WSR 14-11-038
PERMANENT RULES
SPOKANE REGIONAL CLEAN AIR AGENCY

[Filed May 14, 2014, 11:51 a.m., effective September 2, 2014]

Effective Date of Rule: September 2, 2014.

Purpose: Remove "asphalt shingles" as a suspect asbestos-containing material (ACM); summarize asbestos sampling requirements in 40 C.F.R. 763.86; clarify that part of all of the notice of intent (NOI) waiting period and project fee may be waived for demolition of abandoned structures; clarify that standard asbestos project work practices require manual removal methods unless approved by the Spokane Regional Clean Air Agency (SRCAA); add procedures for loose vermiculite containing one percent or less asbestos; clarify that when alternate work plans are prepared, the procedures and requirements in the plan must be followed; clarify that trenchless pipe bursting of asbestos cement pipe is prohibited; reduce the waiting period and a reduced fee for small asbestos projects; and allow refunds for overpayments.

Citation of Existing Rules Affected by this Order: Amending SRCAA Regulation I, Article IX and Section 10.09.

Statutory Authority for Adoption: RCW 70.94.141(1), 70.94.380(2).

Other Authority: Chapter 70.94 RCW, 42 U.S.C. 7401 et seq., 42 U.S.C. 7412.

Adopted under notice filed as WSR 14-05-009 on February 6, 2014.

Changes Other than Editing from Proposed to Adopted Version: A nonsubstantive change was made. Section numbers were reassigned.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's Own Initiative: New 0, Amended 9, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 9, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.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

Matt Holmquist
Compliance Administrator

ARTICLE IX - ASBESTOS CONTROL STANDARDS

AMENDATORY SECTION

The following article of SRCAA Regulation I is amended:

Article IX – Asbestos Control Standards

ARTICLE IX - ASBESTOS CONTROL STANDARDS

SECTION 9.01 PURPOSE

The Board of Directors of the Spokane Regional Clean Air Agency recognizes that airborne asbestos is a serious health hazard. Asbestos fibers released into the air can be inhaled and cause lung cancer, pleural mesothelioma, peritoneal mesothelioma or asbestosis. The Board of Directors has adopted this regulation to control asbestos emissions primarily resulting from asbestos projects, renovation projects, and demolition projects in order to protect the public health.

SECTION 9.02 DEFINITIONS

A. AHERA Building Inspector means a person who has successfully completed the training requirements for a building inspector established by United States Environmental Protection Agency (EPA) Asbestos Model Accreditation Plan: Interim Final Rule (40 CFR Part 763, Appendix C to Subpart E) and whose certification is current.

B. AHERA Project Designer means a person who has successfully completed the training requirements for an abatement project designer established by EPA Asbestos Model Accreditation Plan: Interim Final Rule (40 CFR Part 763, Appendix C to Subpart E) and whose certification is current.

C. Asbestos means the asbestiform varieties of actinolite, amosite (cummingtonite-grunerite), tremolite, chrysotile (serpentinite), crocidolite (riebeckite), or anthophyllite.

D. Asbestos-Containing Material (ACM) means any material containing more than one percent (1%) asbestos as determined using the method specified in the EPA publication, *Method for the Determination of Asbestos in Building Materials*, EPA/600/R-93/116, July 1993 or a more effective method as approved or required by EPA. It includes all loose vermiculite (e.g., vermiculite attic insulation, vermiculite block fill) and any material presumed to be asbestos-containing.

E. Asbestos-Containing Waste Material (ACWM) means any waste that contains or is contaminated with asbestos-containing material ((~~, except for nonfriable asbestos-containing roofing that remains nonfriable~~)). Asbestos-containing waste material includes asbestos-containing material that has been removed from a structure, disturbed, or deteriorated in a way that it is no longer an integral part of the structure or component, asbestos waste from control equipment, materials used to enclose the work area during an asbestos project, asbestos-containing material collected for disposal, asbestos-contaminated waste, debris, containers, bags, protective clothing, or high efficiency particulate air (HEPA) filters. Asbestos-containing waste material does not include samples of asbestos-containing material taken for testing or enforcement purposes.

F. Asbestos Project means any activity involving the abatement, renovation, demolition, removal, salvage, cleanup or disposal of asbestos-containing material, or any other action or inaction that disturbs or is likely to disturb any asbestos-containing material. It includes the removal and disposal of asbestos-containing material or asbestos-containing waste material. It does not include the application of duct

tape, rewettable glass cloth, canvas, cement, paint, or other non-asbestos materials to seal or fill exposed areas where asbestos fibers may be released ((~~nor does it include nonfriable asbestos-containing roofing material that will not be rendered friable~~)).

