WSR 14-10-002

PERMANENT RULES

HEALTH CARE AUTHORITY

(Washington Apple Health)

[Filed April 23, 2014, 2:11 p.m., effective May 24, 2014]

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

Purpose: The agency is amending this rule to match State Plan Amendment 13-15, which makes trauma hospitals eligible to receive supplemental payments for trauma care services they provided to managed care enrollees.

Citation of Existing Rules Affected by this Order: Amending WAC 182-550-5450.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: Washington State Plan Amendment 13-15.

Adopted under notice filed as WSR 14-07-036 on March 11, 2014.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 1, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 1, Repealed 0.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: April 23, 2014.

Kevin M. Sullivan
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-17-017, filed 8/9/13, effective 9/9/13)

WAC 182-550-5450 Supplemental distributions to approved trauma service centers. (1) The trauma care fund (TCF) is an amount appropriated to the medicaid agency each state fiscal year (SFY), at the legislature's sole discretion, for the purpose of supplementing the agency's payments to eligible trauma service centers for providing qualified trauma services to medicaid clients.

(2) ((~~The agency makes supplemental distributions from the TCF to qualified hospitals, subject to the provisions in this section and subject to legislative action.~~)) Encounter data, for trauma care provided to medicaid clients enrolled in an agency-contracted managed care organization, may be included when calculating supplemental distributions from the TCF, so long as the beginning dates of service for trauma care are on and after July 1, 2013.

(3) To qualify for supplemental distributions from the TCF, a hospital must:

(a) Be designated or recognized by the department of health (DOH) as an approved Level I, Level II, or Level III adult or pediatric trauma service center;

(b) Meet the provider requirements in this section and other applicable rules;

(c) Meet the billing requirements in this section and other applicable rules;

(d) Submit all information the agency requires to monitor the program; and

(e) Comply with DOH's Trauma Registry reporting requirements.

(4) Supplemental distributions from the TCF are:

(a) Allocated into five payment pools. Timing of payments is described in subsection (5) of this section. Distributions from the payment pools to the individual hospitals are determined by first summing the agency's qualifying payments to each eligible hospital since the beginning of the service year ((~~and expressing~~)). This amount is then expressed as a percentage of the agency's total payments to all eligible hospitals for qualifying services provided during the service year-to-date. For TCF purposes, service year is defined as the SFY. Each hospital's qualifying payment percentage for the service year-to-date is multiplied by the available amount for the service year-to-date, and then the agency subtracts what has been allocated to each hospital for the service year-to-date to determine the portion of the current payment pool to be paid to each qualifying hospital. Eligible hospitals and qualifying payments are described in (a)(i) through (iii) of this subsection. Qualifying payments are the agency's payments to:

(i) Level I, Level II, and Level III trauma service centers for qualified medicaid trauma cases since the beginning of the service year. The agency determines the countable payment for trauma care provided to medicaid clients based on date of service, not date of payment;

(ii) The Level I, Level II, and Level III hospitals for trauma cases transferred to these facilities since the beginning of the service year. A Level I, Level II, or Level III hospital that receives a transferred trauma case from any lower level hospital is eligible for ((~~the~~)) an enhanced payment, regardless of the client's injury severity score (ISS); and

(iii) Level II and Level III hospitals for qualified trauma cases (those that meet or exceed the ISS criteria in (b) of this subsection) transferred by these hospitals since the beginning of the service year to a trauma service center with a higher designation level.

(b) Paid only for a medicaid trauma case that meets:

(i) The ISS of thirteen or greater for an adult trauma patient (a client age fifteen or older);

(ii) The ISS of nine or greater for a pediatric trauma patient (a client younger than age fifteen); or

(iii) The conditions of (c) of this subsection.

(c) Made to hospitals, as follows, for a trauma case that is transferred:

(i) A hospital that receives the transferred trauma case qualifies for payment regardless of the ISS if the hospital is designated or recognized by DOH as an approved Level I, Level II, or Level III adult or pediatric trauma service center;

(ii) A hospital that transfers the trauma case qualifies for payment only if:

(A) ((~~It~~)) The hospital is designated or recognized by DOH as an approved Level II or Level III adult or pediatric trauma service center; and

(B) The ISS requirements in (b)(i) or (ii) of this subsection are met.

(iii) A hospital that DOH designates or recognizes as an approved Level IV or Level V trauma service center does not qualify for supplemental distributions for trauma cases that are transferred in or transferred out, even when the transferred cases meet the ISS criteria in (b) of this subsection.

(d) Not funded by disproportionate share hospital (DSH) funds; and

(e) Not distributed by the agency to:

(i) Trauma service centers designated or recognized as Level IV or Level V;

(ii) Critical access hospitals (CAHs), except when the CAH is also a Level III trauma service center; or

(iii) Any facility for follow-up services related to the qualifying trauma incident but provided to the client after the client has been discharged from the initial hospitalization for the qualifying injury.

(5) Distributions for an SFY are paid as follows:

(a) The first supplemental distribution from the TCF is made three to six months after the SFY begins;

(b) Subsequent distributions are made approximately every two to four months after the first distribution is made, except as described in (c) of this subsection;

(c) The final distribution from the TCF for an SFY is:

(i) Made one year after the end of the SFY;

(ii) Limited to the remaining balance of the agency's TCF appropriation for that SFY; and

(iii) Distributed based on each eligible hospital's percentage share of the total payments made by the agency to all designated trauma service centers for qualified trauma services provided during the relevant SFY.

(6) For purposes of the supplemental distributions from the TCF, all of the following apply:

(a) ((~~The agency considers a provider's request for a trauma claim adjustment only if the adjustment request is received by the agency within three hundred sixty-five calendar days from the date of the initial trauma service.~~)) At its discretion, and with sufficient public notice, the agency may adjust the deadline for submission and/or adjustment of trauma claims in response to budgetary program needs;

(b) The agency considers a provider's request for a trauma claim adjustment only if the adjustment request is received by the agency within three hundred sixty-five calendar days from the date of the initial trauma service;

(c) Except as provided in (a) of this subsection, the deadline for making adjustments to a trauma claim is the same as the deadline for submitting the initial claim to the agency as specified in WAC 182-502-0150(3). See WAC 182-502-0150 (11) and (12) for other time limits applicable to TCF claims;

((~~(c)~~)) (d) All claims and claim adjustments are subject to federal and state audit and review requirements; and

((~~(d)~~)) (e) The total amount of supplemental distributions from the TCF disbursed to eligible hospitals by the agency in any SFY cannot exceed the amount appropriated by the legislature for that SFY. The agency has the authority to take whatever actions necessary to ensure the department stays within the TCF appropriation.

WSR 14-10-009
PERMANENT RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed April 24, 2014, 1:07 p.m., effective May 25, 2014]

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

Purpose: WAC 392-122-160 State special education program—Reporting, requires updating to change the age reporting requirement for special education students. Starting in the 2013–14 school year, the student's age will be determined by the student's birthday. Two-year-old special education students that turn three during the school year will be reported in the age 3–5 category.

Citation of Existing Rules Affected by this Order: Amending WAC 392-122-160.

Statutory Authority for Adoption: RCW 28A.150.290.

Adopted under notice filed as WSR 14-06-010 on February 20, 2014.

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.

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

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

Date Adopted: April 10, 2014.

Randy Dorn
Superintendent of
Public Instruction

AMENDATORY SECTION (Amending WSR 96-03-002, filed 1/3/96, effective 2/3/96)

WAC 392-122-160 State special education program—Reporting. (1) At such times as are designated by the superintendent of public instruction, each school district shall report the number of eligible special education students receiving special education according to instructions provided by the superintendent of public instruction. The disability condition shall be one of such conditions in WAC 392-122-135. The age for the purpose of determining the special education program allocation calculated in WAC 392-122-105 shall be the age of the student ((~~as of midnight August 31 of the school year~~)) on the monthly enrollment count date as defined by WAC 392-121-119. The age reported by the

school district shall be for apportionment purposes only and not for determination of a child's eligibility for access to a special education program.

(2) Each school district shall provide, upon request, such additional data as are necessary to enable the superintendent of public instruction to allocate and substantiate the school district's allocation of state special education moneys.

WSR 14-10-017
PERMANENT RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2013-22—Filed April 25, 2014, 4:03 p.m., effective May 26, 2014]

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

Purpose: Based on the significant changes in health care delivery and access to care that will occur after January 1, 2014, due to health care reform, the commissioner determined that updating regulations is reasonable and necessary. Both qualified health plans and health plans offered outside of the exchange must have networks that at a minimum ensure access to covered services without unreasonable delay and address the specific needs of the populations served. Clarification of the provider network criteria in these areas is needed to support issuer filings. Issuers will benefit from written guidance regarding the commissioner's review standards for provider networks in general and the inclusion of essential community providers in networks for qualified health plans. The proposed rule also includes requirements for provider directories and creates a more transparent process for the building and maintenance of provider networks.

Citation of Existing Rules Affected by this Order: Repealing WAC 284-43-340; and amending WAC 284-43-130, 284-43-200, 284-43-205, 284-43-220, 284-43-250, and 284-43-331.

Statutory Authority for Adoption: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200.

Other Authority: RCW 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. 156.230, 45 C.F.R. 156.235, 45 C.F.R. 156.245.

Adopted under notice filed as WSR 13-19-092 [14-07-102] on March 19, 2014.

Changes Other than Editing from Proposed to Adopted Version: WAC 284-43-130(15), stand alone definition of "issuer" was stricken as it created an internal discrepancy in the definition section. Maintained as part of the definition of "health carrier," WAC 284-43-130(14). Renumbered section.

WAC 284-43-130(30), struck "within the state" from definition. Stricken to more accurately reflect the marketplace as issuers offer plans in border counties which utilize providers and facilities in neighboring states to provide sufficient number and choice of providers to enrollees in a manner that limits the amount of travel.

WAC 284-43-130(30), changed "health plan" to "product" for consistency.

WAC 284-43-200 (11)(a), changed "medical" to "mental" to accurately reflect the name of the publication.

WAC 284-43-200(12), changed "preventative" to "preventive" for consistency with WAC 284-43-878(9).

WAC 284-43-200 (13)(b)(i), ratio of "enrollee to primary care provider" was changed to "primary care provider to enrollee" to accurately reflect the ratio.

WAC 284-43-200 (13)(b)(iii), changed "their" to "a" in reference to a primary care provider for consistency.

WAC 284-43-200 (15)(d), struck reference to subsection (d) of (3) and subsection (4) as these are no longer valid cross references.

WAC 284-43-220 (3)(e)(i)(E), struck "each area" and made "specialty" plural. Also struck "each" and included "the." Both changes made to accurately reflect the intent of the section.

WAC 284-43-220 (3)(e)(iii), struck "this" for readability.

WAC 284-43-220 (3)(f), changed "health plan" to "product" for consistency.

WAC 284-43-220 (3)(f)(i)(K), changed "processes" to "issuer's process" to differentiate from the department of health's corrective actions.

WAC 284-43-220 (4)(b), corrected "An area with" to "An area within" to accurately reflect the definition.

WAC 284-43-220 (3)(d)(i)(A), added "and facilities" for consistency.

WAC 284-43-220 (3)(e)(i)(C), include "substance use disorder" in title of map and also included "substance use disorder" where specialty mental health providers are referenced. Amended language for consistency with other areas of the rule that reference mental health and substance use disorder providers.

WAC 284-43-222 (5)(a), name of addendum was corrected.

WAC 284-43-229(4), amended language to make consistent with the section, changed "lowest cost tier of the network" to read "lowest cost-sharing tier of the network."

Throughout rule reference to "file" or "filing" was changed to "submit" or "submitted" to make the rule consistent.

A final cost-benefit analysis is available by contacting Kate Reynolds, P.O. Box 40258, Olympia, WA 98504-0258, phone (360) 725-7170, fax (360) 586-3109, e-mail rules coordinator@oic.wa.gov.

Number of Sections Adopted in Order to Comply with Federal Statute: New 4, Amended 2, Repealed 1; Federal Rules or Standards: New 4, Amended 2, Repealed 1; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

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

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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: April 25, 2014.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 12-23-005, filed 11/7/12, effective 11/20/12)

WAC 284-43-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

(2) "Authorization" or "certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Clinical review criteria" means the written screens, decision rules, medical protocols, or guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.

(4) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

(5) "Covered person" or "enrollee" means an individual covered by a health plan including ((~~an enrollee,~~)) a subscriber, policyholder, or beneficiary of a group plan.

(6) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(7) "Emergency services" has the meaning set forth in RCW 48.43.005.

(8) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(9) "Facility" means an institution providing health care services, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

(10) "Formulary" means a listing of drugs used within a health plan.

(11) "Grievance" has the meaning set forth in RCW 48.43.005.

(12) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(13) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(14) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020, and includes "issuers" as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

(15) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(16) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. §1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. §450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. §47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. §1603(29).

(17) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

(((~~(17)~~))) (18) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

(((~~(18)~~))) (19) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

(((~~(19)~~))) (20) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

(((~~(20)~~))) (21) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for ((~~carriers~~)) issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

(((~~(21)~~))) (22) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in *Physicians Current Procedural Terminology,* published by the American Medical Association.

(((~~(22)~~))) (23) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

(((~~(23)~~))) (24) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

(((~~(24)~~))) (25) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

(((~~(25)~~))) (26) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

(((~~(26)~~))) (27) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(((~~(27)~~))) (28) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(((~~(28)~~))) (29) "Service area" means the geographic area or areas where a specific product is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

(30) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005(33) comprising from one to fifty eligible employees.

(((~~(29)~~))) (31) "Substitute drug" means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

(((~~(30)~~))) (32) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

AMENDATORY SECTION (Amending WSR 01-03-033, filed 1/9/01, effective 7/1/01)

WAC 284-43-200 Network ((~~adequacy~~)) access—General standards. (1) ((~~A health carrier shall~~)) An issuer must maintain each ((~~plan~~)) provider network for each health plan in a manner that is sufficient in numbers and types of

providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to ((~~covered persons~~)) enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An issuer must demonstrate that for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.

(2) Each ((~~covered person shall~~)) enrollee must have adequate choice among ((~~each type of~~)) health care providers, including those ((~~types of providers who~~)) providers which must be included in the network under WAC 284-43-205, and for qualified health plans and qualified stand-alone dental plans, under WAC 284-43-222. ((~~In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. The carrier's~~))

(3) An issuer's service area ((~~shall~~)) must not be created in a manner designed to discriminate or that results in discrimination against persons because of age, gender, gender identity, sexual orientation, disability, national origin, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status((~~. Each carrier shall ensure that its networks will meet these requirements by the end of the first year of initial operation of the network and at all times thereafter~~)).

(((~~(2)~~))) (4) An issuer must establish sufficiency and adequacy of choice ((~~may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care authority and the department of social and health services) and by private managed care accreditation organizations may be used to demonstrate sufficiency. At a minimum, a carrier will be held accountable for meeting those standards described under WAC 284-43-220.~~

~~(3) In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.~~

~~(4) The health carrier shall~~)) of providers based on the number and type of providers and facilities necessary within the service area for the plan to meet the access requirements set forth in this subchapter. Where an issuer establishes medical necessity or other prior authorization procedures, the issuer must ensure sufficient qualified staff is available to provide timely prior authorization decisions on an appropriate basis, without delays detrimental to the health of enrollees.

(5) In any case where the issuer has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must ensure through referral by the primary care provider or otherwise that the enrollee obtains the covered service from a provider or facility within reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities. An issuer must satisfy this obligation even if an alternate access delivery request has been submitted and is pending commissioner approval.

An issuer may use facilities in neighboring service areas to satisfy a network access standard if one of the following types of facilities is not in the service area, or if the issuer can provide substantial evidence of good faith efforts on its part to contract with the facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the facility. This applies to the following types of facilities:

(a) Tertiary hospitals;

(b) Pediatric community hospitals;

(c) Specialty or limited hospitals, such as burn units, rehabilitative hospitals, orthopedic hospitals, and cancer care hospitals;

(d) Neonatal intensive care units; and

(e) Facilities providing transplant services, including those that provide solid organ, bone marrow, and stem cell transplants.

(6) An issuer must establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of ((~~covered persons. Health carriers shall~~)) enrollees, and located so as to not result in unreasonable barriers to accessibility. Issuers must make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. ((~~For example, a carrier should not require travel of thirty miles or more when a provider who meets carrier standards is available for inclusion in the network and practices within five miles of enrollees.~~

~~In determining whether a health carrier has complied with this provision, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the carrier under reasonable terms and conditions.~~

~~(5) A health carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to covered persons.~~

~~(6) Beginning July 1, 2000, the health carrier shall disclose to covered persons~~))

(7) A single case provider reimbursement agreement must be used only to address unique situations that typically occur out-of-network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in the network and do not support a determination of network access.

(8) An issuer must disclose to enrollees that limitations or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of ((~~participating providers and facilities. The carrier shall provide instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes. For example, a covered person relying on such instructions or processes could discover if the choice of a particular primary care provider would result in the covered person's inability to obtain a referral to certain other participating providers.~~

~~(7)~~)) the issuer. A description of the health plan's referral and authorization practices, including information about how to contact customer service for guidance, must be set forth as an introduction or preamble to the provider directory for a health plan. In the alternative, the description of referral and authorization practices may be included in the summary of benefits and explanation of coverage for the health plan.

(9) To provide adequate choice to ((~~covered persons~~)) enrollees who are American Indians/Alaska Natives, each health ((~~carrier shall~~)) issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are ((~~covered persons~~)) enrollees have access to covered medical and behavioral health services provided by Indian health care ((~~services and facilities that are part of the Indian health system~~)) providers.

((~~Carriers shall~~)) Issuers must ensure that such ((~~covered persons~~)) enrollees may obtain covered medical and behavioral health services from the Indian health ((~~system~~)) care provider at no greater cost to the ((~~covered person~~)) enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider. ((~~Carriers~~)) Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits ((~~a carrier~~)) an issuer from limiting coverage to those health services that meet ((~~carrier~~)) issuer standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

(10) An issuer must have a demonstrable method and contracting strategy to ensure that contracting hospitals in a plan's service area have the capacity to serve the entire enrollee population based on normal utilization.

(11) At a minimum, an issuer's provider network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy.

(a) Adequate networks include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from mental health providers. There must be mental health providers of sufficient number and type to provide diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* or other recognized diagnostic manual or standard.

(b) An issuer must establish a reasonable standard for the number and geographic distribution of mental health providers who can treat serious mental illness of an adult and serious emotional disturbances of a child, taking into account the various types of mental health practitioners acting within the scope of their licensure.

The issuer must measure the adequacy of the mental health network against this standard at least twice a year, and submit an action plan with the commissioner if the standard is not met.

(c) Emergency mental health services, including crisis intervention and crisis stabilization services, must be included in an issuer's provider network.

(d) An issuer must include a sufficient number and type of mental health and substance use disorder treatment providers and facilities within a service area based on normal utilization patterns.

(e) An issuer must ensure that an enrollee can identify information about mental health services and substance use disorder treatment including benefits, providers, coverage, and other relevant information by calling a customer service representative during normal business hours.

(12) The provider network must include preventive and wellness services, including chronic disease management and smoking cessation services as defined in RCW 48.43.005(37) and WAC 284-43-878(9). If these services are provided through a quit-line or help-line, the issuer must ensure that when follow-up services are medically necessary, the enrollee will have access to sufficient information to access those services within the service area. Contracts with quit-line or help-line services are subject to the same conditions and terms as other provider contracts under this section.

(13) For the essential health benefits category of ambulatory patient services, as defined in WAC 284-43-878(1), an issuer's network is adequate if:

(a) The issuer establishes a network that affords enrollee access to urgent appointments without prior authorization within forty-eight hours, or with prior authorization, within ninety-six hours of the referring provider's referral.

(b) For primary care providers the following must be demonstrated:

(i) The ratio of primary care providers to enrollees within the issuer's service area as a whole meets or exceeds the average ratio for Washington state for the prior plan year;

(ii) The network includes such numbers and distribution that eighty percent of enrollees within the service area are within thirty miles of a sufficient number of primary care providers in an urban area and within sixty miles of a sufficient number of primary care providers in a rural area from either their residence or work; and

(iii) Enrollees have access to an appointment, for other than preventive services, with a primary care provider within ten business days of requesting one.

(c) For specialists:

(i) The issuer documents the distribution of specialists in the network for the service area in relation to the population distribution within the service area; and

(ii) The issuer establishes that when an enrollee is referred to a specialist, the enrollee has access to an appointment with such a specialist within fifteen business days for nonurgent services.

(d) For preventive care services, and periodic follow-up care including, but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological or imaging monitoring for recurrence of disease, the issuer permits scheduling such services in advance, consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

(14) The network access requirements in this subchapter apply to stand-alone dental plans offered through the exchange or where a stand-alone dental plan is offered outside of the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits. All such stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions.

(a) An issuer of such stand-alone dental plans must demonstrate that, for the dental plan's defined service area, all services required under WAC 284-43-879(3) are available to all enrollees without unreasonable delay.

(b) Dental networks for pediatric oral services must be sufficient for the enrollee population in the service area based on expected utilization.

(15) Issuers must meet all requirements of this subsection for all provider networks. An alternate access delivery request under WAC 284-43-201 may be proposed only if:

(a) There are sufficient numbers and types of providers or facilities in the service area to meet the standards under this subchapter but the issuer is unable to contract with sufficient providers or facilities to meet the network standards in this subchapter; or

(b) An issuer's provider network has been previously approved under this section, and a provider or facility type subsequently becomes unavailable within a health plan's service area; or

(c) A county has a population that is fifty thousand or fewer, and the county is the sole service area for the plan, and the issuer chooses to propose an alternative access delivery system for that county; or

(d) A qualified health plan issuer is unable to meet the standards for inclusion of essential community providers, as provided under WAC 284-43-222(3).

(16) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-201 Alternate access delivery request. (1) Where an issuer's network meets one or more of the criteria in WAC 284-43-200 (15)(a) through (d), the issuer may submit an alternate access delivery request for the commissioner's review and approval. The alternate access delivery request must be made using the Alternate Access Delivery Request Form C, as provided in WAC 284-43-220 (3)(d).

(a) An alternate access delivery system must provide enrollees with access to medically necessary care on a reasonable basis without detriment to their health.

(b) The issuer must ensure that the enrollee obtains all covered services in the alternate access delivery system at no greater cost to the enrollee than if the service was obtained from network providers or facilities or must make other arrangements acceptable to the commissioner.

(i) Copayments and deductible requirements must apply to alternate access delivery systems at the same level they are applied to in-network services.

(ii) The alternate access delivery system may result in issuer payment of billed charges to ensure network access.

(c) An issuer must demonstrate in its alternate access delivery request a reasonable basis for not meeting a standard as part of its filing for approval of an alternate access delivery system, and include an explanation of why the alternate access delivery system provides a sufficient number or type of the provider or facility to which the standard applies to enrollees.

(d) An issuer must demonstrate a plan and practice to assist enrollees to locate providers and facilities in neighboring service areas in a manner that assures both availability and accessibility. Enrollees must be able to obtain health care services from a provider or facility within the closest reasonable proximity of the enrollee in a timely manner appropriate for the enrollee's health needs.

Alternate access delivery systems include, but are not limited to, such provider network strategies as use of out-of-state and out of county or service area providers, and exceptions to network standards based on rural locations in the service area.

(2) The commissioner will not approve an alternate access delivery system unless the issuer provides substantial evidence of good faith efforts on its part to contract with providers or facilities, and can demonstrate that there is not an available provider or facility with which the issuer can contract to meet provider network standards under WAC 284-43-200.

(a) Such evidence of good faith efforts to contract, where required, will be submitted as part of the issuer's Alternate Access Delivery Request Form C submission, as described in WAC 284-43-220 (3)(d).

(b) Evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The practice of entering into a single case provider reimbursement agreement with a provider or facility in relation to a specific enrollee's condition or treatment requirements is not an alternate access delivery system for purposes of establishing an adequate provider network. A single case provider reimbursement agreement must be used only to address unique situations that typically occur out of network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Sin-

gle case provider reimbursement agreements must not be used to fill holes or gaps in a network for the whole population of enrollees under a plan, and do not support a determination of network access.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-203 Use of subcontracted networks. (1) The primary contractor with each provider and facility in an issuer's network must be specifically identified in network report filings with the commissioner. An issuer may use subcontracted networks as part of a provider network for a service area, subject to the following requirements:

(a) An issuer must not elect to use less than one hundred percent of the subcontracted network or networks in its service area.

(b) An issuer may use a combination of directly contracting with providers and use of a subcontracted network in the same service area.

(2) Upon request by the commissioner, an issuer must produce an executed copy of its agreement with a subcontracted network, and certify to the commissioner that there is reasonable assurance the providers listed as part of the subcontracted network are under enforceable contracts with the subcontractor. The contract with the subcontracted network's administrator must provide the issuer with the ability to require providers to conform to the requirements in chapter 284-43 WAC, subchapter B.

(3) If an issuer permits a facility or provider to delegate functions, the issuer must require the facility or provider to:

(a) Include the requirements of this subchapter in its contracting documents with the subcontractor, including providing the commissioner with access to any pertinent information related to the contract during the contract term, for up to ten years from the final date of the contract period, and in certain instances, where required by federal or state law, periods in excess of ten years;

(b) Provide the issuer with the right to approve, suspend or terminate any such arrangement.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-204 Provider directories. (1) Provider directories must be updated at least monthly, and must be offered to accommodate individuals with limited-English proficiency or disabilities. An issuer must post the current provider directory for each health plan online, and must make a printed copy of the current directory available to an enrollee upon request as required under RCW 48.43.510 (1)(g).

(2) For each health plan, the associated provider directory must include the following information for each provider:

(a) The specialty area or areas for which the provider is licensed to practice and included in the network;

(b) Any in-network institutional affiliation of the provider, such as hospitals where the provider has admitting privileges or provider groups with which a provider is a member;

(c) Whether the provider may be accessed without referral;

(d) Any languages, other than English, spoken by the provider.

(3) An issuer must include in its electronic posting of a health plan's provider directory a notation of any primary care, chiropractor, women's health care provider, or pediatrician whose practice is closed to new patients.

(4) If an issuer maintains more than one provider network, its posted provider directory or directories must make it reasonably clear to an enrollee which network applies to which health plan.

(5) Information about any available telemedicine services must be included and specifically described.

(6) Information about any available interpreter services, communication and language assistance services, and accessibility of the physical facility must be identified in the directory, and the mechanism by which an enrollee may access such services.

(7) An issuer must include information about the network status of emergency providers as required by WAC 284-43-252.

(8) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

AMENDATORY SECTION (Amending WSR 99-16-036, filed 7/28/99, effective 8/28/99)

WAC 284-43-205 Every category of health care providers. (1) ((~~To effectuate the requirement of RCW 48.43.045 that health plans provide coverage for treatments and services by every category of provider, health carriers shall~~)) Issuers must not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for ((~~conditions covered by basic health plan (BHP) services as defined by RCW 48.43.005(4). If the BHP covers the condition, the carrier may~~)) services covered as essential health benefits, as defined in WAC 284-43-878 and RCW 48.43.715, for individual and small group plans; and as covered by the basic health plan, as defined in RCW 48.43.005(4), for plans other than individual and small group.

For individual and small group plans, the issuer must not exclude a category of provider who is licensed to provide services for ((~~that~~)) a covered condition, and is acting within the scope of practice, unless such services would not meet the ((~~carrier's~~)) issuer's standards pursuant to RCW 48.43.045 (1)(((~~(b)~~))) (a). For example, ((~~if the BHP provides coverage for~~)) if the issuer covers outpatient treatment of lower back pain as part of the essential health benefits, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope of practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(((~~(b) may~~))) (a) must not be excluded from the network.

(2) RCW 48.43.045 (1)(((~~(b)~~))) (a) permits ((~~health carriers~~)) issuers to require providers to abide by certain standards. These standards may not be used in a manner designed

to exclude categories of providers unreasonably. For example, ((~~health carriers may~~)) issuers must not decide that a particular category of provider can never render any cost-effective or clinically efficacious services and thereby exclude that category of provider completely from health plans on that basis. ((~~However, health carriers may determine that particular services for particular conditions by particular categories of providers are not cost-effective or clinically efficacious, and may exclude such services from coverage or reimbursement under a health plan. Any such determinations must be supported by relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy.~~))

(3) Health plans are not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers based on relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy. However, health plans ((~~may~~)) must not contain unreasonable limits, and ((~~may~~)) must not include limits on the type of provider permitted to render the covered service unless such limits comply with RCW 48.43.045 (1)(((~~(b)~~))) (a).

(4) This section does not prohibit health plans from using restricted networks. ((~~Health carriers~~)) Issuers offering plans with restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. ((~~A health carrier~~)) An issuer is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan.

