORDS

WAC



**WAC 183-04-010 Purpose.** The purpose of this chapter is to implement the public records provisions of chapter 42.17 RCW.

[Statutory Authority: Chapters 34.05, 42.17 RCW. 01-12-002, § 183-04-010, filed 5/23/01, effective 6/23/01.]

**WAC 183-04-020 Definitions.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Commission" means the Washington citizens' commission on salaries for elected officials. Where appropriate, the term "commission" also refers to the staff and employees of the commission.