G. Asbestos Survey means a written report resulting from a thorough inspection performed pursuant to Section 9.03 of this Regulation.

H. Asphalt Shingles means asphalt roofing in shingle form, composed of glass felt or felts impregnated and coated on both sides with asphalt, and surfaced on the weather side with mineral granules. Some asphalt shingle styles are commonly referred to as three-tab shingles.

I. Competent Person means a person who is capable of identifying asbestos hazards and selecting the appropriate asbestos control strategy, has the authority to take prompt corrective measures to eliminate the hazards, and has been trained and is currently certified in accordance with the standards established by the Washington State Department of Labor and Industries, the federal Occupational Safety & Health Administration, or the United States Environmental Protection Agency (whichever agency has jurisdiction).

J Component means any equipment, pipe, structural member, or other item or material.

((~~I~~)) K. Contiguous means touching or adjoining.

((~~J. Component means any equipment, pipe, structural member, or other item or material.~~))

((~~K~~)) L. Controlled Area means an area to which only certified asbestos workers, representatives of the Agency, or other persons authorized by the Washington Industrial Safety and Health Act (WISHA), have access.

((~~L~~)) M. Demolition means wrecking, razing, leveling, dismantling, or burning of a structure, making the structure permanently uninhabitable or unusable in part or whole. It includes any related handling operations. ((~~Pursuant to the EPA asbestos National Emission Standards for Hazardous Air Pollutants (NESHAP), 40 CFR Part 61, Subpart M, i~~)) It also includes moving a structure (except a mobile home which remains intact) and wrecking or taking out of any load-supporting structural member (except in an owner-occupied, single-family residence) ((~~of a facility together with any related handling operations and includes moving a facility~~)).

((~~M~~)) N. Disposal Container means a carton, bag, drum, box, or crate designed for the purpose of safely transporting and disposing of asbestos-containing waste material.

((~~N. Facility means an institutional, commercial, public, industrial or residential structure, installation or building (including any structure, installation or building containing condominiums, or individual dwelling units operated as a residential cooperative, but excluding residential buildings having four or fewer dwelling units); any ship; or any active or inactive waste disposal site. The term includes any structure, installation or building that was previously subject to the Asbestos NESHAP, regardless of its current function, apartments which are an integral part of a commercial facility, and mobile structures used for non-residential purposes. It also includes homes that are demolished or renovated to build non-residential structures (e.g., homes demolished for highway construction projects).~~))

O. Friable Asbestos-Containing Material means asbestos-containing material that, when dry, can be crumbled, pulverized, or reduced to powder by hand pressure or by the forces expected to act upon the material in the course of demolition, renovation, or disposal. Each of these descriptions is separate and distinct, meaning the term includes asbestos-containing material that, when dry, can be:

1. Crumbled by hand pressure or by the forces expected to act upon the material in the course of renovation, demolition, or disposal;

2. Pulverized by hand pressure or by the forces expected to act upon the material in the course of renovation, demolition, or disposal; or

3. Reduced to powder by hand pressure or by the forces expected to act upon the material in the course of renovation, demolition, or disposal).

Such materials include, but are not limited to, thermal system insulation, surfacing material, Nicolet roofing paper and similar asbestos papers, and cement asbestos products.

P. Homogeneous Area means an area of surfacing material, thermal system insulation material, or a miscellaneous material that is uniform in color or texture. Unless approved otherwise by SRCAA, rubble piles, debris piles, ash, soil, and similar materials are not homogeneous areas.

((~~P~~)) Q. Leak-Tight Container means a dust-tight and liquid tight disposal container, at least 6-mil thick, that encloses asbestos-containing waste material and prevents solids or liquids from escaping or spilling out. Such containers may include sealed plastic bags, metal or fiber drums, and sealed polyethylene plastic.

((~~Q~~)) R. Nonfriable Asbestos-Containing Material means asbestos-containing material that is not friable (e.g.((~~,~~)) when dry, cannot be crumbled, pulverized, or reduced to powder by hand pressure or by the forces expected to act on the material in the course of demolition, renovation, or disposal).