(a) Health plan((~~s~~)) networks that use "gatekeepers" or "medical homes" for access to specialist providers may use them for access to specified categories of providers.

(b) For purposes of this section:

(i) "Gatekeeper" means requiring a referral from a primary care or direct access provider or practitioner to access specialty or in-patient services.

(ii) "Medical home" means a team based health care delivery model for patient centered primary care that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes as modified and updated by the Agency for Healthcare Research and Quality, the U.S. Department of Health and Human Services (HRSA), and other state and federal agencies.

(5) ((~~Health carriers may~~)) Issuers must not offer coverage for health services for certain categories of providers solely as a separately priced optional benefit.

(6) The insurance commissioner may grant reasonable temporary extensions of time for implementation of RCW 48.43.045 or this section, or any part thereof, for good cause shown.

(((~~(7) All health carriers and their plans, provider contracts, networks and operations shall conform to the provisions of this section WAC 284-43-205, by January 1, 2000.~~)))

AMENDATORY SECTION (Amending WSR 11-07-015, filed 3/8/11, effective 4/8/11)

WAC 284-43-220 Network reports—Format. ((~~Each health carrier must file with the commissioner a Provider Network Form A and a Network Enrollment Form B.~~)) (1) An issuer must submit its provider network materials to the commissioner for approval prior to or at the time it files a newly offered health plan.

(a) For individual and small groups, the submission must occur when the issuer submits its plan under WAC 284-170-870. For groups other than individual and small, the submission must occur when the issuer submits a new health plan and as required in this section.

(b) The commissioner may extend the time for filing for good cause shown.

(c) For plan year 2015 only, the commissioner will permit a safe harbor standard. An issuer who can not meet the submission requirements in (e) and (f) of this subsection will be determined to meet the requirements of those subsections even if the submissions are incomplete, provided that the issuer:

(i) Identifies specifically each map required under subsection (3)(e)(i) of this section, or Access Plan component required under subsection (3)(f) of this section, which has not been included in whole or part;

(ii) Explains the specific reason each map or component has not been included; and

(iii) Sets forth the issuer's plan to complete the submission, including the date(s) by which each incomplete map and component will be completed and submitted.

(2) Unless indicated otherwise, the issuer's reports must be submitted electronically and completed consistent with the posted submission instructions on the commissioner's web site, using the required formats.

(3) For plan years beginning January 1, 2015, an issuer must submit the following specific documents and data to the commissioner to document network access:

(a) **Provider Network Form A.** ((~~A carrier~~)) An issuer must ((~~file an electronic~~)) submit a report of all participating providers by network.

((~~This report must contain all data items shown in Provider Network Form A prescribed by and available from the commissioner. Updated reports must be filed each month.~~))

(i) The Provider Network Form A must be submitted for each network being reviewed for network access. A network may be used by more than one plan.

(ii) An issuer must indicate whether a provider is an essential community provider as instructed in the commissioner's Provider Network Form A instructions.

(iii) An issuer must submit an updated, accurate Provider Network Form A on a monthly basis by the 5th of each month for each network and when a material change in the network occurs as described in subchapter B.

(iv) Filing of this data satisfies the reporting requirements of RCW 48.44.080 and the requirements of RCW 48.46.030 relating to filing of notices that describe((~~s~~)) changes in the provider network.

(((~~(2)~~))) (b) **Provider directory certification.** An issuer must submit at the time of each Provider Network Form A submission a certification that the provider directory posted on the issuer's web site is specific to each plan, accurate as of the last date of the prior month. A certification signed by an officer of the issuer must confirm that the provider directory contains only providers and facilities with which the issuer

has a signed contract that is in effect on the date of the certification.

(c) **Network Enrollment Form B.** ((~~By March 31, 2004, and every year thereafter, a carrier must prepare an electronic report showing the total number of covered persons who were entitled to health care services during each month of the year, excluding nonresidents. A separate~~)) The Network Enrollment Form B report provides the commissioner with an issuer's count of total covered lives for the prior year, during each month of the year, for each health plan by county.

(i) The report must be ((~~filed~~)) submitted for each network ((~~by line of business~~)) as a separate report. The report must contain all data items shown in and conform to the format of Network Enrollment Form B prescribed by and available from the commissioner.

(((~~(3)~~))) (ii) An issuer must submit this report by March 31st of each year.

(d) **Alternate Access Delivery Request Form C.** For plan years that begin on or after January 1, 2015, alternate access delivery requests must be submitted when an issuer's network meets one or more of the criteria in WAC 284-43-200 (15)(a) through (d). Alternate access delivery requests must be submitted to the commissioner using the Alternate Access Delivery Request Form C.

(i) The Alternate Access Delivery Request Form C submission must address the following areas, and may include other additional information as requested by the commissioner:

(A) A description of the specific issues the alternate access delivery system is intended to address, accompanied by supporting data describing how the alternate access delivery system ensures that enrollees have reasonable access to sufficient providers and facilities, by number and type, for covered services;

(B) A description and schedule of cost-sharing requirements for providers that fall under the alternate access delivery system;

(C) The issuer's proposed method of noting on its provider directory how an enrollee can access provider types under the alternate access delivery system;

(D) The issuer's marketing plan to accommodate the time period that the alternate access delivery system is in effect, and specifically describe how it impacts current and future enrollment and for what period of time;

(ii) Provider Network Form A and Network Enrollment Form B submissions are required in relation to an alternate access delivery system on the basis described in subsections (1) and (2) of this section.

(iii) If a network becomes unable to meet the network access standards after approval but prior to the health product's effective date, an alternate access delivery request must include a timeline to bring the network into full compliance with this subchapter.

(e) **Geographic Network Reports.**

(i) The geographic mapping criteria outlined below are minimum requirements and will be considered in conjunction with the standards set forth in WAC 284-43-200 and 284-43-222. One map for each of the following provider types must be submitted:

(A) Hospital and emergency services. Map must identify provider locations, and demonstrate that each enrollee in the service area has access within thirty minutes in an urban area and sixty minutes in a rural area from either their residence or workplace to general hospital facilities including emergency services.

(B) Primary care providers. Map must demonstrate that eighty percent of the enrollees in the service area have access within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace to a primary care provider with an open practice. The provider type selected must have a license under Title 18 RCW that includes primary care services in the scope of license.

(C) Mental health and substance use disorder providers. For general mental health providers, such as licensed psychiatrists, psychologists, social workers, and mental health nurse practitioners, the map must demonstrate that eighty percent of the enrollees in the service area have access to a mental health provider within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace. For specialty mental health providers and substance use disorder providers, the map must demonstrate that eighty percent of the enrollees have access to the following types of service provider or facility: Evaluation and treatment, voluntary and involuntary inpatient mental health and substance use disorder treatment, outpatient mental health and substance use disorder treatment, and behavioral therapy. If one of the types of specialty providers is not available as required above, the issuer must propose an alternate access delivery system to meet this requirement.

(D) Pediatric services. For general pediatric services, the map must demonstrate that eighty percent of the covered children in the service area have access to a pediatrician or other provider whose license under Title 18 RCW includes pediatric services in the scope of license. This access must be within thirty miles in an urban area and sixty miles in a rural area of their family or placement residence. For specialty pediatric services, the map must demonstrate that eighty percent of covered children in the service area have access to pediatric specialty care within sixty miles in an urban area and ninety miles in a rural area of their family or placement residence. The pediatric specialty types include, but are not limited to, nephrology, pulmonology, rheumatology, hematology-oncology, perinatal medicine, neurodevelopmental disabilities, cardiology, endocrinology, and gastroenterology.

(E) Specialty services. An issuer must provide one map for the service area for specialties found on the American Board of Medical Specialties list of approved medical specialty boards. The map must demonstrate that eighty percent of the enrollees in the service area have access to an adequate number of providers and facilities in each specialty. Subspecialties are subsumed on the map.

(F) Therapy services. An issuer must provide one map that demonstrates that eighty percent of the enrollees have access to the following types of providers within thirty miles in an urban area and sixty miles in a rural area of their residence or workplace: Chiropractor, rehabilitative service providers and habilitative service providers.

(G) Home health, hospice, vision, and dental providers. An issuer must provide one map that identifies each provider or facility to which an enrollee has access in the service area for home health care, hospice, vision, and pediatric oral coverage, including allied dental professionals, dental therapists, dentists, and orthodontists.

(H) Covered pharmacy dispensing services. An issuer must provide one map that demonstrates the geographic distribution of the pharmacy dispensing services within the service area. If a pharmacy benefit manager is used by the issuer, the issuer must establish that the specifically contracted pharmacy locations within the service area are available to enrollees through the pharmacy benefit manager.

(I) Essential community providers. An issuer must provide one map that demonstrates the geographic distribution of essential community providers, by type of provider or facility, within the service area. This requirement applies only to qualified health plans as certified in RCW 43.71.065.

(ii) Each report must include the provider data points on each map, title the map as to the provider type or facility type it represents, include the network identification number the map applies to, and the name of each county included on the report.

(iii) For plan years beginning January 1, 2015, and every year thereafter, an issuer must submit reports as required in subsection (1) of this section to the commissioner for review and approval, or when an alternate access delivery request is submitted.

(f) **Access Plan.** An issuer must establish an access plan specific to each product that describes the issuer's strategy, policies, and procedures necessary to establishing, maintaining, and administering an adequate network.

(i) At a minimum, the issuer's policies and procedures referenced in the access plan must address:

(A) Referral of enrollees out-of-network, including criteria for determining when an out-of-network referral is required or appropriate;

(B) Copayment and coinsurance determination standards for enrollees accessing care out-of-network;

(C) Standards of accessibility expressed in terms of objectives and minimum levels below which corrective action will be taken, including the proximity of specialists and hospitals to primary care sources, and a method and process for documentation confirming that access will not result in delay detrimental to health of enrollees;

(D) Monitoring policies and procedures for compliance, including tracking and documenting network capacity and availability;

(E) Standard hours of operation, and after-hours, for prior authorization, consumer and provider assistance, and claims adjudication;

(F) Triage and screening arrangements for prior authorization requests;

(G) Prior authorization processes that enrollees must follow, including the responsibilities and scope of use of nonlicensed staff to handle enrollee calls about prior authorization;

(H) Specific procedures and materials used to address the needs of enrollees with limited-English proficiency and literacy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(I) Assessment of the health status of the population of enrollees or prospective enrollees, including incorporation of the findings of local public health community assessments, and standardized outcome measures, and use of the assessment data and findings to develop network or networks in the service area;

(J) Notification to enrollees regarding personal health information privacy rights and restrictions, termination of a provider from the network, and maintaining continuity of care for enrollees when there is a material change in the provider network, insolvency of the issuer, or other cessation of operations;

(K) Issuer's process for corrective action for providers related to the provider's licensure, prior authorization, referral and access compliance. The process must include remedies to address insufficient access to appointments or services.

(ii) An access plan applicable to each product must be submitted with every Geographic Network Report when the issuer seeks initial certification of the network, submits its annual rate filing to the commissioner for review and approval, or when an alternative access delivery request is required due to a material change in the network.

(iii) The current access plan, with all associated data sets, policies and procedures, must be made available to the commissioner upon request, and a summary of the access plan's associated procedures must be made available to the public upon request.

(4) For purposes of this section((~~: (a) "Line of business" means either individual, small group or large group coverage;~~

~~(b) "Network" means the group of participating providers and facilities providing health care services to a particular line of business.~~)), "urban area" means:

(a) A county with a density of ninety persons per square mile; or

(b) An area within a twenty-five mile radius around an incorporated city with a population of more than thirty thousand.

NEW SECTION

WAC 284-43-221 Essential community providers for exchange plans—Definition. "Essential community provider" means providers listed on the Centers for Medicare and Medicaid Services Non-Exhaustive List of Essential Community Providers. This list includes providers and facilities that have demonstrated service to medicaid, low-income, and medically underserved populations in addition to those that meet the federal minimum standard, which includes:

(1) Hospitals and providers who participate in the federal 340B Drug Pricing Program;

(2) Disproportionate share hospitals, as designated annually;

(3) Those eligible for Section 1927 Nominal Drug Pricing;

(4) Those whose patient mix is at least thirty percent medicaid or medicaid expansion patients who have approved applications for the Electronic Medical Record Incentive Program;

(5) State licensed community clinics or health centers or community clinics exempt from licensure;

(6) Indian health care providers as defined in WAC 284-43-130(17);

(7) Long-term care facilities in which the average residency rate is fifty percent or more eligible for medicaid during the preceding calendar year;

(8) School-based health centers as referenced for funding in Sec. 4101 of Title IV of ACA;

(9) Providers identified as essential community providers by the U.S. Department of Health and Human Services through subregulatory guidance or bulletins;

(10) Facilities or providers who waive charges or charge for services on a sliding scale based on income and that do not restrict access or services because of a client's financial limitations;

(11) Title X Family Planning Clinics and Title X look-alike Family Planning Clinics;

(12) Rural based or free health centers as identified on the Rural Health Clinic and the Washington Free Clinic Association web sites; and

(13) Federal qualified health centers (FQHC) or FQHC look-alikes.

NEW SECTION

WAC 284-43-222 Essential community providers for exchange plans—Network access. (1) An issuer must include essential community providers in its provider network for qualified health plans and qualified stand-alone dental plans in compliance with this section and as defined in WAC 284-43-221.

(2) An issuer must include a sufficient number and type of essential community providers in its provider network to provide reasonable access to the medically underserved or low-income in the service area, unless the issuer can provide substantial evidence of good faith efforts on its part to contract with the providers or facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The following minimum standards apply to establish adequate qualified health plan inclusion of essential community providers:

(a) Each issuer must demonstrate that at least thirty percent of available primary care providers, pediatricians, and hospitals that meet the definition of an essential community provider in each plan's service area participate in the provider network;

(b) The issuer's provider network must include access to one hundred percent of Indian health care providers in a service area, as defined in WAC 284-43-130(17), such that qualified enrollees obtain all covered services at no greater cost than if the service was obtained from network providers or facilities;

(c) Within a service area, fifty percent of rural health clinics located outside an area defined as urban by the 2010 Census must be included in the issuer's provider network;

(d) For essential community provider categories of which only one or two exist in the state, an issuer must demonstrate a good faith effort to contract with that provider or providers for inclusion in its network, which will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider;

(e) For qualified health plans that include pediatric oral services or qualified dental plans, thirty percent of essential community providers in the service area for pediatric oral services must be included in each issuer's provider network;

(f) Ninety percent of all federally qualified health centers and FQHC look-alike facilities in the service area must be included in each issuer's provider network;

(g) At least one essential community provider hospital per county in the service area must be included in each issuer's provider network;

(h) At least fifteen percent of all providers participating in the 340B program in the service area, balanced between hospital and nonhospital entities, must be included in the issuer's provider network;

(i) By 2016, at least seventy-five percent of all school-based health centers in the service area must be included in the issuer's network.

(4) An issuer must, at the request of a school-based health center or group of school-based health centers, offer to contract with such a center or centers to reimburse covered health care services delivered to enrollees under an issuer's health plan.

(a) If a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with a school-based health center or group of school-based health centers. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(b) "School-based health center" means a school-based location for the delivery of health services, often operated as a partnership of schools and community health organizations, which can include issuers, which provide on-site medical and mental health services through a team of medical and mental health professionals to school-aged children and adolescents.

(5) An issuer must, at the request of an Indian health care provider, offer to contract with such a provider to reimburse covered health care services delivered to qualified enrollees under an issuer's health plan.

(a) Issuers are encouraged to use the current version of the Washington State Indian Health Care Provider Addendum, as posted on http://www.aihc-wa.com, to supplement the existing provider contracts when contracting with an Indian health care provider.

(b) If an Indian health care provider requests a contract and a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with the Indian health care provider. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(6) These requirements do not apply to integrated delivery systems pursuant to RCW 43.71.065.

NEW SECTION

WAC 284-43-229 Tiered provider networks. (1) "Tiered provider network" means a network that identifies and groups providers and facilities into specific groups to which different provider reimbursement, enrollee cost-sharing, or provider access requirements, or any combination thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior.

(a) An issuer may use a term other than tiered network as long as the term is not misleading or susceptible to confusion with a specific licensee designation, such as accountable care organization.

(b) An issuer must not use tiered networks to limit access to certain categories of providers or facilities.

(2) When an issuer's contracts include the placement of providers or facilities in tiers, and the network design results in cost differentials for enrollees, the issuer must disclose to enrollees at the time of enrollment the cost difference and the basis for the issuer's placement of providers or facilities in one tier or another.

(3) The lowest cost-sharing tier of a tiered network must provide enrollees with adequate access and choice among health care providers and facilities for essential health benefits as set forth in WAC 284-43-878, 284-43-879, and 284-43-880.

(4) Cost-sharing differentials between tiers must not be imposed on an enrollee if the sole provider or facility type or category required to deliver a covered service is not available to the enrollee in the lowest cost-sharing tier of the network.

(a) All enrollees must have reasonable access to providers and facilities at the lowest cost tier of cost-sharing.

(b) Variations in cost-sharing between tiers must be reasonable in relation to the premium rate charged.

(5) An issuer must include with the Provider Compensation Agreement the metrics and methodology used to assign participating providers and facilities to tiers. An issuer must be able to demonstrate to the commissioner's satisfaction that its assignment of providers and facilities to tiers, when based on a rating system, is consistent with the issuer's placement methodology.

(a) When an issuer revises or amends a quality, cost-efficiency or tiering program related to its provider network, it must provide notice to affected providers and facilities of the proposed change sixty days before notifying the public of the program. The notice must explain the methodology and data, if any, used for particular providers and facilities and include information on provider appeal rights as stated in the provider agreement.

(b) An issuer must make its physician cost profile available to providers and facilities under a tiered network, including the written criteria by which the provider's performance is measured.

(6) An issuer's provider and facility ranking program, and the criteria used to assign providers and facilities to different tiers, must not be described in advertising or plan documents so as to deceive consumers as to issuer rating practices and their affect on available benefits. When a tiered network is used, an issuer must provide detailed information on its web site and if requested, make available in paper form information about the tiered network including, but not limited to:

(a) The providers and facilities participating in the tiered network;

(b) The selection criteria, if any, used to place the providers and facilities, but not including the results of applying those selection criteria to a particular provider or facility;

(c) The potential for providers and facilities to move from one tier to another at any time; and

(d) The tier in which each participating provider or facility is assigned.

(7) For any health plan in effect on a tiered network's reassignment date, an issuer must make a good faith effort to provide information to affected enrollees at least sixty days before the reassignment takes effect. This information includes, but is not limited to, the procedure the enrollee must follow to choose an alternate provider or facility to obtain treatment at the same cost-sharing level. The specific classes of enrollees to whom notice must be sent are:

(a) Patients of a reassigned primary care provider if their primary care provider is reassigned to a higher cost-sharing level;

(b) A patient in the second or third trimester of pregnancy if a care provider or facility in connection with her pregnancy is reassigned to a higher cost-sharing level;

(c) A terminally ill patient if a provider or facility in connection with the illness is reassigned to a higher cost-sharing level; and

(d) Patients under active treatment for cancer or hematologic disorders, if the provider or facility that is delivering the care is reassigned to a higher cost-sharing level.

NEW SECTION

WAC 284-43-230 Assessment of access. (1) The commissioner will assess whether an issuer's provider network access meets the requirements of WAC 284-43-200, 284-43-201, and 284-43-205 such that all health plan services to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. Factors considered by the commissioner will include the following:

(a) The location of the participating providers and facilities;

(b) The location of employers or enrollees in the health plan;

(c) The range of services offered by providers and facilities for the health plan;

(d) Health plan provisions that recognize and provide for extraordinary medical needs of enrollees that cannot be adequately treated by the network's participating providers and facilities;

(e) The number of enrollees within each service area living in certain types of institutions or who have chronic, severe, or disabling medical conditions, as determined by the population the issuer is covering and the benefits provided;

(f) The availability of specific types of providers who deliver medically necessary services to enrollees under the supervision of a provider licensed under Title 18 RCW;

(g) The availability within the service area of facilities under Titles 70 and 71 RCW;

(h) Accreditation as to network access by a national accreditation organization including, but not limited to, the National Committee for Quality Assurance (NCQA), the Joint Commission, Accreditation Association of Ambulatory Health Care (AAAHC), or URAC.

(2) In determining whether an issuer has complied with the provisions of WAC 284-43-200, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the issuer under reasonable terms and conditions.

(3) If the commissioner determines that an issuer's proposed or current network for a health plan is not adequate, the commissioner may, for good cause shown, permit the issuer to propose changes sufficient to make the network adequate within a sixty-day period of time. The proposal must include a mechanism to ensure that new enrollees have access to an open primary care provider within ten business days of enrolling in the plan while the proposed changes are being implemented. This requirement is in addition to such enforcement action as is otherwise permitted under Title 48 RCW.

AMENDATORY SECTION (Amending WSR 00-04-034, filed 1/24/00, effective 2/24/00)

WAC 284-43-250 ((~~Health carrier~~)) Issuer standards for women's right to directly access certain health care practitioners for women's health care services. (1)(a) "Women's health care services" ((~~is defined to~~)) means organized services to provide health care to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but ((~~need~~)) are not ((~~be~~)) limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. ((~~General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations.~~)) Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include((~~,~~)): Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

(b) ((~~A carrier may~~)) An issuer must not exclude or limit access to covered women's health care services offered by a particular type of women's health care provider, practitioner, or facility in a manner that would unreasonably restrict access to that type of provider, practitioner, or facility or covered service. For example, ((~~a carrier may~~)) an issuer must not impose a limitation on maternity services that would require all child birth to occur in a hospital attended by a physician, thus((~~,~~)) preventing a woman from choosing between and using the birthing services of an advanced registered nurse practitioner ((~~specialist in midwifery~~)), a certified midwife, or a licensed midwife.

(c) ((~~A carrier may~~)) An issuer must not impose notification or prior authorization requirements upon women's health care practitioners, providers, and facilities who render women's health care services or upon women who directly access such services unless such requirements are imposed upon other providers offering similar types of service. For example, ((~~a carrier may~~)) an issuer must not require a directly accessed women's health care practitioner to notify the plan within seven days of providing direct women's health care services if a primary care provider would not also be required to provide seven-day notice to the ((~~carrier~~)) issuer for the same or similar service.

(2) ((~~A health carrier shall~~)) An issuer must not deny coverage for medically appropriate laboratory services, imaging services, diagnostic services, or prescriptions for pharmaceutical or medical supplies, which are ordered by a directly accessed women's health care practitioner, and which are within the practitioner's scope of practice, if such services would be covered when provided by another type of health care practitioner. ((~~A health carrier shall~~)) An issuer must not require authorization by another type of health care practitioner for these services. For example, if the ((~~carrier~~)) issuer would cover a prescription if the prescription had been written by the primary care provider, the ((~~carrier shall~~)) issuer must cover the prescription written by the directly accessed women's health care practitioner.

(3)(a) All ((~~health carriers shall~~)) issuers must permit each female ((~~policyholder, subscriber, enrolled participant, or beneficiary of carrier policies, plans, and programs written, amended, or renewed after July 23, 1995,~~)) enrollee of a health plan to directly access ((~~the types of women's health care practitioners identified in RCW 48.42.100(2),~~)) providers or practitioners for appropriate covered women's health care services without prior referral from another health care practitioner.

(b) ((~~Beginning July 1, 2000,~~)) An issuer may limit direct access ((~~may be limited~~)) to those women's health care practitioners who have signed participating provider agreements with the ((~~carrier~~)) issuer for a specific ((~~benefit~~)) health plan network. Irrespective of the financial arrangements ((~~a carrier~~)) an issuer may have with participating providers, ((~~a carrier~~)) an issuer may not limit and ((~~shall~~)) must not permit a network provider to limit access to a subset of participating women's health care practitioners within the network. Such an impermissible limitation might arise when a primary care provider's group practice receives a capitation payment for comprehensive care to ((~~a covered person~~)) an enrollee and then represents to the ((~~covered person~~)) enrollee that only those gynecologists in the primary care provider's clinic are available for direct access. Nothing in this subsection ((~~shall~~)) must be interpreted to prohibit ((~~a carrier~~)) an issuer from contracting with a provider to render limited health care services.

(c) Every ((~~carrier shall~~)) issuer must include in each provider network((~~,~~)) a sufficient number of each type of practitioner included in the definition of women's health care practitioners in RCW 48.42.100(2). A "sufficient number" means enough to reasonably ensure that enrollees can exercise their right of direct access within their service area, based on the number of providers with women's health care service in the scope of their license, and the number of enrollees. An issuer must demonstrate the basis on which it determined the sufficiency of the number and type of providers under this section.

(d) ((~~Beginning July 1, 2000,~~)) A woman's right to directly access practitioners for health care services, as provided under RCW 48.42.100, includes the right to obtain appropriate women's health care services ordered by the practitioner from a participating facility used by the practitioner.

(4) To inform enrollees of their rights under RCW 48.42.100, all ((~~health carriers shall~~)) issuers must include in enrollee handbooks a written explanation of a woman's right to directly access ((~~women's health care practitioners for~~)) covered women's health care services. Enrollee handbooks ((~~shall~~)) must include information regarding any limitations to direct access, including, but not limited to:

(a) Limited direct access based on a benefit plan's closed network of practitioners, if appropriate; and

(b) The ((~~carrier's~~)) issuer's right to limit coverage to medically necessary and appropriate women's health care services.

(5) No ((~~carrier~~)) issuer shall impose cost-sharing, such as copayments or deductibles, for directly accessed women's health care services, that are not required for access to health care practitioners acting as primary care providers.

NEW SECTION

WAC 284-43-252 Hospital emergency service departments and practice groups. Enrollees must have access to emergency services twenty-four hours per day, seven days per week. An issuer must make good faith attempts to contract with provider groups offering services within hospital emergency departments, if the hospital is included in its network. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider groups. If the issuer is unsuccessful in contracting with provider groups offering services within contracted hospital emergency departments, the issuer's provider directory must prominently note that while the hospital's emergency department is contracted, the providers within the department are not.

AMENDATORY SECTION (Amending WSR 99-21-016, filed 10/11/99, effective 11/11/99)

WAC 284-43-331 Effective date. (1) All participating provider and facility contracts entered into after the effective date of these rules ((~~shall~~)) must comply with these rules no later than ((~~July 1, 2000~~)) January 1, 2015.

(2) Participating provider and facility contracts entered into prior to the effective date of these rules ((~~shall~~)) must be amended upon renewal to comply with these rules, and all such contracts ((~~shall~~)) must conform to these provisions no later than January 1, ((~~2001~~)) 2015. The commissioner may extend the January 1, ((~~2001~~)) 2015, deadline for ((~~a health carrier~~)) an issuer for an additional ((~~six months~~)) one year, if the ((~~health carrier~~)) issuer makes a written request. That request must explain how a good faith effort at compliance has been made, provide the specific reasons the deadline cannot be met, and state the date the ((~~health carrier~~)) issuer expects to be in compliance (no more than ((~~six months~~)) one year beyond January 1, ((~~2001~~)) 2015).

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 284-43-340 Effective date.

WSR 14-10-019
PERMANENT RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 14-95—Filed April 25, 2014, 4:50 p.m., effective May 26, 2014]

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

Purpose: See Reviser's note below.

Citation of Existing Rules Affected by this Order: Amending WAC 220-55-040, 232-12-047, 232-12-051, 232-12-054, 232-12-242, 232-12-828, 232-28-248, 232-28-273, 232-28-283, 232-28-296, 232-28-337, 232-28-342, 232-28-357, 232-28-358, 232-28-359, 232-28-360, 232-28-622, 232-28-623, and 232-28-624.

Statutory Authority for Adoption: RCW 77.12.047, 77.12.240, 77.32.070.

Adopted under notice filed as WSR 14-03-135 on January 22, 2014.

Changes Other than Editing from Proposed to Adopted Version: See Reviser's note below.

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 4, Amended 19, 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: April 11, 2014.

Miranda Wecker, Chair
Fish and Wildlife Commission

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 14-11 issue of the Register.

WSR 14-10-025
PERMANENT RULES
DEPARTMENT OF HEALTH

[Filed April 28, 2014, 9:40 a.m., effective May 29, 2014]

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

Purpose: Amends WAC 246-12-010, defines who may place a health care credential in military status or inactive military-related status; amends chapter 246-12 WAC, Part 4 by directing affected military and military-related practitioners to chapter 246-12 WAC, Part 13; creates chapter 246-12 WAC, Part 13 to establish a process for confirming eligibility for military and inactive military-related status, the process to maintain each, and how to return to active status.

Citation of Existing Rules Affected by this Order: Amending WAC 246-12-010, 246-12-090, 246-12-100, and 246-12-110.

Statutory Authority for Adoption: RCW 43.70.270(3).

Adopted under notice filed as WSR 13-23-039 on November 14, 2013.