((~~R~~)) S. Nonfriable Asbestos-Containing Roofing means an asbestos-containing roofing material where all of the following apply:

1. The roofing is a nonfriable asbestos-containing material;

2. The roofing is in good condition and is not peeling, cracking, or crumbling;

3. The roofing binder is petroleum-based and asbestos fibers are suspended in that base with individual fibers still encapsulated; and

4. The roofing binder exhibits enough plasticity to prevent the release of asbestos fibers in the process of removing and disposing of it.

((~~S~~)) T. Owner-Occupied, Single-Family Residence means any non-multiple unit building containing space for uses such as living, sleeping, preparation of food, and eating that is used by one family who owns the property as their domicile (permanent and primary residence) both prior to and after renovation or demolition, and can demonstrate such to the Agency upon request (e.g.((~~,~~)) utility bills). This term includes houses, mobile homes, trailers, detached garages, outbuildings, houseboats, and houses with a "mother-in-law apartment" or "guest room". This term does not include rental property, multiple unit buildings (e.g.((~~,~~)) duplexes and con-

dominiums with two or more units) or multiple-family units, nor does this term include any mixed-use building (e.g.((,)) a business being operated out of a residence), structure, or installation that contains a residential unit. This term does not include structures used for structural fire training exercises (Regulation I, Article VI, Section 6.01 and 40 CFR Part 61, Subpart M), structures previously subject to the federal asbestos NESHAP (40 CFR Part 61, Subpart M), structures that are part of a larger installation (e.g., military base, company housing, apartment complex, housing complex, institution, industrial operation, etc.), or government ordered demolitions.

((~~T~~)) U. Owner's Agent means any person who leases, operates, controls, or is responsible for an asbestos project, renovation, demolition, or property subject to Article IX of this Regulation. It also includes the person(s) submitting a notification pursuant to Section 9.04 of this Regulation and/or performing the asbestos survey.

((~~U~~)) V. Person means any individual, firm, public or private corporation, association, partnership, political subdivision, municipality, or government agency.

((~~V~~)) W. Renovation means altering a structure or component in any way, other than demolition.

((~~W~~)) X. Structure means something built or constructed, in part or in whole. Examples include, but are not limited to, the following in part or in whole: houses, garages, commercial buildings, mobile homes, bridges, "smoke" stacks, pole-buildings, canopies, lean-tos, and foundations. This term does not include normally mobile equipment (e.g., cars, recreational vehicles, boats, etc.).

((~~X~~)) Y. Surfacing Material means material that is sprayed-on, troweled-on, or otherwise applied to surfaces including, but not limited to, acoustical plaster on ceilings, paints, fireproofing material on structural members, or other material on surfaces for decorative purposes.

((~~Y~~)) Z. Suspect Asbestos-Containing Material means material that has historically contained asbestos including, but not limited to, surfacing material, thermal system insulation, roofing material (excluding asphalt shingles), fire barriers, gaskets, flooring material, and cement siding. Suspect asbestos-containing material must be presumed to be asbestos-containing material unless demonstrated otherwise (e.g.((,)) as determined using the method specified in the EPA publication, ((~~Method for the Determination of Asbestos in Building Materials~~)) *Method for the Determination of Asbestos in Building Materials*, EPA/600/R-93/116, July 1993((.)).

((~~Z~~)) AA. Thermal System Insulation (TSI) means material applied to pipes, fittings, boilers, tanks, ducts, or other structural components to prevent heat loss or gain.

AB ((~~A~~)). Visible Emissions means any emissions that are visually detectable without the aid of instruments. The term does not include condensed uncombined water vapor.

AC ((~~B~~)). Wallboard System means joint compound and tape specifically applied to cover nail holes, joints and wall corners. It does not mean "add on materials" such as sprayed on materials, paints, textured ceilings or wall coverings. A wallboard system where joint compound and tape have become an integral system (40 CFR Part 61 FRL4821-7) may be analyzed as a composite sample for determining if it is an asbestos-containing material.

AD (~~C~~). Waste Generator means any owner or owner's agent that generates, produces, or is in part or whole, responsible for an activity that results in asbestos-containing waste material.

AE ((~~D~~)). Workday means Monday through Friday 8:00 a.m. to 4:30 p.m. excluding legal holidays observed by the Agency. For purposes of filing a notification or notification amendment via SRCAA's website pursuant to Section 9.04, and unless specified otherwise on SRCAA's website, a workday means any day of the week and any time of the day.

Reviser's note: The typographical errors in the above material occurred in the copy filed by the Spokane Regional Clean Air Agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

SECTION 9.03 ASBESTOS SURVEY REQUIREMENTS

A. Except as provided for in Section 9.03.F of this Regulation, it shall be unlawful for any person to cause or allow any renovation, demolition, or asbestos project unless the property owner or the owner's agent first obtains an asbestos survey, performed by an AHERA building inspector.

B. Asbestos Survey Procedures.

1. An asbestos survey must consist of a written report resulting from a thorough inspection performed by an AHERA building inspector. The AHERA building inspector must use the procedures in EPA regulations 40 CFR 763.86 or an alternate asbestos survey method pursuant to Section 9.03.F.3 of this Regulation. The inspection, and resulting asbestos survey report, must be performed to determine whether materials, components, or structures to be worked on, renovated, removed, disturbed, impacted, or demolished (including materials on the outside of structures) contain asbestos.

2. Except as provided for in Section 9.03.F of this Regulation, only an AHERA building inspector may determine, by performing an asbestos survey, that a material is not a suspect asbestos-containing material and that a suspect asbestos-containing material does not contain asbestos.

3. The required number of bulk asbestos samples must be collected per the sampling procedures detailed in EPA regulations 40 CFR Part 763.86 and analyzed pursuant to this Article to determine that suspect asbestos-containing material does not contain asbestos.

a. An AHERA building inspector shall collect, in a statistically random manner, a minimum of three bulk samples from each homogeneous area of any surfacing material that is not assumed to be asbestos-containing material, and shall collect the samples as follows:

i. At least three (3) bulk samples shall be collected from each homogeneous area that is 1,000 square feet or less.

ii. At least five (5) bulk samples shall be collected from each homogeneous area that is greater than 1,000 square feet but less than or equal to 5,000 square feet.

iii. At least seven (7) bulk samples shall be collected from each homogeneous area that is greater than 5,000 square feet.

b. Except as provided for in 40 CFR 763.86 (b)(2)-(4), an AHERA building inspector shall collect, in a statistically random manner, at least three (3) bulk samples from each homo-

geneous area of thermal system insulation that is not assumed to be asbestos-containing material.

c. An AHERA building inspector shall collect, in a manner sufficient to determine whether material is asbestos-containing material or not asbestos-containing material, at least two (2) bulk samples from each homogeneous area of any miscellaneous material that is not assumed to be asbestos-containing material.

d. Bulk samples must be analyzed by laboratories accredited by the National Institute of Standards and Technology's (formerly the National Bureau of Standards) National Voluntary Laboratory Accreditation Program (NVLAP) or an equivalent standard approved by SRCAA. Except for wallboard systems as defined in Section 9.02.AC, bulk samples shall not be composited for analysis.

e. Bulk samples shall be analyzed for asbestos content by polarized light microscopy (PLM) using the method specified in the EPA publication, *Method for the Determination of Asbestos in Building Materials*, EPA/600/R-93/116, July 1993 or a more effective method as approved or required by EPA.

((~~2. Except as provided for in Section 9.03.F of this Regulation, only an AHERA building inspector may determine, by performing an asbestos survey, that a suspect asbestos-containing material does not contain asbestos. Per the sampling procedures detailed in EPA regulations 40 CFR Part 763.86, the required number of bulk asbestos samples must be collected and analyzed pursuant to Section 9.02.D of this Regulation to determine that material does not contain asbestos.~~

~~3. Bulk samples must be analyzed for asbestos pursuant to Section 9.02.D of this Regulation by laboratories accredited by the National Voluntary Laboratory Accreditation Program (NVLAP).~~))

C. Asbestos Survey Report.

These requirements apply to asbestos surveys, regardless of when they were performed. Except where additional information is required pursuant to EPA Regulation 40 CFR Part 763.85, asbestos surveys shall contain, at a minimum, all of the following information:

1. General Information.

a. Date that the inspection was performed;

b. AHERA Building Inspector signature, certification number, date certification expires, and name and address of entity providing AHERA Building Inspector certification;

c. Site address(es)/location(s) where the inspection was performed;

d. Description of the structure(s)/area(s) inspected (e.g., use, approximate age and approximate outside dimensions);

e. The purpose of the inspection (e.g., pre-demolition asbestos survey, renovation of 2nd floor, removal of acoustical ceiling texturing due to water damage, etc.), if known;

f. Detailed description of any limitations of the asbestos survey (e.g., inaccessible areas not inspected, survey limited to renovation area, etc.);

g. Identify and describe all homogeneous areas of suspect asbestos-containing materials ((~~and their locations~~)), except where limitations of the asbestos survey identified in Section 9.03.C.1.f (paragraph above) prevented such identification and include whether each homogeneous material is surfacing material, thermal system insulation, or miscellaneous material;

h. Identify materials presumed to be asbestos-containing material;

i. Exact location where each bulk asbestos sample was taken (e.g., schematic and/or other detailed description sufficient for any person to match the material(s) sampled and tested to the material(s) on site);

j. Complete copy of the laboratory report for bulk asbestos samples analyzed, which includes all of the following:

1) Laboratory name, address and NVLAP certification number;

2) Bulk sample numbers;

3) Bulk sample descriptions;

4) Bulk sample results showing asbestos content; and

5) Name of the person at the laboratory that performed the analysis.

2. Information Regarding Asbestos-Containing Materials (including those presumed to contain asbestos).

a. Describe the color of each asbestos-containing material;

b. Identify the location of each asbestos-containing material within a structure, on a structure, from a structure, or otherwise associated with the project (e.g.((~~,~~)) schematic and/or other detailed description); ((~~and~~))

c. Provide the approximate quantity of each asbestos-containing material (generally in square feet or linear feet)((~~.~~)); and

d. Describe the condition of each asbestos-containing material (e.g. good, damaged). If the asbestos-containing material is damaged, describe the general extent and type of damage (e.g., flaking, blistering, crumbling, water damage, fire damage).

D. Asbestos Survey Posting.

Except as provided for in Section 9.03.F of this Regulation, a complete copy of an asbestos survey ((~~shall~~) must be posted by the property owner or the owner's agent in a readily accessible and visible area ((~~at the work site~~)) at all times for inspection by SRCAA and all persons at the work site. This applies even when the asbestos survey performed by ((~~H~~)) an AHERA Building Inspector ((~~determines~~)) states there are no ((~~suspect~~)) asbestos-containing materials in the work area((~~, this determination shall be posted by the property owner or the owner's agent in a readily accessible and visible area at the work site for all persons at the work site~~)). During demolition, if it is not practical to post the asbestos survey, it must be readily accessible and made readily available for inspection by SRCAA and all persons at the demolition site.

E. Asbestos Survey Retention.

The property owner, owner's agent, and the AHERA building inspector that performed the asbestos survey (when the asbestos survey has been performed by an AHERA building inspector), shall retain a complete copy of the asbestos survey for at least 24 months from the date the inspection was performed and provide a copy to the Agency upon request.

F. Exceptions.

1. Owner-Occupied, Single-Family Residence Renovation Performed by the Owner-Occupant.

For renovation of an owner-occupied, single-family residence performed by the owner-occupant, an asbestos survey

is not required. An owner-occupant's assessment for the presence of asbestos-containing material prior to renovation of an owner-occupied, single-family residence is adequate. A written report is not required.

2. Presuming Suspect Asbestos-Containing Materials are Asbestos-Containing Materials.

It is not required that an AHERA building inspector evaluate (e.g.((,)) sample and test) any material presumed to be asbestos-containing material. If material is presumed to be asbestos-containing material, this determination shall be posted by the property owner or the owner's agent in a readily accessible and visible area at the work site for all persons at the work site. The determination shall include a description, approximate quantity, and location of presumed asbestos-containing material within a structure, on a structure, from a structure, or otherwise associated with the project. The property owner, owner's agent, and the person that determined that material would be presumed to be asbestos-containing material, shall retain a complete copy of the written determination for at least 24 months from the date it was made and shall provide a copy to the Agency upon request. Except for Section 9.03.A-E, all other requirements of this Regulation remain in effect.

3. Alternate Asbestos Survey.

A written alternate asbestos survey method shall be prepared and used on occasions when conventional sampling methods required in EPA regulations 40 CFR 763.86 cannot be exclusively performed (all other asbestos survey requirements in Section 9.03 of this Regulation apply). For example, conventional sampling methods may not be possible on fire damaged buildings or portions thereof((,)) (e.g. when materials are not intact or homogeneous areas are not identifiable). Conventional sampling methods shall not be used for rubble or debris piles, and ash or soil unless approved otherwise in writing by the Agency((, because they are not structures with intact materials and identifiable homogeneous areas)). If conventional sampling methods cannot exclusively be used and material is not presumed to be asbestos-containing material, ((A)) alternate asbestos survey methodology ((may)) must be used alone or, when possible, in combination with conventional survey methodology. An alternate asbestos survey methodology typically includes random sampling according to a grid pattern (e.g.((,)) random composite bulk samples at incremental 1' depths from 10' x 10' squares of a debris pile), but is not limited to such. An illustration of how the principles of such sampling techniques are applied can be found in the EPA publication, *Preparation of Soil Sampling Protocols: Sampling Techniques & Strategies*, EPA/600/R-92/128, July 1992.