Changes Other than Editing from Proposed to Adopted Version: Chapter 246-12 WAC, Part 4, the phrase "for military and military-related status" was added after each use of "except as provided in Part 13 of this chapter…" to clarify that these sections apply to credential holders that are not currently in military or military-related status. Technical edits made to chapter 246-12 WAC, Part 4, to correct hyphens. Housekeeping changes were made for consistency.

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 7, 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 4, 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 7, Amended 4, Repealed 0.

Date Adopted: April 25, 2014.

Jessica Todorovich
Deputy Secretary
for John Wiesman, DrPH, MPH
Secretary

AMENDATORY SECTION (Amending WSR 07-21-133, filed 10/23/07, effective 12/1/07)

WAC 246-12-010 Definitions. (1) "Business": A business is an adult family home provider owned by a corporation regulated under chapter 18.48 RCW; a pharmaceutical firm regulated under chapter 18.64 RCW; or a nursing pool regulated under chapter 18.52C RCW; or a health care assistant regulated under chapter 18.135 RCW.

(2) "Credential": A credential is a license, certification, or registration issued to a person to practice a regulated health care profession. Whether the credential is a license, certification or registration is determined by the law regulating the profession.

(3) "Declaration": A declaration is a statement signed by the practitioner on a form provided by the department of health for verifying continuing education, AIDS training, or other requirements. When required, declarations must be completed and signed to be effective verification to the department.

(4) "Disciplinary suspension": The regulatory entity places the credential in disciplinary suspension status when there is a finding of unprofessional conduct. Refer to the Uniform Disciplinary Act (RCW 18.130.160).

(5) "Local organization for emergency services or management": Has the same meaning as that found in RCW 38.52.010.

(6) "Mandated suspension": The department of health places the credential in mandated suspension status when a law requires suspension of a credential under certain circumstances. This suspension is nondiscretionary for the department of health. Examples of mandated suspension are default on a student loan and failure to pay child support. The practitioner may not practice while on mandated suspension. The credential must be returned to active status before the practitioner may practice. See Part 6 of this chapter.

(7) "Practitioner": A practitioner is an individual health care provider listed under the Uniform Disciplinary Act, RCW 18.130.040.

(8) "Regulatory entities": A "regulatory entity" is a board, commission, or the secretary of the department of health designated as the authority to regulate one or more professions or occupations in this state. Practitioner health care practice acts and the Uniform Disciplinary Act (UDA) designate whether it is a board, commission, or the secretary of the department of health which has the authority to adopt rules, discipline health care providers, and determine requirements for initial licensure and continuing education requirements.

The regulatory entity determines whether disciplinary action should be taken on a credential for unprofessional conduct. These actions may include revocation, suspension, practice limitations or conditions upon the practitioner.

(9) "Renewal": Every credential requires renewal. The renewal cycle is either one, two, or three years, depending on the profession.

(10) "Secretary": The secretary is the secretary of the department of health or his or her designee.

(11) "Status": All credentials are subject to the Uniform Disciplinary Act (UDA) regardless of status. A credential status may be in any one of the following:

(a) Most credentials are in **"active"** status. These practitioners are authorized to practice the profession. These practitioners need to renew the credential each renewal cycle. See Part 2 of this chapter.

(b) The department of health places the credential in **"expired"** status if the credential is not renewed on time. While in expired status, the practitioner is not authorized to practice. Practice on an expired status is a violation of law and subject to disciplinary action. See Part 2 of this chapter.

(c) A practitioner may place the credential in **"inactive"** status if authorized by the regulatory entity. This means the practitioner is not practicing the profession. See Part 4 of this chapter.

(d) A practitioner may place the credential in **"inactive military-related"** status if he or she is a spouse or registered domestic partner of a member of the United States Armed Forces or the United States Public Health Service Commissioned Corps and the service member is deployed or stationed in a location outside of Washington state.

(e) A practitioner may place the credential in **"military"** status if he or she is a member of the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States.

(f) A practitioner may place the credential in **"retired active"** status if authorized by the regulatory entity. This means the practitioner can practice only intermittently or in emergencies. See Part 5 of this chapter.

PART 4
INACTIVE CREDENTIAL FOR NONMILITARY PRACTITIONERS

AMENDATORY SECTION (Amending WSR 98-05-060, filed 2/13/98, effective 3/16/98)

WAC 246-12-090 How to obtain an inactive credential for nonmilitary practitioners. Except as provided in Part 13 of this chapter for military and military-related status, a practitioner may obtain an inactive credential if authorized by the regulatory entity. Refer to the profession rules to determine if this status is available.

(1) ((~~To obtain an inactive credential the practitioner must submit a letter notifying the department of health of the intent to obtain an inactive credential.~~

~~(2)~~)) Except as provided in Part 13 of this chapter for military and military-related status, a practitioner may apply for an inactive credential if he or she meets the following criteria:

(a) Holds an active Washington state credential;

(b) Is in good standing; and

(c) Will not practice in Washington.

(2) To obtain an inactive credential, the practitioner must notify the department of health in writing of the intent to obtain an inactive credential.

(3) The practitioner may obtain an inactive credential at any time the criteria in subsection ((~~(2)~~)) (1) of this section are met. The fee for the initial inactive credential will be due when the active credential expires. Portions of the current renewal fee will not be prorated or refunded for the remaining active renewal cycle.

AMENDATORY SECTION (Amending WSR 98-05-060, filed 2/13/98, effective 3/16/98)

WAC 246-12-100 How to renew an inactive credential for nonmilitary practitioners. (1) The expiration for all credentials is the practitioner's birthday. Except as provided in Part 13 of this chapter for military and military-related status, to renew an inactive credential, the practitioner must:

(a) Pay the inactive credential renewal fee; and

(b) Pay the substance abuse monitoring surcharge, if required by the profession.

(2) To determine the renewal cycle, refer to the individual laws and rules pertaining to your profession.

(3) Inactive credential renewal fees are accepted by the department no sooner than ninety days prior to the expiration date.

(4) Prior to the inactive credential expiration date, courtesy renewal notices are mailed to the address on file. Practitioners should return the renewal notice when renewing their credential. Failure to receive a courtesy renewal notice does not relieve or exempt the inactive credential renewal requirement.

AMENDATORY SECTION (Amending WSR 98-05-060, filed 2/13/98, effective 3/16/98)

WAC 246-12-110 How to return to active status from inactive status for nonmilitary practitioners. Except as provided in Part 13 of this chapter for military and military-related status, to change an inactive credential to an active credential status the practitioner must:

(1) Notify the department in writing of the change;

(2) Pay the appropriate current active renewal fee;

(3) Pay the current substance abuse monitoring surcharge, if required by the profession((~~,~~));

(4) Provide a written declaration that no action has been taken by a state or federal jurisdiction or hospital which would prevent or restrict the practitioner's practice of the profession;

(5) Provide a written declaration that he or she has not voluntarily given up any credential or privilege or has not been restricted in the practice of the profession in lieu of or to avoid formal action;

(6) Provide a written declaration that continuing education and competency requirements for the two most recent years have been met, if required for the profession;

(7) Provide other written declarations or documentation, if required for the profession;

(8) Satisfy other competency requirements of the regulatory entity; if required; and

(9) If not previously provided, provide proof of AIDS education as required for the profession and in Part 8 of this chapter.

PART 13
MILITARY AND MILITARY-RELATED STATUS

NEW SECTION

WAC 246-12-500 Who can obtain a military status or military-related status credential. (1) A practitioner

who is a member of the United States Armed Forces, the United States Public Health Service Commissioned Corps, or the Merchant Marine of the United States may obtain a military status credential if his or her credential is valid and in force and effect.

(2) A practitioner who is the spouse or registered domestic partner of member of the United States Armed Forces or the United States Public Health Service Commissioned Corps who is deployed or stationed in a location outside of Washington state may request that his or her credential be placed in inactive military-related status if the credential is valid and in force and effect.

(3) A credential is valid and in force and effect if it is active and in good standing. "In good standing" means the credential is not currently subject to any sanction, terms, conditions or restrictions required by formal or informal discipline or an agreement to practice with conditions under chapter 18.130 RCW, the Uniform Disciplinary Act.

NEW SECTION

WAC 246-12-510 How to obtain a military status credential. (1) To obtain a military status credential the practitioner must submit a written request notifying the department of the intent to obtain a military status credential.

(2) A practitioner may obtain a military status credential if he or she:

(a) Holds an active Washington state credential that is valid and in force and effect; and

(b) Submits to the department an official copy of service orders verifying that he or she is a member of the armed forces or other services described in WAC 246-12-500(1).

(3) The practitioner may obtain a military status credential at any time the criteria in subsection (2) of this section are met. There is no fee due for military status. Portions of the current renewal fee will not be prorated or refunded.

(4) A military status credential remains in full force and effect so long as service continues and allows practice throughout the state of Washington unless sooner suspended or revoked by the regulatory entity.

NEW SECTION

WAC 246-12-520 How to maintain a military status credential. (1) The expiration date for all credentials is the practitioner's birthday, except for faculty, postgraduate education, associate, or trainee credentials authorized by law.

(2) As long as a practitioner's military service continues, the practitioner is not required to renew his or her credential, but should maintain the credential in military status. To maintain a military status credential, the practitioner should submit to the department an official copy of service orders verifying that he or she is an active duty member of the United States Armed Forces, the United States Public Health Services Commissioned Corps, or the Merchant Marine of the United States.

(3) The department will mail courtesy maintenance notices to the practitioner's address on file using credential renewal cycles.

(4) A practitioner should return the courtesy maintenance notice to the department with an official copy of their service orders.

(5) Military status credential maintenance requests are accepted by the department no sooner than ninety days prior to the date the credential would expire if not in military status.

(6) Continuing education is not required while the credential is in military status.

NEW SECTION

WAC 246-12-530 How to return to active status from military status. (1) To change the status of a credential from military status to active status, the practitioner must submit to the department:

(a) Written notification of the change in his or her service status;

(b) An official copy of the practitioner's discharge papers (DD214);

(c) The appropriate current active renewal fee;

(d) The current substance abuse monitoring surcharge, if required by the profession as part of the renewal fee.

(2) The practitioner must request the military status credential be changed from military status to active status within six months of honorable discharge by meeting the requirements of subsection (1) of this section.

(3) A practitioner who does not comply with subsection (2) of this section will be subject to late fees as required by WAC 246-12-040.

(4) Continuing education requirements will apply after the first post-discharge renewal.

NEW SECTION

WAC 246-12-540 How to obtain an inactive military-related status credential. A person is military related if he or she is the spouse or registered domestic partner of a service member in the United States Armed Forces or United States Public Health Services Commissioned Corps.

(1) To obtain an inactive military-related status credential the practitioner must:

(a) Submit a written request that the department place his or her credential in inactive military-related status;

(b) Hold an active Washington state credential that is valid and in force and effect;

(c) Submit to the department an official copy of service orders verifying that his or her spouse or registered domestic partner is a member of the service described in WAC 246-12-500(2) and has been deployed or stationed in a location outside of Washington state;

(d) Submit a copy of his or her marriage certificate or certificate of registered domestic partnership.

(2) There is no fee due for placing a credential in inactive military-related status. Portions of the current renewal fee will not be prorated or refunded.

(3) The practitioner may not practice in the state of Washington when his or her credential is in inactive military-related status.

NEW SECTION

WAC 246-12-550 How to maintain an inactive military-related status credential. The expiration date for all credentials is the practitioner's birthday, except for faculty, postgraduate education, associate, or trainee credentials authorized by law.

(1) The practitioner may maintain a credential in inactive military-related status for as long as his or her spouse or registered domestic partner continues to be stationed or deployed in a location outside of the state of Washington and he or she remains married to or in a registered domestic partnership with that person.

(2) To maintain an inactive military-related status credential, the practitioner should submit to the department an official copy of service orders verifying that his or her spouse or registered domestic partner continues to be deployed or stationed in a location outside of Washington state.

(3) The department will mail courtesy maintenance notices to the practitioner's address on file using credential renewal cycles.

(4) Inactive military-related status credential maintenance requests are accepted by the department no sooner than ninety days prior to the date the credential would expire if not in inactive military-related status.

(5) Continuing education is not required while the credential is in an inactive military-related status.

NEW SECTION

WAC 246-12-560 How to return to active status from inactive military-related status. (1) A practitioner in inactive military-related status can return his or her credential to active status at any time.

(2) To change a credential from an inactive military-related status to active status the practitioner must:

(a) Pay the appropriate current active renewal fee;

(b) Pay the current substance abuse monitoring surcharge, if required by the profession as part of renewal;

(c) Submit documentation of the service member's current service or discharge status.

(3) If the practitioner requests a change to active status after his or her spouse or registered domestic partner is discharged, he or she must submit an official copy of the discharge papers (DD214) showing that his or her spouse or registered domestic partner was honorably discharged within the previous six months.

(4) The credential must be changed from inactive military-related status to active status within six months of the military personnel's honorable discharge by meeting the requirements of subsections (2) and (3) of this section.

(5) A practitioner who does not comply with subsection (3) of this section will be subject to late fees as required by WAC 246-12-040.

(6) After returning a credential to active status, applicable continuing education requirements will apply during the following renewal.

WSR 14-10-028
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)
[Filed April 28, 2014, 12:02 p.m., effective May 29, 2014]

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

Purpose: The department is amending chapter 388-101 WAC, Certified community residential services and supports, to comply with changes to state law made by the 2013 legislature in SB 5510 Vulnerable adults—Abuse. In addition, the department is amending rules to comply with SHB 2056 Assisted living facilities (chapter 10, Laws of 2012). Changes related to SB 5510 include amending the definition of the term "neglect." Changes related to SHB 2056 (chapter 10, Laws of 2012) include replacing the term "boarding home" with "assisted living facility" in chapter 18.20 RCW.

Citation of Existing Rules Affected by this Order: Amending WAC 388-101-3000, 388-101-3020, 388-101-3060, 388-101-3230, 388-101-3630, 388-101-3660, 388-101-3730, and 388-101-3880.

Statutory Authority for Adoption: RCW 71A.12.030 and [71A.12].080.

Adopted under notice filed as WSR 13-23-101 on November 20, 2013.

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 8, 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 8, Repealed 0.

Date Adopted: April 22, 2014.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-02-048, filed 12/30/11, effective 1/30/12)

WAC 388-101-3000 Definitions. "Abandonment" means action or inaction by a person or entity with a duty of care for a vulnerable adult that leaves the vulnerable person without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means:

(1) The willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult;

(2) In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or

mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish; and

(3) Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

(a) **"Sexual abuse"** means any form of nonconsensual sexual contact, including but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual contact may include interactions that do not involve touching, including but not limited to sending a client sexually explicit messages, or cuing or encouraging a client to perform sexual acts. Sexual abuse includes any sexual contact between a staff person, who is not also a resident or client, of a facility or a staff person of a program authorized under chapter 71A.12 RCW, and a vulnerable adult living in that facility or receiving service from a program authorized under chapter 71A.12 RCW, whether or not it is consensual.

(b) **"Physical abuse"** means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints unless the restraints are consistent with licensing and certification requirements, and includes restraints that are otherwise being used inappropriately.

(c) **"Mental abuse"** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

(d) **"Exploitation"** means an act of forcing, compelling, or exerting undue influence over a vulnerable adult causing the vulnerable adult to act in a way that is inconsistent with relevant past behavior, or causing the vulnerable adult to perform services for the benefit of another.

"Associated with the applicant" means any person listed on the application as a partner, officer, director, or majority owner of the applying entity, or who is the spouse or domestic partner of the applicant.

"Case manager" means the division of developmental disabilities case resource manager or social worker assigned to a client.

"Certification" means a process used by the department to determine if an applicant or service provider complies with the requirements of this chapter and is eligible to provide certified community residential services and support to clients.

"Chaperone agreement" means a plan or agreement that describes who will supervise a community protection program client when service provider staff is not present. This plan or agreement is negotiated with other agencies and individuals who support the client, including the client's legal representative and family.

"Chemical restraint" means the use of psychoactive medications for discipline or convenience and not prescribed to treat the client's medical symptoms.

"Client" means a person who has a developmental disability as defined in RCW ((~~71A.10.020(3)~~)) 71A.10.020(4) and who also has been determined eligible to receive services by the division of developmental disabilities under chapter 71A.16 RCW. For purposes of informed consent and decision making requirements, the term "client" includes the client's legal representative to the extent of the representative's legal authority.

"Client services" means instruction and support services that service providers are responsible to provide as identified in the client's individual support plan.

"Crisis diversion" means temporary crisis residential services and supports provided to clients at risk of psychiatric hospitalization and authorized by the division of developmental disabilities.

"Crisis diversion bed services" means crisis diversion that is provided in a residence maintained by the service provider.

"Crisis diversion support services" means crisis diversion that is provided in the client's own home.

"Department" means the Washington state department of social and health services.

"Financial exploitation" means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any person or entity for any person's or entity's profit or advantage other than the vulnerable adult's profit or advantage. Some examples of financial exploitation are given in RCW 74.34.020(6).

"Functional assessment" means a comprehensive evaluation of a client's challenging behavior(s). This evaluation is the basis for developing a positive behavior support plan.

"Group home" means a residence that is licensed as either ((~~a boarding home~~)) an assisted living facility or an adult family home by the department under chapters 388-78A or 388-76 WAC. Group homes provide community residential instruction, supports, and services to two or more clients who are unrelated to the provider.

"Group training home" means a certified nonprofit residential facility that provides full-time care, treatment, training, and maintenance for clients, as defined under RCW 71A.22.020(2).

"Immediate" or **"immediately"** means within twenty-four hours for purposes of reporting abandonment, abuse, neglect, or financial exploitation of a vulnerable adult.

"Individual financial plan" means a plan describing how a client's funds will be managed when the service provider is responsible for managing any or all of the client's funds.

"Individual instruction and support plan" means a plan developed by the service provider and the client. The individual instruction and support plan:

(1) Uses the information and assessed needs documented in the individual support plan to identify areas the client would like to develop;

(2) Includes client goals for instruction and support that will be formally documented during the year; and

(3) Must contain or refer to other applicable support or service information that describes how the client's health and welfare needs are to be met (e.g. individual financial plan, positive behavior support plan, cross system crisis plan, individual support plan, individual written plan, client-specific instructions).

"Individual support plan" means a document that authorizes and identifies the division of developmental disabilities paid services to meet a client's assessed needs.

"Instruction" means goal oriented teaching that is designed for acquiring and enhancing skills.

"Instruction and support services staff" means long-term care workers of the service provider whose primary job function is the provision of instruction and support services to clients. Instruction and support services staff shall also include employees of the service provider whose primary job function is the supervision of instruction and support services staff. In addition, both applicants, prior to initial certification, and administrators, prior to assuming duties, who may provide instruction and support services to clients shall be considered instruction and support services staff for the purposes of the applicable training requirements.

"Legal representative" means a person's legal guardian, a person's limited guardian when the subject matter is within the scope of the limited guardianship, a person's attorney at law, a person's attorney in fact, or any other person who is authorized by law to act for another person.

"Managing client funds" means that the service provider:

(1) Has signing authority for the client;

(2) Disperses the client's funds; or

(3) Limits the client's access to funds by not allowing funds to be spent.

"Mechanical restraint" means a device or object, which the client cannot remove, applied to the client's body that restricts his/her free movement.

"Medication administration" means the direct application of a prescribed medication whether by injection, inhalation, ingestion, or other means, to the body of the client by an individual legally authorized to do so.

"Medication assistance" means assistance with self-administration of medication rendered by a nonpractitioner to a client receiving certified community residential services and supports in accordance with chapter 69.41 RCW and chapter 246-888 WAC.

"Medication service" means any service provided by a certified community residential services and support provider related to medication administration or medication assistance provided through nurse delegation and medication assistance.

"Neglect" means:

(1) A pattern of conduct or inaction by a person or entity with a duty of care that fails to provide the goods and services that maintain physical or mental health of a vulnerable adult, or that fails to avoid or prevent physical or mental harm or pain to a vulnerable adult; or

(2) An act or omission by a person or entity with a duty of care that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety, including but not limited to conduct prohibited under RCW 9A.42.100.

"Physical intervention" means the use of a manual technique intended to interrupt or stop a behavior from occurring. This includes using physical restraint to release or escape from a dangerous or potentially dangerous situation.

"Physical restraint" means physically holding or restraining all or part of a client's body in a way that restricts the client's free movement. This does not include briefly holding, without undue force, a client in order to calm him/her, or holding a client's hand to escort the client safely from one area to another.

"Psychoactive" means possessing the ability to alter mood, anxiety level, behavior, cognitive processes, or mental tension, usually applied to pharmacological agents.

"Psychoactive medications" means medications prescribed to improve or stabilize mood, mental status or behavior. Psychoactive medications include anti-psychotics/neuroleptics, atypical antipsychotics, antidepressants, stimulants, sedatives/hypnotics, and antimania and antianxiety drugs.

"Qualified professional" means a person with at least three years' experience working with individuals with developmental disabilities and as required by RCW 71A.12.220 (12).

"Restrictive procedure" means any procedure that restricts a client's freedom of movement, restricts access to client property, requires a client to do something which he/she does not want to do, or removes something the client owns or has earned.

"Risk assessment" means an assessment done by a qualified professional and as required by RCW 71A.12.230.

"Service provider" means a person or entity certified by the department who delivers services and supports to meet a client's identified needs. The term includes the state operated living alternative (SOLA) program.

"Support" means assistance a service provider gives a client based on needs identified in the individual support plan.

"Supported living" means instruction, supports, and services provided by service providers to clients living in homes that are owned, rented, or leased by the client or their legal representative.

"Treatment team" means the program participant and the group of people responsible for the development, implementation, and monitoring of the person's individualized supports and services. This group may include, but is not limited to, the case manager, therapist, the service provider, employment/day program provider, and the person's legal representative and/or family, provided the person consents to the family member's involvement.

"Vulnerable adult" includes a person:

(1) Sixty years of age or older who has the functional, mental, or physical inability to care for himself or herself; or

(2) Found incapacitated under chapter 11.88 RCW; or

(3) Who has a developmental disability as defined under RCW 71A.10.020; or

(4) Admitted to any facility; or

(5) Receiving services from home health, hospice, or home care agencies licensed or required to be licensed under chapter 70.127 RCW; or

(6) Receiving services from an individual provider.

"Willful" means the deliberate, or nonaccidental, action or inaction by an individual that he/she knew or reasonably should have known could cause a negative outcome, including harm, injury, pain, or anguish.

AMENDATORY SECTION (Amending WSR 08-02-022, filed 12/21/07, effective 2/1/08)

WAC 388-101-3020 Compliance. The service provider must be in compliance with:

(1) All the requirements of this chapter. Except that, the licensing requirements for adult family homes and ((~~boarding homes~~)) assisted living facilities supersede this chapter if the requirements under respective chapters 388-76 and 388-78A WAC conflict with this chapter;

(2) The laws governing this chapter, including chapter 71A.12 and 71A.22 RCW;

(3) The requirements of chapter 74.34 RCW;

(4) The department's residential services contract. Except that, the requirements of this chapter supersede any conflicting requirements with the contract, or appendices to the contract; and

(5) Other relevant federal, state and local laws, requirements, and ordinances.

AMENDATORY SECTION (Amending WSR 10-03-065, filed 1/15/10, effective 2/15/10)

WAC 388-101-3060 Change of ownership. (1) To apply for a change of ownership, an applicant must submit an application and the required reports and documents to the department when there is a change of:

(a) The business entity ownership; or

(b) The form of legal organization.

(2) When applying for a change of ownership, an applicant may be required to provide any or all items listed in WAC 388-101-3050.

(3) For group homes, applicants must also meet the applicable change of ownership requirements found in:

(a) WAC 388-76-10105 for licensed adult family homes; or

(b) WAC 388-78A-2770 through 388-78A-2787 for licensed ((~~boarding homes~~)) assisted living facilities.

(4) If the applicant is not a current service provider, the applicant must apply for initial certification.

AMENDATORY SECTION (Amending WSR 08-02-022, filed 12/21/07, effective 2/1/08)

WAC 388-101-3230 Group homes. A service provider who is a licensed adult family home or ((~~boarding home~~)) assisted living facility must:

(1) Provide care and services in accordance with this chapter and with licensing requirements under chapters 388-76 and 388-78A WAC respectively;

(2) Comply with client rights requirements in chapter 70.129 RCW and this chapter;

(3) Comply with the home's licensing requirements if there is a conflict with requirements in this chapter; and

(4) Comply with this chapter if the requirement is over and above the home's licensing requirements.

AMENDATORY SECTION (Amending WSR 08-02-022, filed 12/21/07, effective 2/1/08)

WAC 388-101-3630 Medication services—General. (1) If the service provider is involved in assisting any client with medications, as identified in the client's individual support plan, the service provider must:

(a) Have systems in place to ensure that medications are given as ordered and in a manner that safeguards the client's health and safety;

(b) Ensure that each client receives their medication as prescribed, except as provided for in the medication refusal section or in the medication assistance section regarding altering medication; and

(c) Have a legible prescription label completed by a licensed pharmacy before providing medication assistance or medication administration to a client for prescribed medications.

(2) Group homes licensed as ((~~a boarding home~~)) an assisted living facility or adult family home must meet the medication management requirements of chapter 388-78A or 388-76 WAC. For any difference in requirements the ((~~boarding home~~)) assisted living facility or adult family home medication rules take precedence over the medication rules of this chapter.

AMENDATORY SECTION (Amending WSR 08-02-022, filed 12/21/07, effective 2/1/08)

WAC 388-101-3660 Medication assistance. If the client is assessed as needing assistance with medication, the service provider may assist the client to take medications in any of the following ways:

(1) Communicating the prescriber's order to the client in such a manner that the client self-administers his/her medication properly;

(2) Reminding or coaching the client when it is time to take a medication;

(3) Opening the client's medication container;

(4) Handing the client the medication container;

(5) Placing the medication in the client's hand;

(6) Transferring medication from one container to another for the purpose of an individual dose (e.g., pouring a liquid medication from the container to a calibrated spoon or medication cup or using adaptive devices);

(7) Altering a medication by crushing or mixing:

(a) Only if the client is aware that the medication is being altered or added to food or beverage; and

(b) A pharmacist or other qualified practitioner has determined it is safe to alter medication; and

(c) It is documented on the prescription container or in the client's record.

(8) Guiding or assisting the client to apply or instill skin, nose, eye and ear preparations. Hand-over-hand administration is not allowed; and

(9) For group homes that have ((~~a boarding home~~)) an assisted living facility or adult family home license, refer to chapter 388-78A or 388-76 WAC for additional tasks that may be allowed.

AMENDATORY SECTION (Amending WSR 08-02-022, filed 12/21/07, effective 2/1/08)

WAC 388-101-3730 Disposal of medications. (1) The service provider or his/her designee must properly dispose of all medications that are discontinued, out of date, or superseded by another.

(2) When disposing client medications the service provider must list the:

(a) Medication;

(b) Amount; and

(c) Date that it was disposed.

(3) Two people, one of whom may be the client, must verify the disposal by signature.

(4) For group homes that have ((~~a boarding home~~)) an assisted living facility or adult family home license, refer to chapters 388-78A or 388-76 WAC for medication disposal requirements.

AMENDATORY SECTION (Amending WSR 08-02-022, filed 12/21/07, effective 2/1/08)

WAC 388-101-3880 Group home providers. (1) When considering restrictive procedures, group home providers licensed as ((~~boarding homes~~)) assisted living facilities must comply with all requirements in chapter 388-78A WAC regarding restraints.

(2) When considering restrictive procedures, group home providers licensed as adult family homes must comply with all requirements in chapter 388-76 WAC regarding restraints.

WSR 14-10-033
PERMANENT RULES
CRIMINAL JUSTICE TRAINING COMMISSION

[Filed April 29, 2014, 12:16 p.m., effective May 30, 2014]

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

Purpose: WAC 139-30-015 Firearms certification—Application, the rule regarding the requirements of a private security firearms certification is being edited as a guard is not required to have an armed guard license at the time of application for a private security firearms certification, as this is an element of the armed guard license.

Citation of Existing Rules Affected by this Order: Amending WAC 139-30-015.

Statutory Authority for Adoption: RCW 43.101.080.

Adopted under notice filed as WSR 13-21-037 on October 9, 2013.

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 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 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 26, 2013.

Sonja Hirsch
Rules Coordinator

AMENDATORY SECTION (Amending WSR 10-04-089, filed 2/2/10, effective 3/5/10)

WAC 139-30-015 Firearms certification—Application. (1) Any application for firearms certification shall:

(a) Be filed with the commission on a form provided by the commission;

(b) Be signed by the principal owner, principal partner, or a corporate officer of the licensed private security company employing the applicant;

(c) Establish through required documentation or otherwise that applicant:

(i) Is at least twenty-one years of age; and

(ii) Possesses a valid and current private security guard license, if applicable.