4. Demolition by Fire Fighting Instruction Fires.

Pursuant to RCW 52.12.150(6), asbestos surveys need not be performed by an AHERA Building Inspector. However, pursuant to Section 9.04.A.((6)) 7.f of this Regulation, the project fee referenced in Section 10.09 and specified in the fee schedule is waived for any demolition performed in accordance with RCW 52.12.150(6), where the good faith inspection referred to in RCW 52.12.150(6) is an asbestos survey performed by an AHERA Building Inspector, as required in Section 9.03.A-E of this Regulation.

5. Underground Storage Tanks.

An asbestos survey is not required prior to renovation or demolition of an underground storage tank. However, if suspect asbestos-containing material is identified during the renovation or demolition of an underground storage tank, work shall cease until it is determined pursuant to Section 9.03((.B and C)) of this Regulation whether or not the suspect asbestos-containing material is asbestos-containing material. All other requirements of this Regulation remain in effect.

Reviser's note: The typographical error in the above material occurred in the copy filed by the Spokane Regional Clean Air Agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

SECTION 9.04 NOTIFICATION (PERMIT) REQUIREMENTS

A. General Requirements.

Except as provided for in Section 9.04.A.((6.e))7, it shall be unlawful for any person to cause or allow any work on an asbestos project or demolition unless a complete notification, including the required fee and any additional information requested by the Control Officer or his/her authorized representative, has been submitted to the Agency, in accordance with the notification waiting period requirements in Article X, Section 10.09 of this Regulation. Unless otherwise approved or required by SRCAA, the notification must be submitted by the property owner or owner's agent on approved forms through the Agency's website or submitted at the Agency's place of business in person or via U.S. mail. Notifications will not be accepted if the earliest project start date is greater than 365 days from the date of submittal.

1. When the Notification Waiting Period Begins.

The notification waiting period shall begin on the workday a complete notification is received by the Agency and shall end after the notification waiting period in Section 10.09 has passed (e.g., The notification waiting period for a notification submitted at the Agency's place of business after 4:30 p.m. on a Friday shall not begin until the following Monday, provided Monday is not a holiday observed by the Agency. A 10-day notification period means work on an asbestos project or demolition can begin on day 11.). A notification is considered complete when all information requested on the notification, including the required fee and any additional information requested by the Control Officer or his/her authorized representative, is received by the Agency. The notification waiting period shall not begin for incomplete notifications (e.g., unpaid fees, notifications where the asbestos project start date and/or completion date and/or demolition start date is listed as "To Be Determined", when types and quantities of asbestos to be removed are unknown, etc.).

2. Project Duration.

The duration of an asbestos project shall be commensurate with the amount of work involved. The duration of the project may take into account applicable scheduling limitations (e.g.((,)) asbestos removal that needs to be done in phases, based on scheduling limitations determined by the property owner) ((provided scheduling limitations can be provided in writing to the Control Officer or his/her authorized representative upon request)). The daily asbestos project work schedule must be provided by the owner or owner's agent to the Agency upon request.

3. Multiple Asbestos Projects or Demolitions.

Notification for 5 or fewer structures may be filed by a property owner or owner's agent on one form if all the following criteria are met:

a. The notification applies only to asbestos projects or demolitions on contiguous real properties having the same owner or real properties with the same owner separated only by a public right-of-way (e.g.((~~,~~)) alley or roadway).

b. The work will be performed by the same abatement and/or demolition contractor.

c. The notification includes the specific site address for each structure. Where a specific site address isn't available for each structure (e.g.((~~,~~)) at a large commercial ((~~facility~~)) site with multiple structures), provide a detailed description/location for each structure.

d. The notification includes the amount and type of asbestos-containing material associated with each structure and indicates which structures will be demolished.