(d) Be accompanied by payment of a processing fee as set by the commission.

(2) After receipt and review of an application, the commission will provide written notification within ten business days to the requesting company regarding applicant's eligibility to obtain and possess a firearms certification.

(3) An armed private security guard must be qualified by a firearms instructor certified by the commission and provide the commission with proof of the initial qualification for each firearm that he/she is authorized to use in the performance of his/her duties. All firearms carried by armed private security guards in the performance of their duties must be owned or leased by the employer.

(4) It shall be the responsibility of the employer to insure that the armed private security guard demonstrates proficiency standards on an annual basis with each firearm that he/she is certified to use. Proficiency standards shall be set by the commission.

WSR 14-10-034
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed April 29, 2014, 2:47 p.m., effective May 30, 2014]

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

Purpose: The purpose of amending chapter 388-111 WAC, Residential habilitation centers—Compliance standards, is to comply with and be consistent with SHB 2056 Assisted living facilities (chapter 10, Laws of 2012) passed in the 2012 legislative session. The department is also amending

the chapter to comply with federal law regarding terminology used in intermediate care facilities for individuals with intellectual disabilities (ICF/IID) regulations. Changes related to SHB 2056 include replacing the term "boarding home" with "assisted living facility" to be consistent with amendments to chapter 18.20 RCW. Changes related to federal law regarding terminology used in the ICF/IID program include changing references to "mental retardation" to "intellectual disability" and changing all references to "mentally retarded individual" to "an individual with an intellectual disability."

Citation of Existing Rules Affected by this Order: Amending WAC 388-111-0001.

Statutory Authority for Adoption: Chapter 74.34 RCW, RCW 74.08.090, and 71A.12.030.

Adopted under notice filed as WSR 13-23-100 on November 20, 2013.

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 1, 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: April 22, 2014.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-01-001, filed 12/7/11, effective 1/7/12)

WAC 388-111-0001 Definitions. "Abandonment" means action or inaction by an individual or entity with a duty of care for a vulnerable adult that leaves the vulnerable individual without the means or ability to obtain necessary food, clothing, shelter, or health care.

"Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment of a vulnerable adult. In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a vulnerable adult, which have the following meanings:

(1) **"Mental abuse"** means any willful action or inaction of mental or verbal abuse. Mental abuse includes, but is not limited to, coercion, harassment, inappropriately isolating a resident from family, friends, or regular activity, and verbal assault that includes ridiculing, intimidating, yelling, or swearing.

(2) **"Physical abuse"** means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical or physical restraints unless the restraint is consistent with certification requirements.

(3) **"Sexual abuse"** means any form of nonconsensual sexual contact, including, but not limited to unwanted or inappropriate touching, rape, sodomy, sexual coercion, sexually explicit photographing, and sexual harassment. Sexual contact may include interactions that do not involve touching, including but not limited to sending a resident sexually explicit messages, or cuing or encouraging a resident to perform sexual acts. Sexual abuse includes any sexual contact between a staff person and a resident, whether or not it is consensual.

(4) **"Exploitation"** means an act of forcing, compelling, or exerting undue influence over a resident causing the resident to act in a way that is inconsistent with relevant past behavior, or causing the resident to perform services for the benefit of another.

"Administrative hearing" is a formal hearing proceeding before a state administrative law judge that gives an individual an opportunity to appeal a finding of abandonment, abuse, neglect or financial exploitation of a resident.

"Administrative law judge (ALJ)" means an impartial decision maker who presides over an administrative hearing. ALJs are employed by the office of administrative hearings (OAH), which is a separate state agency. ALJs are not DSHS employees or DSHS representatives.

"Department" means the department of social and health services (DSHS).

"Facility":

(1) Except as defined in subsection (2) of this definition, the term "facility" means an intermediate care facility for ((~~persons~~)) individuals with intellectual disabilities ((~~(ICF/ID)~~)) (ICF/IID).

(2) When used in the definition of "mandated reporter", the term "facility" means a residence licensed or required to be licensed under chapter 18.20 RCW, ((~~boarding homes~~)) assisted living facilities; chapter 18.51 RCW, nursing homes; chapter 70.128 RCW, adult family homes; chapter 72.36 RCW, soldiers' homes; or chapter 71A.20 RCW, residential habilitation centers; or any other facility licensed by the department.

"Financial exploitation" means the illegal or improper use, control over, or withholding of the property, income, resources, or trust funds of the vulnerable adult by any individual or entity for any individual's or entity's profit or advantage other than the vulnerable adult's profit or advantage. Some examples of financial exploitation are given in RCW 74.34.020(6).

"Individual" means anyone used by the facility to provide services to residents, who is alleged to have abandoned, abused, neglected, misappropriated property of, or financially exploited a resident. "Individual" includes, but is not limited to, employees, contractors and volunteers. "Individual" also includes a person used by the certified nursing facility portion of a residential habilitation center operated under chapter 71A.20 RCW.

"Intermediate care facility for ((~~persons~~)) individuals with intellectual disabilities ((~~(ICF/ID)~~)) (ICF/IID)" means an institution certified under chapter 42 C.F.R., Part 483, Subpart I, unless the facility is licensed as a nursing home under chapter 18.51 RCW or as ((~~a boarding home~~)) an assisted living facility under chapter 18.20 RCW.

"Mandated reporter" is an employee of the department; law enforcement officer; social worker; professional school personnel; individual provider; an employee of a facility; an operator of a facility; an employee of a social service, welfare, mental health, adult day health, adult day care, home health, home care, or hospice agency; county coroner or medical examiner; Christian Science practitioner; or health care provider subject to chapter 18.130 RCW.

"Neglect" means that an individual or entity with a duty to care for residents has:

(1) By an act or omission, demonstrated a serious disregard of consequences of such magnitude as to constitute a clear and present danger to the resident's health, welfare or safety; or

(2) Through conduct or inaction, or a pattern of conduct or inaction, failed to provide a resident with the goods and services that maintain physical or mental health of a vulnerable adult, or that failed to avoid or prevent physical harm, pain, mental anguish, or mental illness.

"Resident" means an individual residing in a facility or in the certified nursing facility portion of a residential habilitation center operated under chapter 71A.20 RCW.

"Willful" means the deliberate, or nonaccidental, action or inaction by an individual that he or she knew or reasonably should have known could cause a negative outcome, including harm, injury, pain or anguish.

WSR 14-10-040
PERMANENT RULES
DEPARTMENT OF FINANCIAL INSTITUTIONS
(Securities Division)

[Filed April 29, 2014, 4:00 p.m., effective May 30, 2014]

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

Purpose: In 2007 the National Association of Securities Dealers (NASD) consolidated with the member regulation operations of the New York Stock Exchange to form the Financial Industry Regulatory Authority (FINRA). The rules adopted by the securities division in Title 460 WAC have not yet been updated to reflect this name change but we are now proposing to do so. As the substantive matters covered by these rules will be unchanged by these updates, these changes will have no substantive effect on existing rules or how they are administered. Further, the amendments will prevent confusion by eliminating any references to an organization that no longer exists under its prior name.

Citation of Existing Rules Affected by this Order: Amending WAC 460-20B-020, 460-20B-030, 460-20B-060, 460-21B-060, 460-21C-010, 460-22B-040, 460-22B-090, 460-23B-030, 460-24A-047, and 460-28A-025.

Statutory Authority for Adoption: RCW 21.20.450.

Adopted under notice filed as WSR 14-05-077 on February 18, 2014.

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 10, 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: April 29, 2014.

Scott Jarvis
Director

AMENDATORY SECTION (Amending WSR 95-24-002, filed 11/22/95, effective 12/23/95)

WAC 460-20B-020 Definitions. For the purposes of this chapter and chapters 460-21B, 460-22B, and 460-23B WAC:

(1) "Central Registration Depository" ("CRD") shall mean the national registration system operated by the ((~~National Association of Securities Dealers~~)) Financial Industry Regulatory Authority, Inc. pursuant to a contract with the North American Securities Administrators Association.

(2) "Balance sheet" shall mean a balance sheet prepared in accordance with generally accepted accounting principles.

(3) "Branch office," for the purpose of this chapter, shall mean any office, residence or other place or location in this state where the business of a registered broker-dealer is conducted and which is owned or controlled by, or operated directly or indirectly for the benefit of, the registered broker-dealer, and where the business of a broker-dealer is conducted by a principal, salesperson, or salespersons for such registered broker-dealer, except that the following are not considered branch offices:

(a) Any location identified in a telephone directory line listing or on a business card or letterhead, which listing, card, or letterhead also sets forth the address and telephone number of the office from which persons conducting business from the location are directly supervised;

(b) Any location referred to, in an advertisement by a broker-dealer, by its local telephone number or local post office box provided that such reference may not include the street address of the location and that such reference also sets forth the address and telephone number of the office from which persons conducting business at the location are directly supervised;

(c) Any location identified by address in a broker-dealer's sales literature, provided that the sales literature also sets forth the address and telephone number of the office

from which persons conducting business at the location are directly supervised; or

(d) The principal office of the broker-dealer.

(4) "OTC non-NASDAQ equity securities" shall mean equity securities not traded on a national securities exchange or on NASDAQ. Equity securities quoted on ((~~the NASD's~~)) FINRA's OTC Bulletin Board are OTC non-NASDAQ equity securities.

AMENDATORY SECTION (Amending WSR 95-16-026, filed 7/21/95, effective 8/21/95)

WAC 460-20B-030 Registration procedure. (1) Broker-dealers that are members of the ((~~National Association of Securities Dealers~~)) Financial Industry Regulatory Authority must:

(a) Submit Form BD designating Washington as a state in which the broker-dealer requests registration to the Central Registration Depository together with the required fee; and

(b) Submit to the securities division in a form acceptable to the administrator such additional information as the administrator may require.

(2) Broker-dealers that are not members of the ((~~National Association of Securities Dealers~~)) Financial Industry Regulatory Authority must submit the following to the securities division:

(a) A check for the required fee made out to "state treasurer";

(b) A complete Form BD;

(c) Balance sheet as of a date not more than ninety days before the date of filing, and computation of net capital and aggregate indebtedness ratio of the same date as the balance sheet;

(d) A copy of any subordination agreement;

(e) Proof of passage of qualifying examinations by the designated principals;

(f) Such other information as the administrator may require.

AMENDATORY SECTION (Amending WSR 95-16-026, filed 7/21/95, effective 8/21/95)

WAC 460-20B-060 Notice of changes by broker-dealers. (1) Each licensed broker-dealer shall, upon any change in the information contained in its application for a certificate (other than financial information contained therein), promptly file an amendment to such application setting forth the changed information (and in any event within thirty days after the change occurs).

(2) Each licensed broker-dealer shall notify the administrator of the employment of any new agent in Washington, giving the full name and Social Security number of the individual involved, the date of employment, and the location of the office in which he or she will be employed by submitting a completed ((~~NASD~~)) FINRA Form U-4 to the administrator or the administrator's designee within twenty-one days after the event occurs.

(3) Each licensed broker-dealer shall notify the administrator of the termination of employment of any agent in Washington by submitting a completed ((~~NASD~~)) FINRA Form U-5 to the administrator or the administrator's designee, within thirty days after the event occurs.

(4) With respect to any broker-dealer registered under the Securities Exchange Act of 1934, it shall be sufficient compliance with subsection (1) of this section if a copy of an amendment to Form BD of the Securities and Exchange Commission containing the required information, or transmitted for filing to, the administrator not later than the date on which such amendment is required to be filed with the Securities and Exchange Commission.

AMENDATORY SECTION (Amending WSR 08-14-006, filed 6/19/08, effective 7/20/08)

WAC 460-21B-060 Dishonest or unethical business practices—Broker-dealers. The phrase "dishonest or unethical practices" as used in RCW 21.20.110 (1)(g) as applied to broker-dealers is hereby defined to include any of the following:

(1) Engaging in a pattern of unreasonable and unjustifiable delays in the delivery of securities purchased by any of its customers and/or in the payment upon request of free credit balances reflecting completed transactions of any of its customers;

(2) Inducing trading in a customer's account which is excessive in size or frequency in view of the financial resources and character of the account;

(3) Recommending to a customer to purchase, sell or exchange any security without reasonable grounds to believe that such transaction or recommendation is suitable for the customer based upon reasonable inquiry concerning the customer's investment objectives, financial situation and needs, and any other relevant information known by the broker-dealer;

(4) Executing a transaction on behalf of a customer without authorization to do so;

(5) Exercising any discretionary power in effecting a transaction for a customer's account without first obtaining written discretionary authority from the customer, unless the discretionary power relates solely to the time and/or price for the execution of orders;

(6) Executing any transaction in a margin account without securing from the customer a properly executed written margin agreement promptly after the initial transaction in the account;

(7) Failing to segregate customers' free securities or securities held in safekeeping;

(8) Hypothecating a customer's securities without having a lien thereon unless the broker-dealer secures from the customer a properly executed written consent promptly after the initial transaction, except as permitted by rules of the securities and exchange commission;

(9) Entering into a transaction with or for a customer at a price not reasonably related to the current market price of the security or receiving an unreasonable commission or profit;

(10) Failing to furnish to a customer purchasing securities in an offering, no later than the date of confirmation of the transaction, a final or preliminary prospectus, and if the latter, failing to furnish a final prospectus within a reasonable period after the effective date of the offering;

(11) Charging unreasonable and inequitable fees for services performed, including miscellaneous services such as collection of moneys due for principal, dividends or interest, exchange or transfer of securities, appraisals, safekeeping, or custody of securities and other services related to its securities business;

(12) Offering to buy from or sell to any person any security at a stated price unless such broker-dealer is prepared to purchase or sell, as the case may be, at such price and under such conditions as are stated at the time of such offer to buy or sell;

(13) Representing that a security is being offered to a customer "at the market" or a price relevant to the market price unless such broker-dealer knows or has reasonable grounds to believe that a market for such security exists other than that made, created or controlled by such broker-dealer, or by any person for whom he/she is acting or with whom he/she is associated in such distribution, or any person controlled by, controlling or under common control with such broker-dealer;

(14) Effecting any transaction in, or inducing the purchase or sale of, any security by means of any manipulative, deceptive or fraudulent device, practice, plan, program, design or contrivance, which may include but not be limited to:

(a) Effecting any transaction in a security which involves no change in the beneficial ownership thereof;

(b) Entering an order or orders for the purchase or sale of any security with the knowledge that an order or orders of substantially the same size, at substantially the same price, for the sale of any such security, has been or will be entered by or for the same or different parties for the purpose of creating a false or misleading appearance of active trading in the security or a false or misleading appearance with respect to the market for the security; provided, however, nothing in this subsection shall prohibit a broker-dealer from entering bona fide agency cross transactions for its customer;

(c) Effecting, alone or with one or more other persons, a series of transactions in any security creating actual or apparent active trading in such security or raising or depressing the price of such security, for the purpose of inducing the purchase or sale of such security by others;

(15) Guaranteeing a customer against loss in any securities account of such customer carried by the broker-dealer or in any securities transaction effected by the broker-dealer with or for such customer;

(16) Publishing or circulating, or causing to be published or circulated, any notice, circular, advertisement, newspaper article, investment service, or communication of any kind which purports to report any transaction as a purchase or sale of any security unless such broker-dealer believes that such transaction was a bona fide purchase or sale of such security; or which purports to quote the bid price or asked price for any security, unless such broker-dealer believes that such quotation represents a bona fide bid for, or offer of, such security;

(17) Using any advertising or sales presentation in such a fashion as to be deceptive or misleading. An example of such practice would be a distribution of any nonfactual data, material or presentation based on conjecture, unfounded or unrealistic claims or assertions in any brochure, flyer, or display by words, pictures, graphs or otherwise designed to supplement, detract from, supersede or defeat the purpose or effect of any prospectus or disclosure;

(18) Failing to disclose that the broker-dealer is controlled by, controlling, affiliated with or under common control with the issuer of any security before entering into any contract with or for a customer for the purchase or sale of security, the existence of such control to such customer, and if such disclosure is not made in writing, it shall be supplemented by the giving or sending of written disclosure at or before the completion of the transaction;

(19) Failing to make bona fide public offering of all of the securities allotted to a broker-dealer for distribution, whether acquired as an underwriter, a selling group member or from a member participating in the distribution as an underwriter or selling group member;

(20) Failure or refusal to furnish a customer, upon reasonable request, information to which he is entitled, or to respond to a formal written request or complaint;

(21) In connection with the solicitation of a sale or purchase of an OTC non-NASDAQ security, failing to promptly provide the most current prospectus or the most recently filed periodic report filed under Section 13 of the Securities Exchange Act, when requested to do so by a customer;

(22) Marking any order ticket or confirmation as unsolicited when in fact the transaction is solicited;

(23) For any month in which activity has occurred in a customer's account, but in no event less than every three months, failing to provide each customer with a statement of account which with respect to all OTC non-NASDAQ equity securities in the account, contains a value for each such security based on the closing market bid on a date certain: Provided, That this subsection shall apply only if the firm has been a market maker in such security at any time during the month in which the monthly or quarterly statement is issued;

(24) Failing to comply with any applicable provision of the Conduct Rules of the ((~~National Association of Securities Dealers~~)) Financial Industry Regulatory Authority or any applicable fair practice or ethical standard promulgated by the Securities and Exchange Commission or by a self-regulatory organization approved by the Securities and Exchange Commission;

(25) Any acts or practices enumerated in WAC 460-21B-010; or

(26) Using any term or abbreviation thereof in a manner that misleadingly states or implies that a person has special expertise, certification, or training in financial planning, including, but not limited to, the misleading use of a senior-specific certification or designation as set forth in WAC 460-25A-020.

The conduct set forth above is not inclusive. Engaging in other conduct such as forgery, embezzlement, nondisclosure, incomplete disclosure or misstatement of material facts, or manipulative or deceptive practices shall also be grounds for denial, suspension or revocation of registration.

AMENDATORY SECTION (Amending WSR 00-05-055, filed 2/14/00, effective 3/16/00)

WAC 460-21C-010 Definitions. For purposes of this chapter, the following terms have the meanings indicated:

(1) "Financial institution" means federal and state-chartered banks, savings and loan associations, savings banks, credit unions, and the service corporations of such institutions located in this state.

(2) "Networking arrangement" means a contractual or other arrangement between a broker-dealer and a financial institution pursuant to which the broker-dealer conducts broker-dealer services on the premises of such financial institution where retail deposits are taken.

(3) "Broker-dealer services" means the investment banking or securities business as defined in paragraph ((~~(p)~~)) (u) of Article I of the By-Laws of the ((~~National Association of Securities Dealers~~)) Financial Industry Regulatory Authority, Inc.

AMENDATORY SECTION (Amending WSR 95-16-026, filed 7/21/95, effective 8/21/95)

WAC 460-22B-040 Salesperson registration and examination. (1) Every applicant for registration as a securities salesperson of a broker-dealer shall pass the examinations specified below.

(a) For applicants seeking registration as salespersons of broker-dealers that are members of a national securities association or national securities exchange:

(i) The uniform securities agent state law examination (series 63); or the uniform combined state law examination (series 66); and

(ii) The appropriate qualifying examination administered by such national securities association.

(b) For all other applicants seeking registration as salespersons of broker-dealers:

(i) The uniform securities agent state law examination (series 63); or the uniform combined state law examination (series 66); and

(ii) The appropriate qualifying examination administered by the ((~~National Association of Securities Dealers~~)) Financial Industry Regulatory Authority for the activities in which the salesperson is to engage.

(2) Any individual out of the business of effecting transactions in securities for less than two years and who has previously passed the required examinations in subsection (1)(a) or (b) of this section or the Washington state securities examination shall not be required to retake the examination(s) to be eligible to be relicensed upon application.

AMENDATORY SECTION (Amending WSR 08-14-006, filed 6/19/08, effective 7/20/08)

WAC 460-22B-090 Dishonest and unethical business practices—Salespersons. The phrase "dishonest or unethical practices" as used in RCW 21.20.110 (1)(g) as applied to salespersons, is hereby defined to include any of the following:

(1) Engaging in the practice of lending or borrowing money or securities from a customer, or acting as a custodian for money, securities or an executed stock power of a customer;

(2) Effecting securities transactions not recorded on the regular books or records of the broker-dealer which the agent represents, unless the transactions are authorized in writing by the broker-dealer prior to execution of the transaction;

(3) Establishing or maintaining an account containing fictitious information in order to execute transactions which would otherwise be prohibited;

(4) Sharing directly or indirectly in profits or losses in the account of any customer without the written authorization of the customer and the broker-dealer which the agent represents;

(5) Dividing or otherwise splitting the agent's commissions, profits or other compensation from the purchase or sale of securities with any person not also registered for the same broker-dealer, or for a broker-dealer under direct or indirect common control;

(6) Inducing trading in a customer's account which is excessive in size or frequency in view of the financial resources and character of the account;

(7) Recommending to a customer the purchase, sale or exchange of any security without reasonable grounds to believe that such transaction or recommendation is suitable for the customer based upon reasonable inquiry concerning the customer's investment objectives, financial situation and needs, and any other relevant information known by the broker-dealer;

(8) Executing a transaction on behalf of a customer without authorization to do so;

(9) Exercising any discretionary power in effecting a transaction for a customer's account without first obtaining written discretionary authority from the customer, unless the discretionary power relates solely to the time and/or price for the execution of orders;

(10) Executing any transaction in a margin account without securing from the customer a properly executed written margin agreement promptly after the initial transaction in the account;

(11) Entering into a transaction with or for a customer at a price not reasonably related to the current market price of the security or receiving an unreasonable commission or profit;

(12) Failing to furnish to a customer purchasing securities in an offering, no later than the date of confirmation of the transaction, a final or preliminary prospectus, and if the latter, failing to furnish a final prospectus within a reasonable period after the effective date of the offering;

(13) Effecting any transaction in, or inducing the purchase or sale of, any security by means of any manipulative, deceptive or fraudulent device, practice, plan, program, design or contrivance, which may include but is not limited to:

(a) Effecting any transaction in a security which involves no change in the beneficial ownership thereof;

(b) Entering an order or orders for the purchase or sale of any security with the knowledge that an order or orders of substantially the same size, at substantially the same time and substantially the same price, for the sale of any such security, has been or will be entered by or for the same or different par-

ties for the purpose of creating a false or misleading appearance of active trading in the security or a false or misleading appearance with respect to the market for the security;

(c) Effecting, alone or with one or more other persons, a series of transactions in any security creating actual or apparent active trading in such security or raising or depressing the price of such security, for the purpose of inducing the purchase or sale of such security by others;

(14) Guaranteeing a customer against loss in any securities account for such customer carried by the broker-dealer or in any securities transaction effected by the broker-dealer with or for such customer;

(15) Publishing or circulating, or causing to be published or circulated, any notice, circular, advertisement, newspaper article, investment service, or communication of any kind which purports to report any transaction as a purchase or sale of any security unless such broker-dealer believes that such transaction was a bona fide purchase or sale of such security; or which purports to quote the bid price or asked price for any security, unless such broker-dealer believes that such quotation presents a bona fide bid for, or offer of, such security;

(16) Using any advertising or sales presentation in such a fashion as to be deceptive or misleading. An example of such practice would be a distribution of any nonfactual data, material or presentation based on conjecture, unfounded or unrealistic claims or assertions in any brochure, flyer, or display by words, pictures, graphs or otherwise designed to supplement, detract from, supersede or defeat the purpose or effect of any prospectus or disclosure;

(17) In connection with the solicitation of a sale or purchase of an OTC non-NASDAQ security, failing to promptly provide the most current prospectus or the most recently filed periodic report filed under Section 13 of the Securities Exchange Act, when requested to do so by a customer;

(18) Marking any order ticket or confirmation as unsolicited when in fact the transaction is solicited;

(19) Failing to comply with any applicable provision of the Conduct Rules of the ((~~National Association of Securities Dealers~~)) Financial Industry Regulatory Authority or any applicable fair practice or ethical standard promulgated by the Securities and Exchange Commission or by a self-regulatory organization approved by the Securities and Exchange Commission;

(20) Any act or practice enumerated in WAC 460-21B-010; or

(21) Using any term or abbreviation thereof in a manner that misleadingly states or implies that a person has special expertise, certification, or training in financial planning, including, but not limited to, the misleading use of a senior-specific certification or designation as set forth in WAC 460-25A-020.

The conduct set forth above is not inclusive. Engaging in other conduct such a forgery, embezzlement, nondisclosure, incomplete disclosure or misstatement of material facts, or manipulative or deceptive practices shall also be grounds for denial, suspension or revocation of registration.

AMENDATORY SECTION (Amending WSR 95-16-026, filed 7/21/95, effective 8/21/95)

WAC 460-23B-030 Salesperson examination requirements. Every applicant for registration as a securities salesperson of an issuer shall pass the examinations specified below:

(1) For an officer or director of an issuer that is a corporation, or a general partner of an issuer that is a limited partnership, or a manager of an issuer that is a limited liability company seeking registration as a salesperson for an issuer of a single offering of the issuer who will receive no commissions or similar remuneration directly or indirectly in connection with the offer or sale of the issuer's securities, no examination is required;

(2) For an officer or director of the issuer seeking registration as a salesperson for an issuer of a single offering of the issuer, the uniform state law examination (series 63); or the uniform combined state law examination (series 66) is required;

(3) For all other salespersons of issuers:

(a) The uniform securities agent state law examination (series 63); or the uniform combined state law examination (series 66); and

(b) The appropriate qualifying examination administered by the ((~~National Association of Securities Dealers~~)) Financial Industry Regulatory Authority, Inc. for the activities in which the salesperson is to engage;

(4) Any individual out of the securities business of effecting transactions in securities for less than two years and who has previously passed the required examinations in subsection (2) or (3) of this section or the Washington state securities examination shall not be required to retake the examination(s) to be eligible to be relicensed upon application.

AMENDATORY SECTION (Amending WSR 01-16-125, filed 7/31/01, effective 10/24/01)

WAC 460-24A-047 Electronic filing with designated entity. (1) Designation. Pursuant to RCW 21.20.050, the director designates the Investment Adviser Registration Depository operated by the ((~~National Association of Securities Dealers~~)) Financial Industry Regulatory Authority (IARD) to receive and store filings and collect related fees from investment advisers, federal covered advisers, and investment adviser representatives on behalf of the director.

(2) Use of IARD. Unless otherwise provided, all investment adviser, federal covered adviser, and investment adviser representative applications, amendments, reports, notices, related filings, and fees required to be filed with the director pursuant to the rules promulgated under this chapter, shall be filed electronically with and transmitted to IARD. The following additional conditions relate to such electronic filings:

(a) Electronic signature. When a signature or signatures are required by the particular instructions of any filing to be made through IARD, a duly authorized officer of the applicant or the applicant him or herself, as required, shall affix his or her electronic signature to the filing by typing his or her name in the appropriate fields and submitting the filing to Web IARD. Submission of a filing in this manner shall con-

stitute irrefutable evidence of legal signature by any individuals whose names are typed on the filing.

(b) When filed. Solely for purposes of a filing made through IARD, a document is considered filed with the director when all fees are received and the filing is accepted by IARD on behalf of the state.

(3) Electronic filing. Notwithstanding subsection (2) of this section, the electronic filing of any particular document and the collection of related processing fees shall not be required until such time as IARD provides for receipt of such filings and fees and thirty days' notice is provided by the director. Any documents required to be filed with the director that are not permitted to be filed with or cannot be accepted by IARD shall be filed in paper directly with the director.

(4) Hardship exemptions. Notwithstanding subsection (2) of this section, electronic filing is not required under the following circumstances:

(a) Temporary hardship exemption.

(i) Investment advisers registered or required to be registered under RCW 21.20.040, who experience unanticipated technical difficulties that prevent submission of an electronic filing to IARD, may request a temporary hardship exemption from the requirements to file electronically.

(ii) To request a temporary hardship exemption, the investment adviser must:

(A) File Form ADV-H in paper format with the appropriate regulatory authority in the state where the investment adviser's principal place of business is located, no later than one business day after the filing, that is the subject of the Form ADV-H, was due. If the state where the investment adviser's principal place of business is located has not mandated the use of IARD, the investment adviser should file the Form ADV-H with the appropriate regulatory authority in the first state that mandates the use of IARD by the investment adviser; and

(B) Submit the filing that is the subject of the Form ADV-H in electronic format to IARD no later than seven business days after the filing was due.

(iii) Effective date—Upon filing. The temporary hardship exemption will be deemed effective by the director upon receipt of the complete Form ADV-H by appropriate regulatory authority noted in (a)(ii)(A) of this subsection. Multiple temporary hardship exemption requests within the same calendar year may be disallowed by the director.

(b) Continuing hardship exemption.

(i) Criteria for exemption. A continuing hardship exemption will be granted only if the investment adviser is able to demonstrate that the electronic filing requirements of this section are prohibitively burdensome.

(ii) To apply for a continuing hardship exemption, the investment adviser must:

(A) File Form ADV-H in paper format with the director at least twenty business days before a filing is due; and

(B) If a filing is due to more than one state, the Form ADV-H must be filed with the appropriate regulatory authority in the state where the investment adviser's principal place of business is located. If the state where the investment adviser's principal place of business is located has not mandated the use of IARD, the investment adviser should file the Form ADV-H with the appropriate regulatory authority in the first state that mandates the use of IARD by the investment adviser. Any applications received by the director will be granted or denied within ten business days after the filing of Form ADV-H.

(iii) Effective date—Upon approval. The exemption is effective upon approval by the director. The time period of the exemption may be no longer than one year after the date on which the Form ADV-H is filed. If the director approves the application, the investment adviser must, no later than five business days after the exemption approval date, submit filings in paper format (along with the appropriate processing fees) for the period of time for which the exemption is granted.

(c) Recognition of exemption. The decision to grant or deny a request for a hardship exemption will be made by the appropriate regulatory authority in the state where the investment adviser's principal place of business is located. If the state where the investment adviser's principal place of business is located has not mandated the use of IARD, the decision to grant or deny a request for a hardship exemption will be made by appropriate regulatory authority in the first state that mandates the use of IARD by the investment adviser. The decision will be followed by the director if the investment adviser is registered in this state.

AMENDATORY SECTION (Amending Order 304, filed 2/28/75, effective 4/1/75)

WAC 460-28A-025 Exceptions from filing requirements. The following forms and types of advertising are permitted without the necessity for filing or prior authorization by the administrator, unless specifically prohibited.

(1) So-called "tombstone" advertising, containing no more than the following information:

(a) Name and address of issuer.

(b) Identity or title of security.

(c) Per unit offering price, number of shares and amount of offering.

(d) Brief, general description of business.

(e) Name and address of underwriter, or address where offering circular or prospectus can be obtained.

(f) Date of issuance.

(2) Dividend notices, proxy statements and reports to shareholders, including investment company quarterly and semi-annual reports.

(3) Sales literature, advertising or market letters prepared in conformity with the applicable regulations and in compliance with the filing requirements of the SEC, ((~~the NASD~~)) FINRA, or an approved securities exchange.

(4) Factual or informative letters, bulletins or releases, similar to "news letters," relating to issuer's progress or activities, status of the offering or current financial conditions.

WSR 14-10-044
PERMANENT RULES
LIQUOR CONTROL BOARD

[Filed April 30, 2014, 11:21 a.m., effective May 31, 2014]

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

Purpose: These rules are to further clarify current rules implementing I-502 and include additional requirements for marijuana retail licensees as well as marijuana processor and producer licensees.

Citation of Existing Rules Affected by this Order: Amending WAC 314-55-075, 314-55-077, 314-55-079, 314-55-084, 314-55-085, 314-55-089, 314-55-092, 314-55-104, and 314-55-105.

Statutory Authority for Adoption: RCW 69.50.342, 69.50.345.

Adopted under notice filed as WSR 14-07-041 on March 12, 2014.

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 9, 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: April 30, 2014.

Sharon Foster
Chairman

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-075 What is a marijuana producer license and what are the requirements and fees related to a marijuana producer license? (1) A marijuana producer license allows the licensee to produce, harvest, trim, dry, cure, and package marijuana into lots for sale at wholesale to marijuana processor licensees and to other marijuana producer licensees. A marijuana producer can also produce and sell marijuana plants, seed, and plant tissue culture to other marijuana producer licensees. Marijuana production must take place within a fully enclosed secure indoor facility or greenhouse with rigid walls, a roof, and doors. Outdoor production may take place in nonrigid greenhouses, other structures, or an expanse of open or cleared ground fully enclosed by a physical barrier. To obscure public view of the premises, outdoor production must be enclosed by a sight obscure wall or fence at least eight feet high. Outdoor producers must meet security requirements described in WAC 314-55-083.

(2) The application fee for a marijuana producer license is two hundred fifty dollars. The applicant is also responsible for paying the fees required by the approved vendor for fingerprint evaluation.

(3) The annual fee for issuance and renewal of a marijuana producer license is one thousand dollars. The board will conduct random criminal history checks at the time of renewal that will require the licensee to submit fingerprints for evaluation from the approved vendor. The licensee will be responsible for all fees required for the criminal history checks.

(4) The board will initially limit the opportunity to apply for a marijuana producer license to a thirty-day calendar window beginning with the effective date of this section. In order for a marijuana producer application license to be considered it must be received no later than thirty days after the effective date of the rules adopted by the board. The board may reopen the marijuana producer application window after the initial evaluation of the applications received and at subsequent times when the board deems necessary.

(5) Any entity and/or principals within any entity are limited to no more than three marijuana producer licenses.

(6) The maximum amount of space for marijuana production is limited to two million square feet. Applicants must designate on their operating plan the size category of the production premises and the amount of actual square footage in their premises that will be designated as plant canopy. There are three categories as follows:

(a) Tier 1 – Less than two thousand square feet;

(b) Tier 2 – Two thousand square feet to ten thousand square feet; and

(c) Tier 3 – Ten thousand square feet to thirty thousand square feet.

(7) The board may reduce a licensee's or applicant's square footage designated to plant canopy for the following reasons:

(a) If the amount of square feet of production of all licensees exceeds the maximum of two million square feet the board will reduce the allowed square footage by the same percentage.

(b) If fifty percent production space used for plant canopy in the licensee's operating plan is not met by the end of the first year of operation the board may reduce the tier of licensure.

(8) If the total amount of square feet of marijuana production exceeds two million square feet, the board reserves the right to reduce all licensee's production by the same percentage or reduce licensee production by one or more tiers by the same percentage.

(9) The maximum allowed amount of marijuana on a producer's premises at any time is as follows:

(a) Outdoor or greenhouse grows – One and one-quarter of a year's harvest; or

(b) Indoor grows – Six months of their annual harvest.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-077 What is a marijuana processor license and what are the requirements and fees related to a marijuana processor license? (1) A marijuana processor license allows the licensee to process, package, and label usable marijuana and marijuana-infused products for sale at wholesale to marijuana retailers.

(2) A marijuana processor is allowed to blend tested useable marijuana from multiple lots into a single package for sale to a marijuana retail licensee providing the label require-

ments for each lot used in the blend are met and the percentage by weight of each lot is also included on the label.

(3) A marijuana processor is limited in the types of food or drinks they may infuse with marijuana to create an infused edible product. To reduce the risk to public health, food defined as potentially hazardous food in WAC 246-215-0115(88) may not be infused with marijuana. These foods are potentially hazardous as they require time-temperature control to keep them safe for human consumption and prevent the growth of pathogenic microorganisms or the production of toxins. The board may designate other food items that may not be infused with marijuana. Any food that requires refrigeration, freezing, or a hot holding unit to keep it safe for human consumption may not be infused with marijuana.

(4) The recipe for any food infused with marijuana to make an edible product must be kept on file at the marijuana producer's licensed premises and made available for inspection by the WSLCB or their designee.

(5) The application fee for a marijuana processor license is two hundred fifty dollars. The applicant is also responsible for paying the fees required by the approved vendor for fingerprint evaluation.

(((~~(4)~~))) (6) The annual fee for issuance and renewal of a marijuana processor license is one thousand dollars. The board will conduct random criminal history checks at the time of renewal that will require the licensee to submit fingerprints for evaluation from the approved vendor. The licensee will be responsible for all fees required for the criminal history checks.

(((~~(5)~~))) (7) The board will initially limit the opportunity to apply for a marijuana processor license to a thirty-day calendar window beginning with the effective date of this section. In order for a marijuana processor application license to be considered it must be received no later than thirty days after the effective date of the rules adopted by the board. The board may reopen the marijuana processor application window after the initial evaluation of the applications that are received and processed, and at subsequent times when the board deems necessary.

(((~~(6)~~))) (8) Any entity and/or principals within any entity are limited to no more than three marijuana processor licenses.

(((~~(7)~~))) (9) Marijuana processor licensees are allowed to have a maximum of six months of their average useable marijuana and six months average of their total production on their licensed premises at any time.

(10) A marijuana processor must accept returns of products and sample jars from marijuana retailers for destruction, but is not required to provide refunds to the retailer.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-079 What is a marijuana retailer license and what are the requirements and fees related to a marijuana retailer license? (1) A marijuana retailer license allows the licensee to sell only usable marijuana, marijuana-infused products, and marijuana paraphernalia at retail in retail outlets to persons twenty-one years of age and older.

(2) Marijuana extracts, such as hash, hash oil, shatter, and wax can be infused in products sold in a marijuana retail store, but RCW 69.50.354 does not allow the sale of extracts that are not infused in products. A marijuana extract does not meet the definition of a marijuana-infused product per RCW 69.50.101.

(3) Internet sales and delivery of product to customers is prohibited.

(4) The application fee for a marijuana retailer's license is two hundred fifty dollars. The applicant is also responsible for paying the fees required by the approved vendor for fingerprint evaluation.

(5) The annual fee for issuance and renewal of a marijuana retailer's license is one thousand dollars. The board will conduct random criminal history checks at the time of renewal that will require the licensee to submit fingerprints for evaluation from the approved vendor. The licensee will be responsible for all fees required for the criminal history checks.

(6) Marijuana retailers may not sell marijuana products below their acquisition cost.

(7) Marijuana retailer licensees are allowed to have a maximum of four months of their average inventory on their licensed premises at any given time.

(8) A marijuana retailer may transport product to other locations operated by the licensee or to return product to a marijuana processor as outlined in the transportation rules in WAC 314-55-085.

(9) A marijuana retailer may not accept a return of product that has been opened.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-084 Production of marijuana. Only the following specified soil amendments, fertilizers, other crop production aids, and pesticides may be used in the production of marijuana:

(1) ((~~Materials listed or registered by the Washington state department of agriculture (WSDA) or Organic Materials Review Institute (OMRI) as allowable for use in organic production, processing, and handling under the U.S. Department of Agriculture's national organics standards, also called the National Organic Program (NOP), consistent with requirements at 7 C.F.R. Part 205.~~

~~(2)~~)) Pesticides registered by WSDA under chapter 15.58 RCW as allowed for use in the production, processing, and handling of marijuana. Pesticides must be used consistent with the label requirements.

(((~~(3)~~))) (2) Commercial fertilizers registered by WSDA under chapter 15.54 RCW.

(((~~(4)~~))) (3) Potting soil and other growing media available commercially in the state of Washington may be used in marijuana production. Producers growing outdoors are not required to meet land eligibility requirements outlined in 7 C.F.R. Part 205.202.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-085 What are the transportation requirements for a marijuana licensee? (1) **Notification of shipment.** Upon transporting any marijuana or marijuana product, a producer, processor ((~~or~~)), retailer, or certified third-party testing lab shall notify the board of the type and amount and/or weight of marijuana and/or marijuana products being transported, the name of transporter, information about the transporting vehicle, times of departure and expected delivery. This information must be reported in the traceability system described in WAC 314-55-083(4).

(2) **Receipt of shipment.** Upon receiving the shipment, the licensee receiving the product shall report the amount and/or weight of marijuana and/or marijuana products received in the traceability system.

(3) **Transportation manifest.** A complete printed transport manifest on a form provided by the board containing all information required by the board must be kept with the product at all times.

(4) **Records of transportation.** Records of all transportation must be kept for a minimum of three years at the licensee's location.

(5) **Transportation of product.** Marijuana or marijuana products that are being transported must meet the following requirements:

(a) Only the marijuana licensee ((~~or~~)), an employee of the licensee, or a certified testing lab may transport product;

(b) Marijuana or marijuana products must be in a sealed package or container approved by the board pursuant to WAC 314-55-105;

(c) Sealed packages or containers cannot be opened during transport;

(d) Marijuana or marijuana products must be in a locked, safe and secure storage compartment that is secured to the inside body/compartment of the vehicle transporting the marijuana or marijuana products;

(e) Any vehicle transporting marijuana or marijuana products must travel directly from the shipping licensee to the receiving licensee and must not make any unnecessary stops in between except to other facilities receiving product.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-089 What are the tax and reporting requirements for marijuana licensees? (1) Marijuana licensees must submit monthly report(s) and payments to the board. The required monthly reports must be:

(a) On a form or electronic system designated by the board;

(b) Filed every month, including months with no activity or payment due;

(c) Submitted, with payment due, to the board on or before the twentieth day of each month, for the previous month. (For example, a report listing transactions for the month of January is due by February 20th.) When the twentieth day of the month falls on a Saturday, Sunday, or a legal holiday, the filing must be postmarked by the U.S. Postal Service no later than the next postal business day;

(d) Filed separately for each marijuana license held; and

(e) All records must be maintained and available for review for a three-year period on licensed premises (see WAC 314-55-087).

(2) **Marijuana producer licensees:** On a monthly basis, marijuana producers must maintain records and report purchases from other licensed marijuana producers, current production and inventory on hand, sales by product type, and lost and destroyed product in a manner prescribed by the board.

A marijuana producer licensee must pay to the board a marijuana excise tax of twenty-five percent of the selling price on each wholesale sale to a licensed marijuana processor or producer.

(3) **Marijuana processor licensees:** On a monthly basis, marijuana processors must maintain records and report purchases from licensed marijuana producers, production of marijuana-infused products, sales by product type to marijuana retailers, and lost and/or destroyed product in a manner prescribed by the board.

A marijuana processor licensee must pay to the board a marijuana excise tax of twenty-five percent of the selling price on each wholesale sale of usable marijuana and marijuana-infused product to a licensed marijuana retailer.

(4) **Marijuana retailer's licensees:** On a monthly basis, marijuana retailers must maintain records and report purchases from licensed marijuana processors, sales by product type to consumers, and lost and/or destroyed product in a manner prescribed by the board.

A marijuana retailer licensee must pay to the board a marijuana excise tax of twenty-five percent of the selling price on each retail sale of usable marijuana or marijuana-infused products.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-092 What if a marijuana licensee fails to report or pay, or reports or pays late? (1) If a marijuana licensee does not submit its monthly reports and payment(s) to the board as required in WAC 314-55-089: The licensee is subject to penalties.

Penalties: A penalty of two percent per month will be assessed on any payments postmarked after the twentieth day of the month following the month of sale. When the twentieth day of the month falls on a Saturday, Sunday, or a legal holiday, the filing must be postmarked by the U.S. Postal Service no later than the next postal business day. Absent a postmark, the date received at the liquor control board or authorized designee, will be used to assess the penalty of two percent per month on payments received after the twentieth day of the month following the month of sale.

(2) Failure to make a report and/or pay the license taxes and/or penalties in the manner and dates outlined in WAC 314-55-089 will be sufficient grounds for the board to suspend or revoke a marijuana license.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-104 Marijuana processor license extraction requirements. (1) Processors are limited to cer-

tain methods, equipment, solvents, gases and mediums when creating marijuana extracts.

(2) Processors may use the hydrocarbons N-butane, isobutane, propane, or heptane or other solvents or gases exhibiting low to minimal potential human health-related toxicity approved by the board. These solvents must be of at least ninety-nine percent purity and a processor must use them in a professional grade closed loop extraction system designed to recover the solvents, work in ((~~a spark free~~)) an environment with proper ventilation, ((~~and follow all applicable local fire, safety and building codes in processing and the storage of the solvents~~)) controlling all sources of ignition where a flammable atmosphere is or may be present.

(3) Processors may use a professional grade closed loop CO_2 gas extraction system where every vessel is rated to a minimum of nine hundred pounds per square inch ((~~and follow all applicable local fire, safety and building codes in processing and the storage of the solvents~~)). The CO_2 must be of at least ninety-nine percent purity.

(4) Professional grade closed loop systems used by processors must be commercially manufactured and built to codes of recognized and generally accepted good engineering practices, such as:

(a) The American Society of Mechanical Engineers (ASME);

(b) American National Standards Institute (ANSI);

(c) Underwriters Laboratories (UL); or

(d) The American Society for Testing and Materials (ASTM).

(5) Professional closed loop systems, other equipment used, the extraction operation, and facilities must be approved for their use by the local fire code official and meet any required fire, safety, and building code requirements specified in:

(a) Title 296 WAC;

(b) National Fire Protection Association (NFPA) standards;

(c) International Building Code (IBC);

(d) International Fire Code (IFC); and

(e) Other applicable standards including following all applicable fire, safety, and building codes in processing and the handling and storage of the solvent or gas.

(6) Processors may use heat, screens, presses, steam distillation, ice water, and other methods without employing solvents or gases to create kief, hashish, bubble hash, or infused dairy butter, or oils or fats derived from natural sources, and other extracts.

(((~~5~~))) (7) Processors may use food grade glycerin, ethanol, and propylene glycol solvents to create extracts.

(((~~6~~))) (8) Processors creating marijuana extracts must develop standard operating procedures, good manufacturing practices, and a training plan prior to producing extracts for the marketplace. Any person using solvents or gases in a closed looped system to create marijuana extracts must be fully trained on how to use the system, have direct access to applicable material safety data sheets and handle and store the solvents and gases safely.

(((~~7~~))) (9) Parts per million for one gram of finished extract cannot exceed 500 parts per million or residual solvent or gas when quality assurance tested per RCW 69.50.348.

AMENDATORY SECTION (Amending WSR 13-21-104, filed 10/21/13, effective 11/21/13)

WAC 314-55-105 Packaging and labeling requirements. (1) All usable marijuana and marijuana-infused products must be stored behind a counter or other barrier to ensure a customer does not have direct access to the product.

(2) Any container or packaging containing usable marijuana or marijuana-infused products must protect the product from contamination and must not impart any toxic or deleterious substance to the usable marijuana or marijuana product.

(3) Upon the request of a retail customer, a retailer must disclose the name of the accredited third-party testing lab and results of the required quality assurance test for any usable marijuana or other marijuana-infused product the customer is considering purchasing.

(4) Usable marijuana and marijuana-infused products may not be labeled as organic unless permitted by the United States Department of Agriculture in accordance with the Organic Foods Production Act.

(5) The accredited third-party testing lab and required results of the quality assurance test must be included with each lot and disclosed to the customer buying the lot.

(6) A marijuana producer must make quality assurance test results available to any processor purchasing product. A marijuana producer must label each lot of marijuana with the following information:

(a) Lot number;

(b) UBI number of the producer; and

(c) Weight of the product.

(7) Marijuana-infused products meant to be eaten, swallowed, or inhaled, must be packaged in child resistant packaging in accordance with Title 16 C.F.R. 1700 of the Poison Prevention Packaging Act or use standards specified in this subsection. Marijuana-infused product in solid or liquid form may be packaged in plastic four mil or greater in thickness and be heat sealed with no easy-open tab, dimple, corner, or flap as to make it difficult for a child to open and as a tamper-proof measure. Marijuana-infused product in liquid form may also be sealed using a metal crown cork style bottle cap.

(8) A processor may provide a retailer free samples of usable marijuana packaged in a sample jar protected by a plastic or metal mesh screen to allow customers to smell the product before purchase. The sample jar may not contain more than three and one-half grams of usable marijuana. The sample jar and the usable marijuana within may not be sold to a customer and must be ((~~either~~)) returned to the licensed processor who ((~~provide~~)) provided the usable marijuana and sample jar ((~~or destroyed by the retailer after use in the manner described in WAC 314-55-097 and noted in the traceability system~~)).

(9) A producer or processor may not treat or otherwise adulterate usable marijuana with any organic or nonorganic chemical or other compound whatsoever to alter the color, appearance, weight, or smell of the usable marijuana.

(10) Labels must comply with the version of NIST Handbook 130, Uniform Packaging and Labeling Regulation adopted in chapter 16-662 WAC.

(11) **All usable marijuana when sold at retail must include accompanying material that contains the following warnings that state:**

(a) "Warning: This product has intoxicating effects and may be habit forming. Smoking is hazardous to your health";

(b) "There may be health risks associated with consumption of this product";

(c) "Should not be used by women that are pregnant or breast feeding";

(d) "For use only by adults twenty-one and older. Keep out of reach of children";

(e) "Marijuana can impair concentration, coordination, and judgment. Do not operate a vehicle or machinery under the influence of this drug";

(f) Statement that discloses all pesticides applied to the marijuana plants and growing medium during production and processing.

(12) **All marijuana-infused products sold at retail must include accompanying material that contains the following warnings that state:**

(a) "There may be health risks associated with consumption of this product";

(b) "This product is infused with marijuana or active compounds of marijuana";

(c) "Should not be used by women that are pregnant or breast feeding";

(d) "For use only by adults twenty-one and older. Keep out of reach of children";

(e) "Products containing marijuana can impair concentration, coordination, and judgment. Do not operate a vehicle or machinery under the influence of this drug";

(f) "Caution: When eaten or swallowed, the intoxicating effects of this drug may be delayed by two or more hours";

(g) Statement that discloses all pesticides applied to the marijuana plants and growing medium during production of the base marijuana used to create the extract added to the infused product; and

(h) Statement that discloses the type of extraction method, including any solvents, gases, or other chemicals or compounds used to produce or that are added to the extract.

(13) **Labels affixed to the container or package containing usable marijuana sold at retail must include:**

(a) The business or trade name and Washington state unified business identifier number of the licensees that produced, processed, and sold the usable marijuana;

(b) Lot number;

(c) Concentration of THC, THCA, CBD, including a total of active cannabinoids (potency profile);

(d) Net weight in ounces and grams or volume as appropriate;

(e) Warnings that state: "This product has intoxicating effects and may be habit forming";

(f) Statement that "This product may be unlawful outside of Washington state";

(g) Date of harvest((.)); and

(h) The board may create a logo that must be placed on all usable marijuana and marijuana-infused products.

(14) **Sample label mock up for a container or package containing usable marijuana sold at retail with required information:**

(15) **Labels affixed to the container or package containing marijuana-infused products sold at retail must include:**

(a) The business or trade name and Washington state unified business identifier number of the licensees that produced, processed, and sold the usable marijuana;

(b) Lot numbers of all base marijuana used to create the extract;

(c) Batch number;

(d) Date manufactured;

(e) Best by date;

(f) Products meant to be eaten or swallowed, recommended serving size and the number of servings contained within the unit, including total milligrams of active tetrahydrocannabinol (THC), or Delta 9;

(g) Net weight in ounces and grams, or volume as appropriate;

(h) List of all ingredients and any allergens;

(i) "Caution: When eaten or swallowed, the intoxicating effects of this drug may be delayed by two or more hours.";

(j) If a marijuana extract was added to the product, disclosure of the type of extraction process and any solvent, gas, or other chemical used in the extraction process, or any other compound added to the extract;

(k) Warnings that state: "This product has intoxicating effects and may be habit forming";

(l) Statement that "This product may be unlawful outside of Washington state";

(m) The board may create a logo that must be placed on all usable marijuana and marijuana-infused products.

(16) **Sample label mock up (front and back) for a container or package containing marijuana-infused products sold at retail with required information:**

(Front of label)

(Back of label)

WSR 14-10-045
PERMANENT RULES
DEPARTMENT OF RETIREMENT SYSTEMS

[Filed April 30, 2014, 1:24 p.m., effective June 1, 2014]

Effective Date of Rule: June 1, 2014.

Purpose: Updates the deferred compensation program (DCP) rules as part of a general review. Removes annual deferral limits from rule; the current limits will be maintained on the department's DCP web site. Adds a rule to describe how and when participants may make up contributions that were missed during a period of uniformed service. Removes references to the employee retirement benefits board.

Citation of Existing Rules Affected by this Order: Amending WAC 415-501-110, 415-501-330, 415-501-410, 415-501-420, 415-501-430, 415-501-440, 415-501-450, 415-501-472, 415-501-475, 415-501-485, 415-501-486, 415-501-488, 415-501-491, 415-501-495, 415-501-510, and 415-501-590.

Statutory Authority for Adoption: RCW 41.50.050(5).

Adopted under notice filed as WSR 14-03-130 on January 21, 2014.

Changes Other than Editing from Proposed to Adopted Version: Changes include revisions to increase clarity, to allow an in-service distribution based on age, and to ensure conformity with federal regulations.

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 1, Amended 16, 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: April 30, 2014.

Marcie Frost
Director

AMENDATORY SECTION (Amending WSR 05-15-045, filed 7/11/05, effective 8/11/05)

WAC 415-501-110 Definitions. (1) **Accumulated deferrals.** Compensation deferred under the plan, adjusted by income received, increases or decreases in investment value, fees, and any prior distributions made.

(2) **Beneficiary.** ((~~A beneficiary of a participant, a participant's estate, or any other person whose interest in the plan is derived from~~)) The person or entity entitled to receive benefits under the plan after the death of a participant.

(3) **Compensation.** All payments made to a ((~~public employee by the employer~~)) participant by the employer as remuneration for services rendered.

(4) **Deferred compensation.** The amount of the participant's compensation that is deferred under a participation agreement. See WAC 415-501-410.

(5) **Deferred compensation plan or plan.** A plan that allows employees of the state of Washington and approved political subdivisions of the state of Washington to defer a portion of their compensation according to the provisions of Section 457(b) of the Internal Revenue Code.

(6) **Department.** The department of retirement systems created by RCW 41.50.020 or its designee.

(7) **Eligible employee.** Any person who is employed by and receives any type of compensation from a participating employer for whom services are provided, and who is:

(a) A full-time, part-time, or career seasonal employee of Washington state, a county, a municipality, or other political subdivision of the state, whether or not covered by civil service;

(b) An elected or appointed official of the executive branch of the government, including a full-time member of a board, commission, or committee;

(c) A justice of the supreme court, or a judge of the court of appeals or of a superior or district court; or

(d) A member of the state legislature or of the legislative authority of a county, city, or town.

(8) **Eligible rollover distribution.** A distribution to a participant of any or all funds from an eligible retirement plan unless it is:

(a) One in a series of substantially equal annuity payments;

(b) One in a series of substantially equal installment payments payable over ten years or more;

(c) Required to meet minimum distribution requirements of the plan; or

(d) Distributed for hardship or unforeseeable emergency from a 457 plan.

(9) ((~~**Employee retirement benefits board.** The board created by RCW 41.50.086.~~

~~(10)~~)) **Employer.**

(a) The state of Washington; and

(b) Approved political subdivisions of the state of Washington.

(((~~(11)~~)) (10) **Normal retirement age.** An age designated by the participant for purposes of the three-year catch-up provision described in WAC 415-501-430(2). The participant may choose a normal retirement age between:

(a) The earliest age at which an eligible participant has the right to receive retirement benefits without actuarial ((~~adjustment~~)) or similar reduction from his/her retirement plan with the same employer; and

(b) Age seventy and one-half.

(((~~(12)~~)) (11) **Participant.** An eligible employee:

(a) Who has submitted a participation agreement that is approved by the department; and

(b) Who either:

(i) Is currently deferring compensation under the plan; or

(ii) Has previously deferred compensation and has not received a distribution of his/her entire benefit under the plan.

(((~~(13)~~)) (12) **Participation agreement.** The agreement executed by an eligible employee pursuant to WAC 415-501-410, in which the eligible employee chooses to become a plan participant.

(((~~(14)~~)) (13) **You,** as used in this chapter, means a participant as defined in subsection (((~~(12)~~)) (11) of this section.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-330 Does the department maintain a record of my account? The department maintains a deferred compensation account for each participant. When necessary, the department will create and maintain a deferred compensation account for a beneficiary or for a former spouse.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-420 What are the annual deferral limits? ((~~Except as provided in WAC 415-501-430 (catch-up provisions), the maximum you may defer for any taxable year is the lesser of:~~

~~(1) One hundred percent of your includible compensation as defined in IRC Section 457 (e)(5), and Treasury Regulation 1.457.2(g), and determined without regard to community property laws; or~~

~~(2) The annual deferral limit in the following table:~~

~~For taxable year beginning in calendar year:~~	~~Annual deferral limit:~~
~~2001~~	~~$8,500~~
~~2002~~	~~$11,000~~
~~2003~~	~~$12,000~~
~~2004~~	~~$13,000~~
~~2005~~	~~$14,000~~
~~2006~~	~~$15,000~~
~~Beginning January 1, 2007~~	~~$15,000~~ ~~plus cost-of-living adjustments, if any, established by the IRS under 26 U.S.C. 457~~))

(1) The minimum deferral is fifteen dollars per semi-monthly payroll period, thirty dollars for monthly payroll periods.