4. Notification Expiration.

Notifications are valid for no more than 365 days from the earliest original notification start date. A new notification shall be submitted to the Agency for work to be performed beginning or continuing more than 365 days from the earliest original notification start date and shall be accompanied by the appropriate nonrefundable fee as ((~~set forth~~)) referenced in Section 10.09 of this Regulation and as specified in the fee schedule. SRCAA may revoke a notification for cause (e.g. providing any false material statement, representation, or certification). Reason(s) for revocation shall be provided to the owner or owner's agent. If a notification is revoked, a new notification shall be submitted with the appropriate nonrefundable fee pursuant to this Regulation and SRCAA's fee schedule.

5. Notification Posting ((~~Record Keeping~~)).

((~~a.~~)) A copy or printout of the notification((~~,~~)) and all amendments to the notification((~~, and the complete asbestos survey shall be made available for inspection~~ must be posted by the property owner or the owner's agent in a readily accessible and visible area at all times for inspection by SRCAA and all persons at the asbestos project or demolition site. During demolition, if it is not practical to post the asbestos survey, it must be readily accessible and made readily available for inspection by SRCAA and all persons at the demolition site.

6. Notification Retention

((~~b. The property owner and owner's agent shall retain a copy of all asbestos notification records for at least 2 years and make them available to the Agency upon request.~~)) The property owner and owner's agent (including the person that filed the notification), shall retain a complete copy of all notification records for at least 24 months from the date the notification was filed with the Agency and provide a copy to the Agency upon request.

((~~6~~)) 7. Notification Exceptions.

a. Asbestos Project Thresholds.

Notification is not required for asbestos projects involving less than 10 linear feet or 48 square feet (per structure, per calendar year) of any asbestos-containing material. Owners and/or owner's agents must file notification once the 10 linear feet or 48 square feet has been reached on any asbestos project or multiple asbestos project (per structure, per calendar year).

b. Nonfriable Asbestos-Containing Materials: Caulking, Window-Glazing, Roofing.

Except for nonfriable roofing removed in accordance with Section 9.08.B (Leaving Nonfriable Asbestos-Containing Roofing Material in Place During Demolition) or Section 9.08.C (Exception for Hazardous Conditions), ((~~N~~))notification is not required for removal and disposal of the following nonfriable asbestos-containing materials: caulking, window-glazing, or roofing (roofing used on roofs versus other applications). All other asbestos project and demolition requirements remain in effect except as provided by Article IX.

c. Owner-Occupied, Single-Family Residences.

For an asbestos project involving an owner-occupied, single-family residence performed by someone other than the resident owner (e.g.((~~,~~)) an asbestos removal contractor), it shall be the responsibility of the person performing the asbestos project to submit a complete notification, including the required fee and any additional information requested by the Control Officer or his/her authorized representative, to the Agency, in accordance with the notification waiting period requirements in Article X, Section 10.09 of this Regulation. The notification must be submitted by the owner's agent on approved forms. All other asbestos project and demolition requirements remain in effect except as provided by Article IX.

d. Underground Storage Tanks.

Notification is not required for demolition of underground storage tanks with no asbestos. All other asbestos project and demolition requirements remain in effect except as provided by Article IX.

e. Demolition of Structures With a Projected Roof Area ≤120 Square Feet.

Notification is not required for demolition of structures with a projected roof area less than or equal to 120 square feet, unless asbestos-containing material is present. If asbestos-containing material is present, asbestos project notification requirements apply. All other requirements remain in effect except as provided by Article IX.

f. Demolition by Fire Fighting Instruction Fires.

The notification fee in ((~~Section 10.09~~)) the fee schedule is waived for any demolition (when the notification project type is for asbestos removal and demolition or the notification project type is demolition with no asbestos removal) performed in accordance with RCW 52.12.150(6), where the good faith inspection referred to in RCW 52.12.150(6) is an asbestos survey performed by an AHERA Building Inspector, as required in Section 9.03.A-E of this Regulation.

g. Abandoned Asbestos-Containing Material.

The Control Officer may waive part or all of the notification waiting period and project fee, by written authorization, for removal and disposal of abandoned (without the knowledge or consent of the property owner) asbestos-containing materials and for demolition of abandoned structures. All other requirements remain in effect.

h. Emergencies.

The advance notification period may be waived pursuant to Section 10.09.A if an asbestos project or demolition must be conducted immediately because of any of the following:

1) There was a sudden, unexpected event that resulted in a public health or safety hazard;

2) The project must proceed immediately to protect equipment, ensure continuous vital utilities, or minimize property damage;

3) Asbestos-containing materials were encountered that were not identified during the asbestos survey; or

4) The project must proceed to avoid imposing an unreasonable financial burden.

i. State of Emergency.