(2) Except as provided in WAC 415-501-430 (catch-up provisions) and WAC 415-501-435 (uniformed service make-up contributions), the annual deferral limit is the smaller of:

(a) One hundred percent of your includible compensation as defined in IRC Section 457 (e)(5), and Treasury Regulation 1.457.2(g), and determined without regard to community property laws; or

(b) The annual deferral limit established each year by the Internal Revenue Service. The annual deferral limit is published on the department's deferred compensation program web site.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-430 Are there exceptions to the annual deferral limits? As allowed by the Internal Revenue Service, you may defer more than the annual deferral limit

((~~set in WAC 415-501-420~~)) if you qualify to use one of the "catch up" provisions described in this section. You may not use both catch-up provisions during the same taxable year.

(1) **Age fifty and over:** You may defer a higher amount during any ((~~plan~~)) year in which you are age fifty or older. The maximum you may defer each year is the sum of((~~:~~

~~(a)~~)) the annual deferral amount ((~~in WAC 415-501-420~~)) for the current taxable year((~~; and~~

~~(b) The amount in the following table:~~

~~For taxable year beginning in calendar year:~~	~~Age 50 deferral limit:~~
~~2002~~	~~$1,000~~
~~2003~~	~~$2,000~~
~~2004~~	~~$3,000~~
~~2005~~	~~$4,000~~
~~2006~~	~~$5,000~~
~~Beginning January 1, 2007~~	~~$5,000~~ ~~plus cost of living adjustments, if any, established by the IRS under 26 U.S.C. 414~~))

plus the over fifty catch up amount established by the IRS under 26 U.S.C. 414.

(2) **Three years before normal retirement age:** You may defer a higher amount during a period of three consecutive years immediately preceding the taxable year in which you reach normal retirement age as defined in WAC 415-501-110(((~~11~~))) (10). The maximum you may defer during each of the three years is the lesser of:

(a) Twice the annual deferral limit ((~~established in WAC 415-501-420~~)); or

(b) The sum of the annual deferral limit ((~~established in WAC 415-501-420,~~)) for the applicable years, plus the portion of the annual deferral limit for any prior taxable year that you have not previously used.

(i) For years prior to 2002, amounts you deferred under certain other plans must be considered in determining the unused amount, consistent with Treasury Regulation 1.457-4 (c)(3)(iv).

(ii) A prior taxable year may be taken into account only if:

(A) It begins after December 31, 1978;

(B) You were eligible, during any portion of the taxable year, to participate in the plan; and

(C) Compensation deferred under the plan during that year, if any, was subject to a deferral limit under WAC 415-501-420.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-440 How are deferral limits monitored? (1) ((~~Under WAC 415-501-315,~~)) Employers will monitor deferrals to ensure that amounts deferred comply with the ((~~limitations in WAC 415-501-420 and 415-501-430~~)) the annual deferral limit in WAC 415-501-420 and the age-50 catch-up deferral limit.

(2) The department may also monitor deferrals and has the authority to disallow deferral of compensation in excess of the ((~~statutory~~)) limits.

(3) You must also monitor your deferrals to ensure that combined deferrals in two or more deferred compensation plans do not exceed the deferral limits.

(4) If the plan determines that your deferrals into the plan have exceeded the deferral limit, the excess deferrals will be distributed to you as soon as administratively practicable.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-450 May I change my deferral amount? You may change the amount of your deferred compensation through the methods established by the department. Changes may be made only in((~~:~~

~~(1)~~)) whole dollar increments((~~; or~~

~~(2) Whole percentages if percentage deferrals are allowed for your employer~~)).

A change in the amount will be effective for any calendar month only if you notify the department of the change, through the methods available, prior to the month for which the change is requested and prior to ((~~the established payroll cutoff date for~~)) your ((~~employer~~)) employer's established "cutoff date" for the payroll in which the change will occur.

AMENDATORY SECTION (Amending WSR 05-22-109, filed 11/2/05, effective 12/3/05)

WAC 415-501-472 Who determines DCP's investment options? (1) The state investment board, in consultation with the ((~~employee retirement benefits board~~)) department, makes certain investment options available to plan participants. The investment board may:

(a) Open, change, or close investment options according to its investment policy; or

(b) Change investment managers for any investment option.

(2) If the state investment board closes or substantially changes an investment option, the state investment board may transfer the funds invested in that option to another option that, in the board's judgment, most closely ((~~represents~~)) resembles the investment characteristics of the option being closed or changed.

AMENDATORY SECTION (Amending WSR 05-22-109, filed 11/2/05, effective 12/3/05)

WAC 415-501-475 May I choose how I want my deferred compensation invested? (1) You must designate on your participation agreement the investment option(s) in which you wish to have your deferrals invested.

(2) In general, you may change the investment of your accumulated deferrals, the investment of your future deferrals, or both, through the methods established by the department. However, if necessary to protect the performance results of the DCP program, the department has the right to:

(a) Limit the number of times you change investment options;

(b) Limit the frequency of the changes;

(c) Limit the manner of making changes; or

(d) Impose other restrictions.

In addition, changes must be consistent with any restrictions on trading imposed by the investment options involved.

(3) Beneficiaries ((~~receiving a distribution may change investment options according to the provisions of subsection (2) of this section~~)) over age eighteen and former spouses may change the investment options through the methods established by the department once a separate account has been established for them. The guardian of a minor beneficiary may change the investment options on the minor's account if authorized by the order of guardianship.

AMENDATORY SECTION (Amending WSR 06-04-058, filed 1/27/06, effective 2/27/06)

WAC 415-501-485 How do I obtain a distribution? Distribution from the plan is governed by Internal Revenue Code Sections 401 (a)(9) and 457(d); the treasury regulations interpreting these sections; and these rules to the extent they are not inconsistent with the Internal Revenue Code. The options for distribution are set forth in the ((~~*DCP Distribution Booklet.* The booklet will be mailed to you when your employer notifies the department of your termination of employment~~)) instructions which will be provided by the department.

(1) **Date of distribution.** You may choose the date on which to begin distribution from your deferred compensation account, subject to the requirements in (a) through (c) of this subsection. ((~~The department must receive a properly completed distribution form from you at least thirty days prior to the date distribution is to begin.~~))

(a) **Earliest date.** You may not begin distribution prior to your termination of employment, with the following exceptions:

(i) A distribution for an unforeseeable emergency under WAC 415-501-510;

(ii) A voluntary in-service distribution under subsection (4) of this section; ((~~or~~))

(iii) A distribution from funds that were rolled into the deferred compensation account (may be subject to tax penalties); or

(iv) An in-service distribution in any calendar year in which you will reach age seventy and one-half or more.

(b) **Latest date.** You must begin distribution on or before April 1st of the calendar year following the latter of:

(i) The calendar year in which you reach age seventy and one-half; or

(ii) The calendar year in which you retire.

(c) If you do not ((~~make a timely choice of~~)) choose a distribution date, the department will begin distribution according to the minimum distribution requirements in IRC Section 401 (a)(9).

(2) **Method of distribution.** ((~~You must choose a distribution method (amount and frequency) from the payment options outlined in the *DCP Distribution Booklet.*~~)) Payment options include a lump sum payment, partial lump sum payment, periodic payments, or an annuity purchase.

(a) Periodic payments must ((~~be~~)) total at least ((~~fifty dollars per month (if paid monthly) or~~)) six hundred dollars per year.

(b) Beginning at age seventy and one-half or when you terminate employment, whichever comes later, payment must be in an amount to satisfy minimum distribution requirements in IRC Section 401 (a)(9).

(3) **Voluntary in-service distribution.** You may choose to withdraw the total amount payable to you under the plan while you are employed if the following three requirements are met:

(a) Your entire account value does not exceed five thousand dollars;

(b) You have not previously received an in-service distribution; and

(c) ((~~Your deferrals have been suspended during the preceding~~)) You have made no annual deferral during the two-year period ending on the date of the in-service distribution.

(4) **Unforeseeable emergencies.** See WAC 415-501-510.

(5) **Rehire.** If you ((~~terminate and then return to employment for an eligible employer, you may reenroll in the plan. The department will stop your distribution, if applicable, and void any choices of distribution date and method made prior to reenrollment~~)) begin to receive distributions and then return to employment with a DCP employer, distributions from your DCP account will cease. You may request distribution when you are again eligible consistent with these rules.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-486 How will my accumulated deferrals be distributed in the event of my death? If you die before your entire deferred compensation account has been distributed, accumulated deferrals will be paid to the beneficiary or beneficiaries you have designated according to WAC 415-501-480. ((~~If no beneficiary is designated or if the designated beneficiary does not survive you by a period of thirty days, accumulated deferrals will be paid to your surviving spouse, if any. If you do not have a surviving spouse, the accumulated deferrals will be paid to your estate. Provisions regarding distribution to various classes of beneficiaries are set forth in WAC 415-501-487 through 415-501-494.~~)) (1) If one or more primary beneficiaries survive your death by a period of thirty days, your accumulated contributions will be distributed to the surviving primary beneficiaries using the ratio established on your beneficiary designation form.

(2) If no primary beneficiary survives your death, but one or more contingent beneficiaries survive your death by thirty days, your accumulated contributions will be distributed to the surviving contingent beneficiaries using the ratio established on your beneficiary designation form.

(3) If no primary or contingent beneficiary survives your death, but your spouse survives your death by a period of thirty days, your accumulated contributions will be distributed to your surviving spouse.

(4) If no primary beneficiary, contingent beneficiary, or spouse survives your death by a period of thirty days, your accumulated contributions will be distributed to your estate.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-488 How will the account be distributed if my beneficiary is my spouse? If you die ((~~before the entire account has been exhausted, your spouse beneficiary will receive your accumulated deferrals according to the provisions of this section.~~

~~(1) **Date of distribution.** Your spouse beneficiary may choose the date on which to begin receiving the distribution, provided:~~

~~(a) The spouse beneficiary notifies the department of the distribution date within ninety days from the date the department is notified of your death.~~

~~(b) The department receives the election form at least thirty days before distribution is to begin.~~

~~(c) Distribution begins on or before the first day of April of the calendar year following the latter of:~~

~~(i) The year you would have reached age seventy and one-half; or~~

~~(ii) The calendar year in which you die.~~

~~If the beneficiary does not make a timely choice of distribution date, the department will begin distribution according to the minimum distribution requirements in IRC 401 (a)(9).~~

~~(2) **Method of distribution.** The spouse beneficiary must choose a distribution method from the payment options outlined in the *DCP Distribution Booklet*, which will be mailed to your beneficiary when the department is notified of your death. Payment options include a lump sum payment or periodic payments, provided:~~

~~(a) The amount and frequency allows for distribution of the entire account balance during the beneficiary's life expectancy, as computed by the Department of Treasury in IRS Regulation 1.72.9; and~~

~~(b) Periodic distributions made by the department are at least fifty dollars per month, if paid monthly, or six hundred dollars per year.~~)) with money in your account and your beneficiary is your spouse, your account will be distributed in accordance with this rule. An account will be established in the name of your spouse.

(1) The distribution options will be mailed to your spouse when DCP is notified of your death. Your spouse may choose any method of distribution (annuity, periodic payments, or lump sum) that provides at least the required minimum distribution each calendar year until your account is exhausted.

(a) The department must receive your election form at least thirty days before distribution is to begin.

(b) Periodic distributions must total at least six hundred dollars per year.

(c) Receiving more than the required minimum distribution during one calendar year does not excuse your spouse from taking the required minimum in any calendar year to which the required minimum applies.

(2) Required minimum distribution.

(a) First required distribution if you die *before* your "required beginning date" (see WAC 415-501-485 (1)(b)). Beginning in the later of:

(i) The calendar year following the calendar year of your death; or

(ii) The calendar year you would have attained age seventy and one half, your spouse must receive the required minimum distribution. This distribution must be taken by December 31st of the applicable calendar year.

(b) First required distribution if you die *after* your "required beginning date" (see WAC 415-501-485 (1)(b)), your spouse must receive the required minimum distribution during the calendar year following the year of your death. The distribution must be taken by December 31st of the applicable calendar year.

(c) Your spouse must receive the required minimum distribution during each subsequent calendar year until the account is exhausted.

(d) The required minimum distribution in each of the relevant calendar years is based on life expectancies set forth in the treasury regulations.

(3) If your spouse dies before his or her entire account is exhausted, the remainder of the account will be paid to his or her estate.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-491 How will the account be distributed if my beneficiary is not my spouse? If you die ((~~before the entire account has been exhausted and your beneficiary is not your spouse, your accumulated deferrals will be distributed according to the provisions of this section.~~

~~(1) **Date of distribution.** A nonspouse beneficiary may choose the date on which to begin receiving the distribution, provided:~~

~~(a) The beneficiary notifies the department of the distribution date within ninety days from the date the department is notified of your death.~~

~~(b) The department receives the election form at least thirty days before distribution is to begin.~~

~~(c) Distribution begins on or before the first day of April of the calendar year following the latter of:~~

~~(i) The year you would have reached age seventy and one-half; or~~

~~(ii) The calendar year in which you die.~~

~~If the beneficiary does not make a timely choice of distribution date, the department will begin distribution according to the minimum distribution requirements in IRC 401 (a)(9).~~

~~(2) **Method of distribution.** A nonspouse beneficiary must choose a distribution method from the payment options outlined in the *DCP Distribution Booklet*, which will be mailed to your beneficiary when the department is notified of your death. Your beneficiary may choose a lump sum payment or periodic payments.~~

~~(a) If the nonspouse beneficiary begins distribution by the thirty-first day of December of the year following your death:~~

~~(i) The amount and frequency must allow for distribution of the entire account balance during the beneficiary's life expectancy, as computed by the Department of Treasury in IRS Regulation 1.72.9; and~~

~~(ii) Periodic distributions made by the department must be at least fifty dollars per month, if paid monthly, or six hundred dollars per year.~~

~~(b) If the nonspouse beneficiary does not begin distribution by the thirty-first day of December of the year following the year of your death, the entire account balance must be paid out within five years from the date of your death.~~)) with money in your account and your beneficiary is an individual other than your spouse, your account will be distributed in accordance with this rule. An account will be established in the name of your beneficiary.

(1) For rules governing distribution to an entity other than an individual (e.g., a trust, estate, or organization), see WAC 415-501-493.

(2) The distribution options will be mailed to your beneficiary when DCP is notified of your death. Your beneficiary may choose any method of distribution (annuity, periodic payments, or lump sum) that provides at least the required minimum distribution each calendar year until your account is exhausted.

(a) The department must receive your election form at least thirty days before distribution is to begin.

(b) Periodic distributions must total at least six hundred dollars per year.

(c) Receiving more than the required minimum distribution during one calendar year does not excuse your beneficiary from taking the required minimum in any calendar year to which the required minimum applies.

(3) Required minimum distribution.

(a) First required distribution if you die *before* your "required beginning date" (see WAC 415-501-485 (1)(b)), your beneficiary may chose to receive the required minimum distribution under either the "life expectancy rule" or the "five year rule." Your beneficiary must elect one of the two rules at least thirty days before distribution would be required to begin under the life expectancy rule. If a timely election is not received, your beneficiary will be required to receive the required minimum distribution under the "five year rule."

(i) Life expectancy rule. Distribution under this rule allows your beneficiary to spread distribution over his or her life expectancy. Beginning in the calendar year following the calendar year of your death, your beneficiary must receive a required minimum distribution. This distribution must be taken by December 31st of the calendar year.

(ii) Five year rule. Under this rule, the first mandatory distribution is later than under the life expectancy rule. However, the beneficiary's entire account must be distributed on or before December 31st of the fifth calendar year following the calendar year of your death.

(b) First required distribution if you die *after* your "required beginning date" (see WAC 415-501-485 (1)(b)), your beneficiary must receive a required minimum distribution during the calendar year following the year of your death. The distribution must be taken by December 31st of the applicable calendar year.

(c) Your beneficiary must receive a required minimum distribution during each subsequent calendar year until the account is exhausted.

(d) The required minimum distribution in each of the relevant calendar years is based on life expectancies set forth in the treasury regulations.

(4) If your beneficiary dies before his or her entire account is exhausted, the remainder of the account will be paid to his or her estate.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-495 Will the department honor domestic relations orders? (1) The department will honor a domestic relations order (DRO) only if the order:

(a) Was entered by a court of competent jurisdiction((~~,~~)) pursuant to the domestic relations law of any state;

(b) Establishes a right of a spouse or former spouse to a portion of your deferred compensation account pursuant to a division of property;

(c) Clearly states either the dollar amount or a percentage of the account to be transferred to the account of the spouse or former spouse from your account; and

(d) Provides your name and date of birth, and the name and date of birth of your spouse or former spouse.

(2) You must provide the address and Social Security number of both you and your spouse or former spouse to the department. This information may be submitted in a cover letter, in another document, or by other means arranged with the department.

(3) To implement a DRO, the department will establish a separate account for the spouse or former spouse in the amount specified in subsection (1)(c) of this section. ((~~The amount will initially be invested in the savings pool.~~)) The transfer(s) will be prorated across all funds and money sources based on the amount awarded to the spouse or former spouse. Thereafter, the spouse or former spouse may provide investment instructions under WAC ((~~415-501-450~~)) 415-501-475.

(4) Your spouse or former spouse may choose a method of distribution, including ((~~a~~)) an eligible direct rollover.

(5) If a DRO filed with the department prior to January 1, 2002, provides that distribution to the spouse or former spouse is not available until you separate from service, the department will comply with the express terms of the order unless it is subsequently amended.

(6) If the spouse or former spouse has not elected another method of distribution ((~~by~~)) before the original account holder reaches age seventy and one-half, the department will begin distribution in accordance with the minimum distribution requirements in IRC 401 (a)(9) and the treasury regulations thereunder.

(7) If the spouse or former spouse dies before the account is fully distributed, the remaining balance will be paid to ((~~the former spouse's~~)) his or her estate.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-510 May I have some or all of my accumulated deferrals in the event of an unforeseeable emergency? (1) Notwithstanding any other provisions in this chapter, you may request all or a portion of your accumulated deferrals in the event of an unforeseeable emergency. Distribution will be made within sixty days following the department's approval of your request. The amount paid will be limited strictly to that amount reasonably necessary to satisfy the emergency need.

(2) For purposes of this plan, an unforeseeable emergency is severe financial hardship ((~~to you~~)) resulting from:

(a) A personal illness or accident or the illness or injury of a spouse or dependent who meets the definition in Section 152(a) of the Internal Revenue Code;

(b) Loss of your property due to casualty, including the need to rebuild a home following damage not otherwise covered by homeowner's insurance, e.g., as a result of natural disaster; or

(c) Other similar extraordinary and unforeseeable circumstances arising as a result of events beyond your control, such as:

(i) The imminent foreclosure of or eviction from your primary residence due to circumstances that were beyond your control;

(ii) The need to pay medical expenses, including nonrefundable deductibles as well as the cost of prescription drug medication; or

(iii) The need to pay funeral expenses of a participant's or beneficiary's spouse or dependent (as defined in Section 152(a) of the Internal Revenue Code without regard to Sections 152 (b)(1), (2), and (d)(1)).

(3) The circumstances that constitute an unforeseeable emergency depend upon the facts of each case, but, in no case will the department approve a distribution request if the financial hardship is or may be relieved:

((~~(i)~~)) (a) Through reimbursement or compensation by insurance or otherwise; or

((~~(ii)~~)) (b) By liquidation of your assets, to the extent liquidation of such assets would not itself cause severe financial hardship; or

((~~(iii)~~)) (c) By cessation of deferrals under the plan.

(4) Examples: ((~~(a)~~)) The following types of occurrences are not considered unforeseeable emergencies: ((~~(i)~~)) Sending your child to college((~~,~~)) or ((~~(ii)~~)) purchasing a home.

(~~((b) The following types of occurrences may be considered unforeseeable emergencies, depending on the facts in each case:~~

~~(i) Imminent foreclosure of or eviction from your primary residence;~~

~~(ii) Medical expenses, including nonrefundable deductibles, and/or the cost of prescription drug medication;~~

~~(iii) Funeral expenses of your spouse or a dependent as defined in Section 152(a) of the Internal Revenue Code; and~~

~~(iv) Extraordinary expenses resulting from a divorce.~~))

(5) If the department denies your request for distribution, you may request a review of that decision according to the provisions of WAC 415-08-015.

(6) ((~~Unforeseeable emergency requests received by the department, whether approved or denied, will cause a mandatory suspension of deferrals to the plan. You may not resume deferrals sooner than six months from the date of suspension.~~)) If your request meets the requirement for a financial emergency withdrawal, contributions into this plan must cease for a period of at least six months from the date of the withdrawal.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-590 Are department officers and employees ((~~and members of the employee retirement benefits board~~)) eligible to participate in the plan? Department officers and employees ((~~and members of the employee retirement benefits board,~~)) who are otherwise eligible((~~,~~)) may participate in the plan under the same terms and conditions as apply to other participants. Such officers((~~,~~)) and employees((~~, or board members~~)) may not ((~~participate~~)) be involved in any ((~~department or board~~)) decision or action uniquely affecting their own account or participation in the plan.

AMENDATORY SECTION (Amending WSR 04-22-053, filed 10/29/04, effective 11/29/04)

WAC 415-501-410 How do I enroll in the plan? (1) As an eligible employee, you may enroll in the plan by executing a participation agreement.

(2) By signing the participation agreement, you authorize your employer to reduce your gross compensation each month by a specific amount. This amount will be contributed to your deferred compensation account. Your employer will reduce your compensation by the specified amount until you change the amount (WAC 415-501-450) or suspend contributions (WAC 415-501-470).

(3) Deferrals from your compensation will start during the calendar month after the month your participation agreement is approved by the department.

(4) Reenrollment. If you transfer from a state agency to another state agency without a separation of employment, your deferred compensation program (DCP) enrollment will be automatically transferred to the new state agency. Your contributions will automatically continue. If you separate from employment with a DCP employer (break in service) and return to employment with a DCP employer, you must reenroll in the program if you want to resume contributions to DCP.

NEW SECTION

WAC 415-501-435 May I make deferrals that were missed during periods of uniformed service? (1) **Does the plan have a military make-up provision?** Participants meeting certain eligibility requirements are allowed to make up contributions that were missed during periods of absence from employment due to uniformed service, based on federal laws and regulations of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA, 38 U.S.C. Sections 4301 through 4335).

(2) **What constitutes uniformed service?** For the purposes of this rule, uniformed service includes: The Army, Navy, Air Force, Marines, Coast Guard, the commissioned corps of the Public Health Service, the reserve components of the foregoing services, the National Guard, the National Disaster Medical System, and any other category of persons designated as such by the President in a time of war or emergency. Service includes active duty, active duty for training, initial active duty for training, inactive duty training, examination to determine fitness for duty, funeral honors duty, and full-time National Guard duty. Service may be voluntary or involuntary.

(3) **What is the time limit for making up missed deferrals?** Make-up deferrals must be made within a period not exceeding three times the period of uniformed service, but in no case more than five years. This is referred to as the statutory period. The period begins the day you return to work. Missed deferrals can only be made while you are employed by your original employer. If you leave that employer but return to that employer within the statutory period, you may continue to make up deferrals until the end of the statutory period.

(4) **What is the limit on military make-up contributions?** You may contribute up to the maximum contributions for each calendar year that included absence from employment for uniformed service. In addition, you may contribute up to the maximum for the current calendar year.

EXAMPLE:

John is employed from January to June 2008, and defers $5,000 into his DCP account during that time. John is on leave for uniformed service from July 2008 through December 2009, one and one-half years. He returns to employment with this original employer in January 2010.

The deferral limits for this period are as follows: **2008** - $15,500; **2009** - $16,500; **2010** - $16,500; **2011** - $16,500; **2012** - $17,000; **2013** - $17,500; and **2014** - $17,500. John's statutory period for make-up contributions is four and one-half years (through June 2014).

Upon his return to employment, during 2010: For 2010, John may defer $16,500 out of his regular salary (subject to limitations for includable compensation). During 2010, he may also defer:

• Up to $10,500 allocable to 2008 ($15,500 less $5,000 previously deferred); and

• Up to $16,500 allocable to 2009.

He decides to contribute $16,500 for 2010, and $5,000 for 2008.

During 2011. For 2011, John may defer $16,500 out of his regular salary. During 2011, he may also defer:

• Up to $5,500 for 2008 ($15,500 less $10,000 total previously deferred).

• Up to $16,500 for 2009.

(5) **How are make-up deferrals made?** Make-up deferrals are made through payroll deductions after you return to employment. Make-up contributions may not be paid using after-tax payments.

(6) **What conditions must be met to qualify for this provision?** You must not have been released from the uniformed service under dishonorable or other punitive conditions, as set forth in 38 U.S.C. Section 4304. In addition, you must return to employment with your original employer within the time frame specified in USERRA (38 U.S.C. Section 4312) based on your length of service.

WSR 14-10-046
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed April 30, 2014, 2:20 p.m., effective June 1, 2014]

Effective Date of Rule: June 1, 2014.

Purpose: The community services division, economic services administration is amending WAC 388-310-0200 WorkFirst—Activities, 388-310-0800 WorkFirst—Support services, 388-400-0005 Who is eligible for temporary assistance for needy families?, 388-400-0010 Who is eligible for state family assistance?, 388-406-0010 How do I apply for cash assistance or Basic Food benefits?, and 388-406-0055 When do my benefits start?

The department is amending the above WACs to add completion of a WorkFirst orientation as a condition of eligibility for individuals applying for TANF/SFA who will be mandatory participants once TANF/SFA is approved. In addition, amendments made to WAC 388-406-0055 When do my benefits start?, are being amended to remove medical references and to support the creation of the new housing and essential needs referral program.

Citation of Existing Rules Affected by this Order: Amending WAC 388-310-0200, 388-310-0800, 388-400-0005, 388-400-0010, 388-406-0010, and 388-406-0055.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.62.030, 74.09.035, 74.08.090, 74.09.530, and 41.05.021.

Other Authority: 2E2SHB 1738, Laws of 2011 and SHB 2069, chapter 10, Laws of 2013.

Adopted under notice filed as WSR 14-07-101 on March 18, 2014.

Changes Other than Editing from Proposed to Adopted Version: (1) Adding language to WAC 388-310-0200 to more clearly define a mandatory participant and who is required to participate in WorkFirst activities. Changes include adding the words, "a mandatory participant and who is" to subsection (1); removing "required to participate in the WorkFirst activities in your individual responsibility plan, and become what is called" in subsection (1)(a); and adding "When you are a mandatory participant, you are required to participate in the WorkFirst activities in your individual responsibility plan unless you are exempt under WAC 388-310-0300 and 388-310-0350" to subsection (1)(b).

(2) Adding the following language "from the date of application" to subsections (1)(b), (2)(b), and (3)(b) in WAC 388-406-0055 to clarify the starting date of cash assistance.

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 6, 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 6, Repealed 0.

Date Adopted: April 30, 2014.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-12-031, filed 5/29/12, effective 7/1/12)

WAC 388-310-0200 WorkFirst—Activities. (1) **Who is a mandatory participant and who is required to participate in WorkFirst activities?**

(a) You are ((~~required to participate in the WorkFirst activities in your individual responsibility plan, and become what is called~~)) a "mandatory participant," if you((~~:~~

(~~i~~)) are receiving TANF or SFA cash assistance because you are pregnant or the parent or adult in the home((~~; and~~

(~~ii) Are not exempt. For exemptions see WAC 388-310-0300 and 388-310-0350~~)).

(b) When you are a mandatory participant, you are required to participate in the WorkFirst activities in your individual responsibility plan unless you are exempt under WAC 388-310-0300 and 388-310-0350.

(c) Participation is voluntary for all other WorkFirst participants (those who no longer receive or have never received TANF or SFA cash assistance).

((~~(c) If you are a mandatory participant who was suspended from WorkFirst participation under RCW 74.08A.260 (8)(a), the department will restore your participation requirements between July 1, 2012 and June 30, 2013 in a priority order, beginning with participants who are closest to reaching their TANF time limit.~~))

(2) **What activities do I participate in when I enter the WorkFirst program?**

When you enter the WorkFirst program, you will participate in one or more of the following activities (which are described in more detail in other sections of this chapter):

(a) Paid employment (see WAC 388-310-0400 (2)(a) and 388-310-1500);

(b) Self employment (see WAC 388-310-1700);

(c) Job search (see WAC 388-310-0600);

(d) Community jobs (see WAC 388-310-1300);

(e) Work experience (see WAC 388-310-1100);

(f) On-the-job training (see WAC 388-310-1200);

(g) Vocational educational training (see WAC 388-310-1000);

(h) Basic education activities (see WAC 388-310-0900);

(i) Job skills training (see WAC 388-310-1050);

(j) Community service (see WAC 388-310-1400);

(k) Activities provided by tribal governments for tribal members and other American Indians (see WAC 388-310-1400(1) and 388-310-1900);

(l) Other activities identified by your case manager on your individual responsibility plan that will help you with situations such as drug and/or alcohol abuse, homelessness, or mental health issues; and/or

(m) Activities identified by your case manager on your individual responsibility plan to help you cope with family violence as defined in WAC 388-61-001; and/or

(n) Up to ten hours of financial literacy activities to help you become self-sufficient and financially stable.

(3) **If I am a mandatory participant, how much time must I spend doing WorkFirst activities?**

If you are a mandatory participant, you will be required to participate in the activities in your individual responsibility plan, and may be required to participate full time, working, looking for work or preparing for work. You might be required to participate in more than one part-time activity at the same time that adds up to full time participation. You will have an individual responsibility plan (described in WAC 388-310-0500) that includes the specific activities and requirements of your participation.

(4) **What activities do I participate in after I get a job?**

You may be required to participate in other activities, such as job search or training once you are working twenty hours or more a week in a paid unsubsidized job, to bring your participation up to full time.

You may also engage in activities if you are working full time and want to get a better job.

AMENDATORY SECTION (Amending WSR 13-02-048, filed 12/24/12, effective 2/1/13)

WAC 388-310-0800 WorkFirst—Support services. (1) **Who can get support services?**

People who can get support services include:

(a) WorkFirst participants who receive a TANF cash grant;

(b) Sanctioned WorkFirst participants during the required participation before the sanction is lifted or applicants who were terminated while in noncompliance sanction who are doing activities required to reopen cash assistance (WAC 388-310-1600);

(c) TANF/SFA applicants as needed to meet the WorkFirst orientation requirements under WAC 388-400-0005(2) or 388-400-0010(3);

(d) Unmarried or pregnant minors who are income eligible to receive TANF and are:

(i) Living in a department approved living arrangement (WAC 388-486-0005) and are meeting the school requirements (WAC 388-486-0010); or

(ii) Are actively working with a social worker and need support services to remove the barriers that are preventing them from living in a department approved living arrangement and/or meeting the school requirements.

((~~(d)~~)) (e) American Indians who receive a TANF cash grant and have identified specific needs due to location or employment.

(2) **Why do I receive support services?**

Although not an entitlement, you may receive support services for the following reasons:

(a) To help you participate in work and WorkFirst activities that lead to independence.

(b) To help you to participate in job search, accept a job, keep working, advance in your job, and/or increase your wages.

(c) You can also get help in paying your child care expenses through the working connections child care assistance program. (Chapter 170-290 WAC describes the rules for this child care assistance program.)

(3) **What type of support services may I receive and what limits apply?**

There is a limit of three thousand dollars per person per program year (July 1st to June 30th) for WorkFirst support services you may receive. Some types of support services have dollar limit restrictions.

The chart below shows the types of support services that are available for the different activities (as indicated by an "x") and the restrictions that apply.

Definitions:

• Work-related activities include looking for work or participating in workplace activities, such as community jobs or a work experience position.

•• Safety-related activities include meeting significant or emergency family safety needs, such as dealing with family violence.

••• Some support services are available if you need them for other required activities in your IRP.

Type of Support Service	Restrictions	• Work	•• Safety	••• Other
Reasonable accommodation for employment		x		
Clothing/uniforms		x		
Diapers		x		
Haircut		x		
Lunch	Same rate as established by OFM for state employees	x		
Personal hygiene		x		
Professional, trade, association, union and bonds		x		
Relocation related to employment (can include rent, housing, and deposits)		x		
Short-term lodging and meals in connection with job interviews/tests	Same rate as established by OFM for state employees	x		
Tools/equipment		x		
Car repair needed to restore car to operable condition		x	x	
License/fees		x	x	
Mileage reimbursement	Same rate as established by OFM for state employees	x	x	
Transportation allotment		x	x	
Counseling		x	x	x
Educational expenses		x		x
Medical exams (not covered by medicaid)		x	x	x
Public transportation		x	x	x
Testing-diagnostic		x	x	x

(4) **What are the other requirements to receive support services?**

Other restrictions on receiving support services are determined by the department or its agents. They will consider whether:

(a) It is within available funds; and

(b) It does not assist, promote, or deter religious activity; and

(c) There is no other way to meet the cost.

(5) **What happens to my support services if I do not participate as required?**

The department will give you ten days notice, following the rules in WAC 388-310-1600, then discontinue your support services until you participate as required.

AMENDATORY SECTION (Amending WSR 11-22-042, filed 10/27/11, effective 12/1/11)

WAC 388-400-0005 Who is eligible for temporary assistance for needy families? (1) You can get temporary assistance for needy families (TANF), if you:

(a) Can be in a TANF/SFA assistance unit as allowed under WAC 388-408-0015 through 388-408-0030;

(b) Meet the citizenship/alien status requirements of WAC 388-424-0010;

(c) Live in the state of Washington. A child must live with a caretaker relative, guardian, or custodian who meets the state residency requirements of WAC 388-468-0005;

(d) Do not live in a public institution unless specifically allowed under RCW 74.08.025;

(e) Meet TANF/SFA:

(i) Income requirements under chapter 388-450 WAC;

(ii) Resource requirements under chapter 388-470 WAC; and

(iii) Transfer of property requirements under chapter 388-488 WAC.

(f) Assign your rights to child support as required under WAC 388-422-0005;

(g) Cooperate with the division of child support (DCS) as required under WAC 388-422-0010 by helping them:

(i) Prove who is the father of children applying for or getting TANF or SFA; and

(ii) Collect child support.

(h) Tell us your Social Security number as required under WAC 388-476-0005;

(i) Cooperate in a review of your eligibility as required under WAC 388-434-0005;

(j) Cooperate in a quality assurance review as required under WAC 388-464-0001;

(k) Participate in the WorkFirst program as required under chapter 388-310 WAC;

(l) Report changes of circumstances as required under WAC 388-418-0005; and

(m) Complete a mid-certification review and provide proof of any changes as required under WAC 388-418-0011.

(2) If you apply for TANF, have not received TANF or SFA within the past thirty days, and will be a mandatory WorkFirst participant as described in WAC 388-310-0200 once approved, you must complete a WorkFirst orientation before we approve your application.

(3) If you are an adult, you must have an eligible child living with you or you must be pregnant and meet the requirements of WAC 388-462-0010.

(((~~(3)~~))) (4) If you are an unmarried pregnant teen or teen parent:

(a) Your living arrangements must meet the requirements of WAC 388-486-0005; and

(b) You must attend school as required under WAC 388-486-0010.

(((~~(4)~~))) (5) In addition to rules listed in subsection (1) of this section, a child must meet the following rules to get TANF:

(a) Meet the age requirements under WAC 388-404-0005; and

(b) Live in the home of a relative, court-ordered guardian, court-ordered custodian, or other adult acting *in loco parentis* as required under WAC 388-454-0005; or

(c) If the child lives with a parent or other adult relative that provides care for the child, that adult cannot have used up their sixty-month lifetime limit of TANF or SFA cash benefits as defined in WAC 388-484-0005; or

(d) If the child lives with a parent who provides care for the child, that adult cannot have been permanently disqualified from receiving TANF/SFA due to noncompliance sanction as defined in WAC 388-310-1600.

(((~~(5)~~))) (6) You cannot get TANF if you have been:

(a) Convicted of certain felonies and other crimes under WAC 388-442-0010; or

(b) Convicted of unlawful practices to get public assistance under WAC 388-446-0005 or 388-446-0010.

(((~~(6)~~))) (7) If you are a client in a household which is eligible for a tribal TANF program, you cannot receive state and tribal TANF in the same month.

AMENDATORY SECTION (Amending WSR 11-16-056, filed 7/29/11, effective 8/29/11)

WAC 388-400-0010 Who is eligible for state family assistance? (1) To be eligible for state family assistance (SFA), aliens must meet Washington state residency requirements as listed in WAC 388-468-0005 and immigrant eligibility requirements as listed in WAC 388-424-0015.

(2) You are eligible for SFA if you are not eligible for temporary assistance for needy families for the following reasons:

(a) You are a qualified alien and have been in the United States for less than five years as described in WAC 388-424-0006;

(b) You are a nonqualified alien as defined in WAC 388-424-0001, who meets the Washington state residency requirements as listed in WAC 388-468-0005;

(c) You are a nineteen or twenty-year-old student that meets the education requirements of WAC 388-404-0005;

(d) You are a caretaker relative of a nineteen or twenty-year-old student that meets the education requirements of WAC 388-404-0005; or

(e) You are a pregnant woman who has been convicted of misrepresenting their residence in order to receive benefits from two or more states at the same time.

(3) If you apply for SFA, have not received SFA within the past thirty days, and will be a mandatory WorkFirst participant as described in WAC 388-310-0200 once approved, you must complete a WorkFirst orientation before we approve your application.

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

WAC 388-406-0010 How do I apply for cash assistance or Basic Food benefits? (1) You can apply for cash assistance or Basic Food by giving us an application form in person, by mail, by fax, or by completing an online application.

(2) If your entire assistance unit (AU) gets or is applying for supplemental security income (SSI), your AU can file an

application for Basic Food at the local Social Security administration district office (SSADO).

(3) If you are incapacitated, a dependent child, or cannot apply for benefits on your own for some other reason, a legal guardian, caretaker, or authorized representative can apply for you.

(4) You can apply for cash assistance or Basic Food with just one application form.

(5) If you apply for benefits at a local office, we accept your application on the same day you come in. If you apply at an office that does not serve the area where you live, we send your application to the appropriate office by the next business day so that office receives your application on the same day we send it.

(6) We accept your application for benefits if it has at least:

(a) For cash assistance, the name, address, and signatures of the responsible adult AU members or person applying for you. A minor child may sign if there is no adult in the AU. Signatures must be handwritten, electronic or digital as defined by the department, or a mark if witnessed by another person.

(b) For Basic Food, the name, address, and signature of a responsible member of your AU or person applying for you as an authorized representative under WAC 388-460-0005.

(7) As a part of the application process, we may require you to:

(a) Complete an interview if one is required under WAC 388-452-0005;

(b) Meet WorkFirst participation requirements for four weeks in a row if required under WAC 388-310-1600(12);

(c) Give us the information we need to decide if you are eligible as required under WAC 388-406-0030; ((~~and~~))

(d) Give us proof of information as required under WAC 388-490-0005 so we can determine if you are eligible; and

(e) Complete the WorkFirst orientation if required under WAC 388-400-0005(2) or 388-400-0010(3).

(8) If you are eligible for necessary supplemental accommodation (NSA) services under chapter 388-472 WAC, we help you meet the requirements of this section.

AMENDATORY SECTION (Amending WSR 12-10-042, filed 4/27/12, effective 6/1/12)

WAC 388-406-0055 When do my benefits start? The date we approve your application affects the amount of benefits you get. If you are eligible for:

(1) TANF or SFA cash assistance, your benefits start:

(a) The date we have enough information to make an eligibility decision; or

(b) No later than the thirtieth day ((~~for TANF, SFA, PWA, or RCA~~)) from the date of application; or

(c) Once you have completed the WorkFirst orientation if required under WAC 388-400-0005(2) or 388-400-0010(3), back to the date we received all other information needed to determine eligibility.

(2) PWA or RCA cash assistance, your benefits start:

(a) The date we have enough information to make an eligibility decision; or

(b) No later than the thirtieth day from the date of application.

(3) ABD cash assistance, your benefits start:

(a) The date we have enough information to make an eligibility decision; or

(b) No later than the forty-fifth day ((~~for aged, blind, or disabled (ABD) cash assistance~~)) from the date of application unless:

(i) You are confined in a Washington state public institution as defined in WAC 388-406-0005 (6)(a) on the forty-fifth day, in which case your benefits will start on the date you are released from confinement; or

(ii) You are approved for ABD cash assistance at the time of your ((~~medical care services (MCS)~~)) housing and essential needs (HEN) referral incapacity review as described in WAC ((~~182-508-0160~~)) 388-447-0110, in which case your benefits will start on the date you provided sufficient medical evidence to establish disability as defined in WAC 388-449-0001.

((~~(2)~~)) (4) Basic Food, your benefits start from the date you applied unless:

(a) You are recertified for Basic Food. If you are recertified for Basic Food, we determine the date your benefits start under WAC 388-434-0010;

(b) You applied for Basic Food while living in an institution. If you apply for Basic Food while living in an institution, the date you are released from the institution determines your start date as follows. If you are expected to leave the institution:

(i) Within thirty days of the date we receive your application, your benefits start on the date you leave the institution; or

(ii) More than thirty days from the date we receive your application, we deny your application for Basic Food. You may apply for Basic Food again when your date of release from the institution is closer.

(c) We were unable to process your application within thirty days because of a delay on your part. If you caused the delay, but submit required verification by the end of the second thirty-day period, we approve your benefits starting the date you provide the required verification. We start your benefits from this date even if we denied your application for Basic Food.

(d) We initially denied your application for Basic Food and your assistance unit (AU) becomes categorically eligible (CE) within sixty days from the date you applied. If your AU becoming CE under WAC 388-414-0001 makes you eligible for Basic Food, the date we approve Basic Food is the date your AU became CE.

(e) You are approved for transitional food assistance under chapter 388-489 WAC. We determine the date transitional benefits start as described under WAC 388-489-0015.

(f) You receive transitional food assistance with people you used to live with, and are now approved to receive Basic Food in a different assistance unit:

(i) We must give the other assistance unit ten days notice as described under WAC 388-458-0025 before we remove you from the transitional food assistance benefits.

(ii) Your Basic Food benefits start the first of the month after we remove you from the transitional benefits. For exam-

ple, if we remove you from transitional benefits on November 30th, you are eligible for Basic Food on December 1st.

((~~(3) Medical assistance, the date your benefits start is stated in chapter 388-416 WAC.~~

~~(4) For long-term care, the date your services start is stated in WAC 388-106-0045.~~))

WSR 14-10-047

PERMANENT RULES

DEPARTMENT OF AGRICULTURE

[Filed May 1, 2014, 8:08 a.m., effective June 1, 2014]

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

Purpose: The purpose of these amendments is to correct references to the Revised Code of Washington, update addresses, and other nonsignificant housekeeping changes.

Citation of Existing Rules Affected by this Order: Amending WAC 16-319-010, 16-319-020, 16-319-030, and 16-319-041.

Statutory Authority for Adoption: RCW 15.49.310, chapter 34.05 RCW.

Adopted under notice filed as WSR 14-05-088 on February 19, 2014.

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 4, 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: May 1, 2014.

Don R. Hover
Director

AMENDATORY SECTION (Amending Order 1028, filed 8/4/66, effective 9/4/66)

WAC 16-319-010 Forest tree seed certification—Certifying agency. The Washington State Crop Improvement Association((~~, Inc.~~)) is ((~~hereby~~)) designated to act as the ((~~duly~~)) authorized agent of the director of agriculture for the purpose of assisting in certifying forest tree seeds and shall perform such duties as the director may assign as provided in chapter ((~~15.48~~)) 15.49 RCW, specifically RCW ((~~15.48.150(1)~~)) 15.49.370(3).

AMENDATORY SECTION (Amending WSR 87-12-006, filed 5/22/87)

WAC 16-319-020 Forest reproductive material certification standards—Purpose and definitions. (1) Purpose. The purpose of certification of forest reproductive material is to make available reproductive material properly identified by species or species and cultivar, and by source or source and origin.

(2) Definitions:

(a) "Applicant" means the person or organization who submits application for certification of forest reproductive material to certifying agency and who assumes responsibility for compliance with these standards.

(b) "Audit" means periodic examination and check by certifying agency of any part or all of the records and procedures specified in field standards and conditioning standards, and of additional records pertinent to inventory and distribution of reproductive material including verification of corresponding physical inventory to assure that no significant errors or omissions exist.

(c) "Batch" means all or part of a lot of reproductive material of a single species collected during one crop season from within stated breeding zone(s) or from within stated five hundred foot elevation increment(s) in stated seed zone(s) that is collected or processed at one time.

(d) "Breeding zone" means a specific designated unit of land, the description of which is on file at the certifying agency, for which an improved population of trees of a specific species or species cross is being produced.

(e) "Buyer" means person who first receives reproductive material from the collector.

(f) "Certificate of genetic identity" means a document furnished by the producer on demand and verified by the certifying agency describing the ancestry and breeding behavior of a lot of reproductive material.

(g) "Certification of reproductive material" means execution by certifying agency of field inspection, plant/warehouse inspection and/or audit to accomplish the purpose described in subsection (1) of this section.

(h) "Certifying agency" means the ((~~duly~~)) designated agent of the state agency: ((~~In Oregon state, the Oregon Seed Certification Service, 31 Crop Science Building, Oregon State University, Corvallis, Oregon 97331;~~)) In Washington state, the designated agent is the Washington State Crop Improvement Association((~~, Inc., 513 North Front Street, Yakima, Washington 98901~~)).

(i) "Certificate of provenance" means a document issued by certifying agency which verifies source and origin of reproductive material by field inspection and audit. (Only certificates of provenance are issued to satisfy O.E.C.D.)

(j) "Character" means a distinctive trait, but not necessarily an invariable feature, exhibited by all individuals of a group and capable of being described or measured: E.g., growth; form; color; resistance to disease, insects, weather, animals, etc.

(k) "Code" means a unique identification of a group of the producer's pertinent records about a lot of forest reproductive material.

(l) "Collector" means a person who collects forest reproductive material at its source.

(m) "Elevation" means altitude above sea level and is divided in five hundred foot increments as shown below, or may mean appropriate elevational bands as provided for under code ((~~and/~~))or breeding zone.

0 - 500 feet	— Code 05	2501 - 3000 feet	— Code 30
501 - 1000 feet	— Code 10	3001 - 3500 feet	— Code 35
1001 - 1500 feet	— Code 15	3501 - 4000 feet	— Code 40
1501 - 2000 feet	— Code 20	4001 - 4500 feet	— Code 45
2001 - 2500 feet	— Code 25	4501 - 5000 feet	— Code 50

and so forth.

(n) "Field" inspection means observation by certifying agency of all activities and records involved in propagation, collection, buying, production, and transportation of forest reproductive material to assure compliance with field standards.

(o) "Forest reproductive material" means plant material of genera and species of trees which will be used for forestry.

(p) "Genetic identity" means the ancestry and breeding background of selected and tested classes only of the forest reproductive material.

(q) "Genetic superiority" means that forest reproductive material originated from tree(s) whose superiority in one or more characters important to forestry has been proven by tests conducted in specified environments.

(r) "Location" means description by seed zone or portion thereof and elevation and/or breeding zone or code.

(s) "Legal description" means legal cadastral survey subdivision.

(t) "Lot" means a homogeneous quantity of forest reproductive material.

(i) For tested and selected classes, it is of a single species, cultivar, or cross collected during one crop season from a distinctively described and recorded population of trees.

(ii) For source identified class, it is a single species collected during one crop season from within stated seed zone(s) and from within five hundred foot elevation increment(s) ((~~and/~~))or breeding zones or appropriate codes.

(iii) For an audit class, it is a single species collected during one crop season from within stated seed zone(s) and from within five hundred foot elevation increment(s).

(iv) Lots shall be identified by number and/or code or breeding zone.

(u) "Origin" means the location of the indigenous parents; for nonindigenous parents, it is the location from which the seed or plants were originally introduced.

(v) "Plant/warehouse inspection" means observation by certifying agency of all activities and records involved in receiving, processing, storage and labeling of forest reproductive material to assure compliance with conditioning standards.

(w) "Producer" means person, company, bureau or agency with overall responsibility for producing forest reproductive material.

(x) "Provenance" means the original geographic source of seed, pollen or propagules.

(y) "Reproductive material" means seed, pollen, trees, cuttings, scions, etc., originating from forest trees.

(z) "Seed zone" means a geographic area delineated on western forest tree seed council's tree seed zone map published July 1973, or similarly authoritative maps of seed zones as approved by certifying agency.

(aa) "Source" means the location of the immediate parents, the origin of which may be indigenous, nonindigenous, or unknown.

(bb) "Test" means evaluation of parents by comparing the performance of their offspring under more controlled conditions that exist for the parent(s) or other applicable tests which evaluate specific character(s) of the parents or the offspring.

(cc) "Unit of measure" means a consistent volume of measure, i.e., bushels, pounds, grams, number, cubic centimeters, etc.

AMENDATORY SECTION (Amending WSR 87-12-006, filed 5/22/87)

WAC 16-319-030 Classes of reproductive material. (1) "Tested class" means that forest reproductive material came from tree(s) which have been tested for specific character(s) as determined by progeny or other applicable tests and under specified conditions. Further, such forest reproductive material is produced and processed in a manner assuring genetic identity common with the tested material, and, for nursery stock, that it was produced from tested reproductive material. Said forest reproductive material shall be labeled with a blue label stating "tested." Certifying agency shall examine trees and reproductive material; exercise field, plant, and warehouse inspection, and audit all pertinent records involved.

(2) "Selected class" means that reproductive material came from trees that were selected for specific character(s). Two subclasses are recognized:

Subclass A: Reproductive material is obtained from selected trees and, in addition for tree seed, the male parent(s) is also selected.

Subclass B: Applies to tree seed when only one parent is selected.

Both subclasses shall be labeled with a green label stating "selected" and the subclass. Certifying agency shall examine trees and reproductive material; exercise field, plant, and warehouse inspection, and audit all pertinent records involved.

(a) "Selected subclass A" means that the donor or parents of the reproductive material are selected, known, and of record, but have no test results of record, and, for nursery stock, that it was produced from selected subclass A or better reproductive material.

(b) "Selected subclass B" means that only one parent of the tree seed is selected, known, and of record and reproductive material has not been tested, and, for nursery stock, that it was produced from selected subclass B or better reproductive material.

(3) "Source identified class" means that the reproductive material came from within a seed zone(s) or portion thereof (as defined by legal description) and from within a 500-foot elevation increment(s) or breeding zone(s) or code(s).

Subclass A: Personally supervised production.

Subclass B: Procedurally supervised production.

Both classes of said reproductive material shall be labeled with a yellow label stating "source identified" and the subclass. Certifying agency shall exercise field inspection, plant/warehouse inspection, and audit.

(a) "Subclass A source identified" means that applicant and certifying agency personally know beyond a reasonable doubt the seed zone(s) or portion thereof and 500-foot elevation increment(s) within which cones and/or reproductive material were collected; and, for nursery stock, that it was produced from subclass A source identified or better reproductive material. Certifying agency knows location from applicant's prior written plan of his reproductive material collecting and/or producing activities. For source identified subzone collections, a representative of the producer, whose major responsibility is observation of picker location, shall make daily observations within the collection area.

(b) "Subclass B source identified" means that applicant and certifying agency know reproductive material is identified as collected from within a seed zone(s) and from within a 500-foot elevation increment(s), and for nursery stock, that it was produced from subclass B source identified or better reproductive material.

(4) "Audit class" means that the applicant's records of procurement, processing, storage, and distribution state that the reproductive material was collected from within stated seed zone(s) or described portions thereof and from within 500-foot elevation increment(s), and, for nursery stock, certifying agency knows that it was produced from audit class or better reproductive material. Containers of said reproductive material shall carry a serially numbered brown and white label stating "audit certificate." All records of the applicant for this class of reproductive material are subject to audit.

AMENDATORY SECTION (Amending WSR 06-11-066, filed 5/12/06, effective 6/12/06)

WAC 16-319-041 Application for certification of forest reproductive material. (1) The conditions of applicant's submittal and of certifying agency's acceptance of application are:

(a) The application should show all classes for which certification services are requested.

(b) All reproductive material acquired or distributed by applicant of a type for which certification is requested is subject to audit.

(c) Applicant shall be responsible for payment of fees for certification services.

(d) Applicant is responsible for developing a record keeping system and labels available and satisfactory to the certifying agency.

(e) Certifying agency reserves the right to refuse certification service to applicant.

(f) Application for audit certification reproductive material shall be filed with the certifying agency ((~~of the state in which warehouse, nursery, etc., is located with a copy to the certifying agency in the state where the reproductive material is collected~~)).

(2) Timing of application requests for certification services:

(a) Application requests for source identified subclass B and lower classes for the current year's production of reproductive material shall be received by certifying agency from applicant not later than three days prior to initiation of collection, production, or propagation of forest reproductive material.

(b) For source identified subclass A and higher certification class, the applicant shall make application for service, and present a written plan to the certifying agency two weeks prior to the beginning of the collection season. The written plan will include the following:

(i) For subzone collection, areas shall be defined by legal description.

(ii) Details of the collection organization including names of buyers and field supervisors, estimated harvest volume, receiving station location(s), and other pertinent information.

(c) Application requests for all other services shall be received by certifying agency from applicant not later than seven days before need.

(3) The certifying agency establishes the fee schedule for certification services. These may be adjusted at the beginning of a crop year if certifying agency determines that costs are significantly more or less than anticipated: Provided, That increases shall not exceed twenty-five percent.

(a) Cones and seed:

(i) Tested and selected - The service includes review of test plans, audit of pertinent records and field inspection at the hourly job time rate shown in current fee schedule.

(ii) Source identified classes - The fee includes field inspection at the per bushel rate shown in the current fee schedule and audit of conditioning at the hourly rate also shown in the current fee schedule.

The fee for each lot containing less than sixty bushels shall be a maximum of thirty-six dollars: Provided, That the certifying agency, due to specific circumstances, may waive this maximum fee or a part thereof.

(iii) Audit class - The fee includes audit of applicant's field and conditioning records at the hourly rate shown in the current fee schedule.

(b) Trees: The fee includes the verification of the source of the trees from the seed source, stratification, sowing, bed identification, lifting, sorting, package identification, storing and/or transplanting.

(c) Not entered for certification: The fee for audit of reproductive material not entered for certification service is performed as required by and satisfactory to certifying agency to exercise said audit simultaneously with audit of reproductive material which applicant has requested certification service.

(d) The fee for certification classes applied for shall be charged whether or not offered material qualifies.

(e) The certifying agency may provide other services, such as training to comply with these standards, advising on the development of recordkeeping systems directly connected with certification needs if requested by the applicant.

(4) Fee schedule:

(a) Tree cones and seed -

Certification Classes	Field Inspection	Audit	Fee Due
Tested and Selected	$27.00/hr.	$27.00/hr.	When billed
Source Identified Classes:			
Lots 11 bu. and more	$0.90/bu.	$27.00/hr.	
Lots 6-10 bu.	$23.00/lot	$27.00/hr.	
Lots 0-5 bu.	$13.00/lot	$27.00/hr.	
Audit	None	$27.00/hr.	When billed

(b) Tree certification - $27.00/hr.

Seedling certification - Experience has shown that seedling certification normally requires a minimum of five nursery visits totaling approximately thirty-two hours. Plantation certification procedures shall be billed at the hourly rate.

(c) Other services including education to comply with the standards, development of record system, verification of source of pollen, cuttings, audit of forest reproductive material not offered for certification by applicant or other services requested, etc. at $27.00/hr. payable when billed.

(d) OECD certification (certificates of provenance) - $0.60 per certificate plus the hourly audit rate. (Auditors shall issue certificates.)

WSR 14-10-056
PERMANENT RULES
OFFICE OF INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2013-15—Filed May 2, 2014, 12:09 p.m., effective June 2, 2014]

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

Purpose: (1) Identify the information that title insurers and title insurance agents must submit to the statistical reporting agent designated by the commissioner and the process for submitting the information,

(2) Establish how the costs and expenses of the statistical reporting agent and any examination of the statistical reporting agent will be apportioned by and among the title insurers and title insurance agents,

(3) Amend the existing rules regarding information required for the filing of rates for title insurance under RCW 48.29.147,

(4) Amend the existing rules regarding the standards that title insurance rate filings must satisfy under RCW 48.29.147, and

(5) Amend the existing rule establishing a date by which title insurers must file every manual of rules and rates, rating plan, rate schedule, minimum rate, class rate, and rating rule, and every modification of any of these filings, under RCW 48.29.143 and 48.29.147.

Citation of Existing Rules Affected by this Order: Amending WAC 284-29A-010, 284-29A-020, 284-29A-030, 284-29A-050, 284-29A-080, and 284-29A-110.

Statutory Authority for Adoption: RCW 48.02.060, 48.29.005, 48.29.017, and 48.29.140.

Other Authority: RCW 48.03.060(6), 48.29.017, 48.29.140, and 48.29.147.

Adopted under notice filed as WSR 14-07-105 on March 19, 2014.

Changes Other than Editing from Proposed to Adopted Version: The phrase: "except where an allocation process is not needed and the alternate calculation is fully explained" was added at the end of WAC 284-29A-080 (1)(b) and 284-29A-110(3).

A final cost-benefit analysis is available by contacting Jim Tompkins, P.O. Box 40258, Olympia, WA 98504-0258, phone (360) 725-7036, fax (360) 586-3109, e-mail rules coordinator@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 3, Amended 6, 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 3, Amended 6, 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 3, Amended 6, Repealed 0.

Date Adopted: May 2, 2014.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 10-15-092, filed 7/20/10, effective 8/20/10)

WAC 284-29A-010 Finding and purpose. Title insurance protects against financial loss from defects in insured titles of real property. Losses from title insurance policies are not the primary cost to title insurers and title insurance agents. The primary costs incurred by title insurers and title insurance agents are maintenance of tract indexes and research to find title defects before the policies are issued. Title insurance is regulated differently than property and casualty insurance because loss ratios for title insurance are relatively low and expense ratios are fairly high. To implement and administer chapter 48.29 RCW, the commissioner needs detailed information about the costs underlying title insurance policies to regulate rates and ensure consumers are offered fair and equitable premiums. The purpose of this chapter is to adopt rules that establish:

(1) Standards for determining whether a premium rate complies with RCW 48.29.143;

(2) Standards and procedures that apply to RCW 48.29.147;

(3) The date after which title insurers must use rates that have been filed and approved under RCW 48.29.147; ((~~and~~))

(4) Information and data that must be reported to the statistical reporting agent designated by the commissioner;

(5) The allocation of the costs and expenses of the statistical reporting agent among the title insurers and title insurance agents;

(6) The apportionment of the expense of the examination of the statistical reporting agent among the title insurers and title insurance agents;

(7) The duties and obligations of the statistical reporting agent;

(8) The information and manner in which the statistical reporting agent must file the information received from the title insurers and title insurance agents with the commissioner, title insurers, and title insurance agents; and

(9) Requirements for submitting all rate filings through SERFF.

AMENDATORY SECTION (Amending WSR 10-15-092, filed 7/20/10, effective 8/20/10)

WAC 284-29A-020 Definitions. The definitions in this section apply to this chapter:

"Commitment" means the same as in RCW 48.29.010 (3)(c).

"Complete filing" means a package of information containing rates, supporting information, documents and exhibits submitted to the commissioner electronically using the system for electronic rate and form filing (SERFF).

"Date filed" means the date a complete filing has been received and accepted by the commissioner.

"Filer" means a person, organization or other entity that files title insurance rates with the commissioner for a title insurer.

"NAIC" means the National Association of Insurance Commissioners.

"Nonresidential policies" means title insurance policies on properties that are not "residential policies" as defined below.

"Objection letter" means correspondence created in SERFF and sent by the commissioner to the filer that:

(a) Requests clarification, documentation or other information;

(b) Explains errors or omissions in the filing; or

(c) Disapproves the filing under RCW 48.29.147.

"Policy" means a title policy as defined in RCW 48.29.010 (3)(a), and includes endorsements.

"Producer" means:

(a) A "producer of title insurance" as defined in WAC 284-29-205(8); and

(b) An "associate of producers" as defined in RCW 48.29.010 (3)(f).

"Rate" or "rates" means all classification manuals, rate and rule manuals, rating plans, rating schedules, minimum rates, class rates, and rating rules that title insurers must file under RCW 48.29.147.

"Residential policies" means title insurance policies that insure the title to real property having a house, individual condominium unit, mobile home permanently affixed to real estate, or other dwelling unit intended principally for the occupancy of from one to four families, but does not include multifamily structures intended for the use of five plus families, undeveloped lots, or real estate intended principally for business, commercial, industrial, religious, educational, or agricultural purposes even if some portion of the real estate is used for residential purposes.

"SERFF" means the system for electronic rate and form filing. SERFF is a proprietary NAIC computer-based application that allows insurers and other entities to create and submit rate, rule and form filings electronically to the commissioner.

"*Title Company Statistical Report*" means the data filing forms and instructions published on the commissioner's web site at www.insurance.wa.gov and incorporated into this chapter by reference. The data form and instructions are based upon the *Title Agent Statistical Data Plan* adopted by the NAIC.

"Title insurance agent" or "agent" has the same meaning as in RCW 48.17.010(15).

"Title insurance" has the same meaning as in RCW 48.11.100.

"Title insurer" means a title insurance company authorized to conduct title insurance business in this state under chapter 48.05 RCW.

AMENDATORY SECTION (Amending WSR 12-15-049, filed 7/16/12, effective 8/16/12)

WAC 284-29A-030 Transition to prior approval system. (1) On and after ((~~January 1, 2014~~)) July 1, 2016, all rates used in Washington state must be filed and approved under RCW 48.29.147.

(2) Title insurers must submit the rate filings required under RCW 48.29.147 and subsection (1) of this section to the commissioner by ((~~September 1, 2013~~)) March 1, 2016, for rates to be effective on ((~~January 1, 2014~~)) July 1, 2016. This rule allows the commissioner time to take final action on rates filed under this chapter before the effective date of ((~~January 1, 2014~~)) July 1, 2016.

(3) Rates filed under RCW 48.29.140(2) must not be used for commitments issued on or after ((~~January 1, 2014~~)) July 1, 2016.

AMENDATORY SECTION (Amending WSR 10-15-092, filed 7/20/10, effective 8/20/10)

WAC 284-29A-050 Unfairly discriminatory rates. Situations in which the rates are unfairly discriminatory under RCW 48.29.143(1) include, but are not limited to:

(1) ((~~Rating rules that provide for a waiver of the cancellation fee or reduction of the cancellation fee, after a commitment has been issued, to an amount that is less than the expected average cost for the title insurer and its agents to issue a commitment in the defined geographical area covered by the rating rules;~~

~~(2)~~)) Negotiation or bidding of price;

(((~~(3)~~))) (2) Rating rules that do not have a definite charge for every bracket of coverage;

(((~~(4)~~))) (3) Discounts not provided to all qualifying risks; ((~~and~~

~~(5)~~)) (4) Rating plans in which policies:

(a) Generating higher premiums subsidize smaller policies; or

(b) From one geographical area subsidize those from another geographical area.

(((~~(6)~~))) (5) A title insurer's application of more than one rate schedule to similarly situated risks in a county or other defined geographical area. For example, it is unfairly discriminatory for a title insurer to use different rate schedules for business produced by different title insurance agents in a specific rating territory.

NEW SECTION

WAC 284-29A-055 Cancellation fees. (1) In many instances title insurers and title insurance agents issue title insurance commitments prior to issuing title insurance policies. Sometimes the transaction for which the title insurance commitment was issued does not close, the title insurance policy is issued by another title insurer, or the title insurance commitment is canceled. However, since no policy is issued, no title insurance premium is collected by the title insurer or title insurance agent. Therefore, any cancellation fee that title insurers and title insurance agents may collect must not be considered to be premium and thus must not be included in a title insurance rate filing.

(2) However, this shall not be construed in any manner to prohibit title insurers and title insurance agents from charging and collecting a cancellation fee or that title insurers and title insurance agents are required to provide free title commitments.

AMENDATORY SECTION (Amending WSR 10-15-092, filed 7/20/10, effective 8/20/10)

WAC 284-29A-080 Expense component of rates. (1) In support of the expense component of the rates, the title insurer must:

(a) Include estimates of expected expenses to issue title insurance policies and commitments;

(b) Exclude the expected expenses related to escrow and other activities not directly related to title insurance using an allocation based upon the income received from title insurance premiums and escrow income, except where an allocation process is not needed and the alternate calculation is fully explained;

(c) Exclude the expected expenses described in WAC 284-29A-070(2); and

(d) Show how those estimates were calculated and demonstrate how those estimates are connected to the proposed rates.

(2) The expense categories that must be considered when making rates include:

(a) Employees' ((~~salaries and wages~~)) compensation;

(b) ((~~Owners' and partners' salaries and wages representing reasonable compensation for personal services actually performed by owners and partners~~)) Payroll taxes;

(c) Employee benefits;

(d) Contract labor;

(e) Rent, utilities, and repair;

(((~~(e) Insurance;~~

~~(f) Legal expense;~~

~~(g)~~))) (f) Title plant expenses and maintenance;

(g) Abstract and search expenses;

(h) Computer and software;

(i) Business insurance;

(j) Business legal;

(k) Accounting;

(l) Licenses, taxes, and fees;

(((~~(h) Title plant expense and maintenance;~~

~~(i) Office supplies;~~

~~(j) Depreciation;~~

~~(k) Automobile expense;~~

~~(l) Communication expense;~~

~~(m) Education expense;~~

~~(n) Bad debts;~~

~~(o) Interest expense;~~

~~(p) Employee~~)) (m) Marketing and sales;

(n) Travel and lodging;

(((~~(q)~~))) (o) Employee education;

(p) Bank charges;

(q) Charge offs;

(r) Depreciation;

(s) Miscellaneous expenses;

(t) Loss and loss adjustment expense;

(((~~(r) Accounting and auditing expense;~~

~~(s) Public relations expense; and~~

~~(t)~~))) (u) Federal income taxes; and

(v) Other specifically identified expenses.

(3) To support the agent commission component of rates, it is not sufficient to state the commission rate and perform calculations based on that percentage. The title insurer's rate filing must include data that supports the expense component that applies to its title insurance agents.

(4) The supporting information required under this section may ((~~aggregate~~)) include the data from:

(a) Agent reports received by the title insurer in one or more years under ((~~the provisions of WAC 284-29A-110~~)) previous regulatory requirements;

(b) The information received by the title insurer from the statistical reporting agent; and

(c) Any other relevant information.

AMENDATORY SECTION (Amending WSR 12-15-049, filed 7/16/12, effective 8/16/12)

WAC 284-29A-110 Title insurers and title insurance agents must report data to ((~~title insurers~~)) the statistical reporting agent. (1) Each title insurer and title insurance agent must report premium, policy count, and expense data by county annually to ((~~each title insurer for which it produces business in the state of Washington by April 1st~~)) the statistical reporting agent designated by the commissioner for the preceding calendar year by May 31st of each year, except as provided in subsection (((~~(4)~~))) (5) of this section. Every title insurer must file a *Title Company Statistical Report* with the statistical reporting agent even if the title insurer had no written premium from a direct branch operation during the report year. These data must be reported using the *Title Company Statistical Report* and following the instructions published by the commissioner on the commissioner's web site at www.insurance.wa.gov. These forms and instructions((~~,~~

~~called the *Title Insurance Agent Annual Report*,~~)) are incorporated into this chapter by reference.

(2) Each annual report required by this section must include:

(a) The following title order count data:

(i) Number of title orders opened;

(ii) Completed title orders in which a policy was issued; and

(iii) Number of title orders canceled as determined using WAC 284-29-260(10).

(b) Number of noninsurance title products produced:

(i) Number of searches billed to third parties; and

(ii) Number of searches purchased from third parties.

(c)(i) Total settlement, escrow, or closing transactions conducted;

(ii) Number of settlement, escrow, or closing transaction in which a title policy was not issued.

(d) The following premium and policy count data:

(((~~(i) Title insurance premiums for all of the agent's business; and~~

~~(ii) Title insurance premiums produced for the title insurer to which the report is sent.~~

~~(iii) Number of policies issued by all of the title insurers with which the agent does business; and~~

~~(iv) Number of policies issued by the title insurer to which the report is sent.~~

~~(b)~~))) (i) Total number of title policies issued;

(ii) Number of residential policies issued;

(iii) Number of nonresidential policies issued;

(iv) Number of (d)(ii) and (iii) of this subsection in which the title insurer or title insurance agent conducted the settlement, escrow, or closing of the transaction.

(e) The following income data:

(i) Total written premium of the title insurer;

(ii) Total written premium of the title insurance agent;

(iii) Total written premium of the title insurance agent segregated by each title insurer for which the title insurance agent is appointed;

(iv) Total written premium remitted to the title insurers by the title insurance agent segregated by each title insurer for which the title insurance agent is appointed;

(v) Other written premium of the title insurance agent not included in (e)(iii) of this subsection;

(vi) Settlement, escrow, and closing income;

(vii) Title examination income;

(viii) Abstract and search income;

(ix) Income from canceled orders;

(x) Investment income; and

(xi) All other income.

(f) The following expense data related to issuing title insurance policies and commitments for all of the title insurer's or title insurance agent's business, excluding all expenses related to escrow and other activities not directly related to title insurance:

(i) Employees' ((~~salaries and wages~~)) compensation;

(ii) ((~~Owners' and partners' salaries and wages representing reasonable compensation for personal services actually performed by owners and partners~~)) Payroll taxes;

(iii) Employee benefits;

(iv) Contract labor;

(v) Rent, utilities, and repair;

(((~~(v) Insurance;~~

~~(vi) Legal expense;~~

~~(vii) Licenses, taxes, and fees;~~

~~(viii)~~))) (vi) Title plant expense and maintenance;

(((~~(ix) Office supplies;~~

~~(x) Depreciation;~~

~~(xi) Automobile expense;~~

~~(xii) Communication expense;~~

~~(xiii) Education expense;~~

~~(xiv) Bad debts;~~

~~(xv) Interest expense;~~

~~(xvi) Employee~~)) (vii) Abstract and search expenditures;

(viii) Computer and software;

(ix) Business insurance;

(x) Business legal;

(xi) Accounting;

(xii) Licenses, taxes, and fees;

(xiii) Marketing and sales;

(xiv) Travel and lodging;

(((~~(xvii)~~))) (xv) Employee education;

(xvi) Bank charges;

(xvii) Charge offs;

(xviii) Depreciation;

(xix) Miscellaneous expenses;

(xx) Loss ((~~and~~)), loss adjustment expense((~~,~~

~~(xviii) Accounting and auditing expense;~~

~~(xix) Public relations expense; and~~

~~(xx)~~)), loss mitigation, and underwriting expenses;

(xxi) Federal income tax incurred;

(xxii) Other specifically identified expenses((~~,~~

~~(e)~~)); and

(xxiii) Other information required by the commissioner as specified in the *Title Company Statistical Report* under WAC 284-29A-110.

(g) An explanation that((~~:~~

~~(i) Describes how expenses are allocated between the title operations and escrow or other operations of the title insurance agent; and~~

~~(ii)~~)) demonstrates that the expenses described in WAC 284-29A-070(2) have been excluded.

(((~~(d) The estimated average cost to issue a title insurance commitment.~~))

(3) The expense allocation between title insurance related expenses and escrow expenses shall be based upon the income received from title insurance premiums and related income and escrow income, except where an allocation process is not needed and the alternate calculation is fully explained.

(4) If ((~~a title insurer~~)) the statistical reporting agent does not receive a report required under this section by ((~~April 1st~~)) May 31st of each year, the ((~~title insurer~~)) statistical reporting agent must notify the commissioner by ((~~April~~)) June 15th. This notice must include the name of the title insurer or title insurance agent that did not send the report on time.

(((~~(4)~~))) (5) For the ((~~2011~~)) 2013 calendar year report, each title insurer and title insurance agent must submit the report to the ((~~title insurer(s)~~)) statistical reporting agent des-

ignated by the commissioner on or before ((~~April 1, 2013~~)) September 1, 2014.

NEW SECTION

WAC 284-29A-170 Duties of the statistical reporting agent. The duties of the statistical reporting agent designated by the commissioner shall include, but not be limited to, the following:

(1) If any title insurer, title insurance agent, or both, do not file their annual report required by RCW 48.29.017 and WAC 284-29A-110 by May 31st of each year, the statistical reporting agent must notify the commissioner by June 15th of any title insurers or title insurance agents, or both, that failed to file their report;

(2) Review the reports received for quality and accuracy;

(3) Ensure that title insurers and title insurance agents are reporting data similarly and consistently;

(4) In consultation with the commissioner, aggregate data to a level that would not permit any user of the aggregate data to identify data associated with any particular title insurer, title insurance agent, or title insurance transaction;

(5) In consultation with the commissioner, produce the reports of the aggregated data by areas that are similar in expenses;

(6) Prepare and submit a report of the aggregated data to the title insurers, title insurance agents, and the commissioner;

(7) File the individual reports received from the title insurers and title insurance agents with the commissioner; and

(8) Other duties as agreed to between the commissioner and the statistical reporting agent consistent with RCW 48.29.017 and this chapter.

NEW SECTION

WAC 284-29A-180 Allocation of costs and expenses, including any examination costs, of the statistical reporting agent. RCW 48.29.017(1) provides that the costs and expenses of the statistical reporting agent must be borne by all the authorized title insurers and licensed title insurance agents. RCW 48.03.060(6) provides that the expense of any examination of the statistical reporting agent must be borne by all the authorized title insurers and licensed title insurance agents.

(1) The criteria for determining the annual cost and expenses, including any examination costs, of the statistical reporting agent shall be determined by contract between the statistical reporting agent and the commissioner. A pro rata share of the costs and expenses of the statistical reporting agent shall be charged to all authorized title insurers and licensed title insurance agents. The allocation of the costs and expenses, including any examination costs, of the statistical reporting agent among the title insurers and title insurance agents shall be based upon written premium in this state by the title insurer or title insurance agent as compared to the entire written premium for all title insurance business written in this state. The written premium shall be determined as follows:

(a) The title insurer's premium volume for this state will be the amount of written premiums for the title insurer's direct operations as reported on schedule T of the title insurer's annual financial statement for the preceding calendar year. This amount should be the same as the total of direct written premiums by the title insurer in this state as filed with the statistical reporting agent.

(b) The title insurance agent's premium volume for this state will be the amount of direct written premiums for the preceding calendar year for all underwriters from the agents report filed with the statistical reporting agent.

(2) Every title insurer and title insurance agent must pay its portion of the costs and expenses, including any examination costs, of the statistical reporting agent within thirty days of receiving the billing for the costs and expenses, including an examination of the statistical reporting agent.

(3) Failure by a title insurer or title insurance agent to pay timely its portion of the costs and expenses, including any examination costs, of the statistical reporting agent is a violation of RCW 48.29.017 or 48.03.060(6) and will subject a title insurer to disciplinary action under chapter 48.05 RCW and a title insurance agent to disciplinary action under chapter 48.17 RCW.

WSR 14-10-060

PERMANENT RULES

PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed May 5, 2014, 11:09 a.m., effective June 5, 2014]

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

Purpose: Amends WAC 181-78A-535 on the requirements for completion of a professional certification program. Removes panel requirements. **The initial filing WSR 14-07-063 adopting these amendments accidently [accidentally] included a first draft version of the changes. Public hearing and board action was on the second draft. This filing includes the appropriate draft.**

Citation of Existing Rules Affected by this Order: Amending WAC 181-78A-535.

Statutory Authority for Adoption: RCW 28A.410.210.

Adopted under notice filed as WSR 14-04-062 on January 28, 2014.

A final cost-benefit analysis is available by contacting David Brenna, 600 Washington Street South, Room 400, Olympia, WA 98504-7236, phone (360) 725-6238, fax (360) 586-4548, e-mail david.brenna@k12.wa.us.

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 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: March 14, 2014.

David Brenna
Senior Policy Analyst

AMENDATORY SECTION (Amending WSR 12-18-003, filed 8/23/12, effective 9/23/12)

WAC 181-78A-535 Approval standard—Program design. The following requirements shall govern the professional certificate program:

(1) Recruitment and admission.

(a) Programs will, at a minimum, recruit and admit any candidates in their service region who hold a residency certificate and at least two years of experience in the role.

(b) ((~~Learner~~)) Candidate expectations for program requirements, progression, and completion are identified, published, and accessible.

(2) Program design.

(a) Entry seminar.

(i) The program provides an orientation to the process and to the benchmarks/strands.

(ii) ((~~The program includes formalized learning opportunities and other activities directed at developing and verifying that the candidate has achieved acceptable knowledge, skill, and performance at the professional certificate benchmark level, or above, on all standards as defined in WAC 181-78A-270.~~

~~(iii) Administrator~~)) Candidates will ((~~complete~~)) begin a 360-type assessment aligned to the ((~~interstate school leaders licensure consortium standards~~)) professional educator standards board approved standards for the certification role, to be finalized prior to program completion.

(b) Action research project. The program includes a job-embedded, evidence-based project designed to improve student achievement, within which the candidate provides evidence of professional certificate level knowledge, skill, and performance. The project will be evaluated and scored on the basis of a common rubric appropriate for the certification role. The common rubrics shall be developed in collaboration with programs and published by the professional educator standards board.

((~~(b)~~)) (c) Professional performance growth ((~~plan implementation~~)) and verification.

(i) The program includes formalized learning opportunities and other activities directed at developing and verifying that the candidate has achieved acceptable knowledge, skill, and performance at the professional certification benchmark level, or above, on all standards as defined in WAC 181-78A-270.

(ii) The program includes the development of a draft professional growth plan focused on the career level standards.

(((~~c) Panel presentation.~~

~~(i) The program includes a final presentation to a panel that includes experienced P-12 educators in the role, during which the candidate provides evidence of professional certificate level knowledge, skill, and performance.~~

~~(ii) Candidates who do not successfully complete a final presentation receive an individualized analysis of strengths and weaknesses and a plan for assistance, and shall be allowed additional opportunities to present evidence pertaining to strands/benchmarks not previously met.~~))

(3) School-based experiences.

(a) Candidate work produced in the program is responsive to, and integrated with, the job responsibilities of candidates.

(b) Entry and exit criteria and a process for mitigating concerns are provided for candidates.

(4) Collaboration. Program personnel collaborate for continuous program improvement with P-12 partners, PEAB members, and candidates.

(5) Diversity in learning experiences.

(a) Candidates reflect on interactions with diverse populations in order to integrate professional growth in cultural competency as a habit of practice.

(b) Program personnel model equity pedagogy through:

(i) Interactions with diverse populations;

(ii) Reflective practice on their own professional growth in cultural competency;

(iii) Culturally relevant communication and problem solving; and

(iv) Personalized instruction that addresses cultural and linguistic backgrounds.

WSR 14-10-067
PERMANENT RULES
BUILDING CODE COUNCIL
[Filed May 6, 2014, 9:43 a.m., effective June 6, 2014]

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

Purpose: Recodification of chapter 365-110 WAC, Building permit surcharges and fees, to chapter 51-05 WAC, and amended to update references to current adopted codes.

Citation of Existing Rules Affected by this Order: Repealing WAC 365-110-010; and amending WAC 365-110-020 (51-05-100) and 365-110-035 (51-05-200).

Statutory Authority for Adoption: RCW 19.27.074.

Other Authority: RCW 19.27.020, 19.27.031, 19.27.085.

Adopted under notice filed as WSR 14-06-027 on February 25, 2014.

Changes Other than Editing from Proposed to Adopted Version: [No information supplied by agency.]

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 1, 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 1.

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

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

Date Adopted: May 6, 2014.

C. Ray Allshouse
Council Chair

AMENDATORY SECTION (Amending WSR 99-01-089, filed 12/16/98, effective 1/16/99)

WAC 365-110-035 Definitions. 1. ((~~**Department** shall mean the department of community, trade, and economic development.~~

~~2.~~)) **State Building Code fee** shall mean a fee which is required to be collected by cities and counties pursuant to chapter 19.27 RCW. Funds collected shall be used exclusively to implement the provisions of chapters 19.27 and 19.27A RCW.

((~~3.~~)) 2. **Building permit** shall mean a permit issued by a city or a county to construct, enlarge, alter, repair, move, ((~~improve, remove, convert or~~)) demolish, or change the occupancy of any building or structure regulated by the ((~~Uniform~~)) International Building Code as set forth in the ((~~Uniform~~)) International Building Code, section ((~~106.1~~)) 105.1 or by the International Residential Code as set forth in the International Residential Code, section R105.1. This definition shall be subject to the exemptions contained in section ((~~106.2~~)) 105.2 of the ((~~Uniform~~)) International Building Code and section R105.2 of the International Residential Code. Building permits shall not include plumbing, electrical, mechanical permits, or permits issued pursuant to the ((~~Uniform~~)) International Fire Code.

NEW SECTION

The following sections of the Washington Administrative Code are decodified and recodified as follows:

Old WAC Number	New WAC Number
365-110-020	51-05-100
365-110-035	51-05-200

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 365-110-010	Authority.

WSR 14-10-077
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed May 6, 2014, 3:08 p.m., effective June 26, 2014]

Effective Date of Rule: June 26, 2014.

Purpose: The department is amending WAC 388-106-0135 as a result of a settlement agreement reached in *D.B. v. Arnold-Williams*, W.D. Wa. No. 11-cv-2017-RBL, and adding a new section under WAC 388-106-0136. The rules will establish a limitation extension process to request medically necessary additional hours of personal care services for individuals under the age of twenty-one, and provide a fair hearing process to challenge the denial of such services. This filing ensures that the state remains compliant with federal requirements that apply to medical services for individuals under the age of twenty-one.

Citation of Existing Rules Affected by this Order: Amending WAC 388-106-0135.

Statutory Authority for Adoption: RCW 74.08.090, 74.09.520.

Adopted under notice filed as WSR 14-01-105 on December 18, 2013.

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

Date Adopted: April 29, 2014.

Katherine I. Vasquez
Rules Coordinator

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

WAC 388-106-0135 What ((~~are~~)) is the maximum number of hours of personal care services that I can receive for in-home services? (1) If you are age 21 or older, ((~~The~~)) the maximum number of hours that you may receive is the base hours assigned to your classification group and adjusted per WAC 388-106-0130, unless additional hours are authorized through an exception to rule per WAC 388-440-0001. For chore program clients, the maximum personal care hours per month the department will ((~~pay~~)) authorize is one hundred sixteen (116).

(2) If you are under age twenty-one:

(a) The maximum number of hours that you may receive will be the base hours assigned to your classification group and adjusted per WAC 388-106-0130, unless additional hours are authorized under parts (2)(b) or (3) below.

(b) Additional hours may be authorized at the department's discretion through an exception to rule per WAC 388-440-0001. You may request additional hours of personal care services through an exception to rule by contacting your case manager and explaining why you do not believe the authorized hours provide adequate assistance with your personal care tasks. The case manager will document your request and forward the request for review per WAC 388-440-0001. You will be notified in writing of the decision.

(3) If you are under age twenty-one, the department will authorize additional hours of personal care services beyond those authorized under section (2) according to the limitation extension process described below. If the evidence shows that additional personal care assistance is necessary to correct, improve, or prevent further deterioration of your condition, the department will authorize additional hours in the amount required to fully complete your ADLs or IADLs.

(a) You may request a limitation extension in writing within 90 days after you have received the department's written decision under subsection (2)(b); or if 30 days have passed since you requested an exception to rule under subsection (2)(b) and you have not yet received a written decision from DSHS.

(b) You may submit any evidence to show that additional hours of personal care are necessary. The following evidence should be provided:

(i) An explanation of the hours necessary to complete your ADLs and IADLs;

(ii) Documentation of the supports available to you over the course of a week; and,

(iii) An explanation of why informal supports are unavailable to provide the additional assistance you are requesting. When you are living with your legally responsible parent, the considerations described in WAC 388-106-0130 (8)(d) apply to the determination of availability of informal supports.

(c) If requested by the department, you must also provide additional documentation of your situation. If requested documents are not reasonably available to you without cost and/or if you need assistance from the department to obtain the requested documents, you must provide written permission to the department to obtain the documents on your behalf. Documents that the department may ask for include the following:

(i) Your most recent Individualized Educational Plan (IEP), if you are still in school.

(ii) Treatment plans for clinically recommended treatments relevant to your personal care services, such as active range of motion, passive range of motion, bowel program, etc.

(iii) Documents indicating residential time with your noncustodial parent or the availability of a noncustodial parent to provide assistance, such as parenting plans or child support orders. If those documents do not accurately reflect the supports currently available to you, you may also submit information or documents describing the support actually provided by your non-custodial parent.

(d) The department may also require a further review of your functional ability to perform specific ADLs and IADLs, to be conducted at the department's expense. The review must be completed under WAC 182-551-2110 by a qualified occupational therapist. If a qualified occupational therapist is not available to complete the review, the department will designate another qualified healthcare professional to complete the review.

(e) Upon receiving your request for a limitation extension and any additional supporting information you choose to submit under subsection (3)(b), the department will make a decision according to the timeline below.

(i) The department will make a decision under subsection (3) within 30 days unless additional information is required under subsections (3)(c) and/or (3)(d).

(ii) If additional information is required under subsections (3)(c) and/or (3)(d), the department will notify you of what additional information is required within 30 days of the date the department received your request and supporting information, if any. The department will then make a determination under subsection (3) within 15 days of either of the following, whichever comes first:

(A) The date that the department receives all of the requested information, including a report of any review of your functional ability conducted under subsection (3)(d); or,

(B) The date that you notify the department that you will not be providing any additional information.

(f) Additional hours will not be approved to substitute for the duties of legally responsible adults, replace childcare or school, replace recommended equipment available through Medicaid, or provide supervision other than task-specific supervision necessary for you to perform an ADL or IADL.

NEW SECTION

WAC 388-106-0136 What if I disagree with the result of the Limitation Extension decision regarding personal care? (1) In addition to your right to contest the result of your CARE assessment under WAC 388-106-1305, if you are under the age of twenty-one you have the right to an administrative hearing to contest the number of personal care hours authorized pursuant to WAC 388-106-0135(3).

(2) The department will notify you in writing of your right to an administrative hearing under sub-section (1) and will provide you with information about how to request a hearing.