If a state of emergency is declared by an authorized local, state, or federal governmental official due to a storm, flooding, or other disaster, the Control Officer may temporarily waive part or all of the project fee(s) by written authorization. The written authorization shall reference the applicable state of emergency, what fee(s) will be waived, to what extent((~~d~~)) the fee(s) will be waived, and the effective date(s) of the fee(s) waiver.

j. Annual Notification.

A property owner or owner's agent may file one or more annual notifications if all of the following conditions are met:

1) If more than one annual notification is filed for the same real property, there must not be duplication of structures listed on the annual notifications.

2) The total amount of asbestos-containing material for all asbestos projects performed under an annual notification is less than or equal to 259 linear feet and less than or equal to 159 square feet per structure, per calendar year. If any quantity of asbestos-containing material is removed from a structure which is below notification thresholds of 10 linear feet and/or 48 square feet per structure per calendar year, and an annual notification is filed after the removal occurred, the quantity of asbestos-containing material removed from each structure must be applied towards the annual notification removal limits for each structure.

3) The annual notification is valid for one calendar year.

4) The annual notification is exempt from the requirements in Sections 9.04.A.2, 9.04.A.3.b, 9.04.A.3.d, and 9.04.A.4. All other requirements apply.

5) Quarterly reporting forms approved by SRCAA shall be completed and received by SRCAA for the first calendar quarter by April 15, for the second calendar quarter by July 15, for the third calendar quarter by October 15, and for the fourth calendar quarter by January 15. Quarterly reports shall be filed with SRCAA even when no asbestos-containing material is removed for the respective reporting period.

B. Amendments.

((~~1.~~)) Mandatory Amendments.

((~~–~~)) Amendments must be submitted by the person or party that originally submitted the notification unless that person or party explicitly names another person or party that is authorized to file an amendment. An amendment shall be submitted to the Agency for any of the following changes in notification, must be submitted in accordance with Section 9.04.A and the advance notification requirements in Section 10.09 of this Regulation, and if applicable, shall be accompanied by the appropriate nonrefundable fee as set forth in ((~~Section 10.09 of this Regulation~~)) the fee schedule:

1. ((~~a.~~)) Project Type.

Changes in the project type (e.g.((~~,~~)) from asbestos removal only to asbestos removal and demolition) or cancellation of a project filed under a notification.

2. ((~~b.~~)) Job Size.

Increases in the job size category, which increase the fee or changes the advance notification period. For an amendment where the project type or job size category is associated with a higher fee, a fee equal to the difference between the fee associated with the most recently submitted notification and the fee associated with the increased project type or job size category shall be submitted. When there is an increase in the job size category which increases the fee or changes the advance notification period, the additional quantities of asbestos-containing material must be itemized on the amendment form. If the job size increases the 3-day waiting period to a 10-day waiting period, the 10-day waiting period starts from the original notification filing date. If the original notification was filed as an emergency and there is an increase in the job size category which increases the notification fee category, the emergency fee applies to the new fee category.

3. ((~~c.~~)) Type of Asbestos.

Changes in the type or new types of asbestos-containing material that will be removed. All types (except as provided for in Section 9.04.A.7.b) and quantities of asbestos-containing material must be itemized on the amendment form.

4. ((~~d.~~)) Start/End Dates.

Changes in the asbestos project date (i.e. asbestos removal start date, asbestos removal end date or earliest demolition start date). This includes((~~ing~~)) placing a project "on hold" ((~~or "off hold"~~)) (e.g.((~~,~~)) an asbestos project is temporarily delayed and a new ((~~start~~)) project date has not been determined). ((~~confirmed) or canceling a notification altogether.~~)) Placing a project "on hold" is limited to asbestos projects where the remaining types and quantities of asbestos-containing material to be removed are known. When placing a project "on hold", the remaining types and quantities of asbestos-containing material to be removed from each structure shall be itemized on the amendment form. If an asbestos project date is placed "on hold", an amendment taking it "off hold" must be filed prior to work on the asbestos project resuming.

((~~e. Completion Date.~~

~~Changes in the asbestos project completion date including placing a project "on hold" or "off hold" (e.g., an asbestos project is temporarily delayed and a new end date has not been confirmed~~)).

5. Completion Date.

Except as provided below, in the case of additional work to be performed after the last completion date on record, a new notification shall be submitted to the Agency and shall be accompanied by the appropriate nonrefundable fee as set forth in the fee schedule. Where the notification project type indicates asbestos removal only, the last completion date on record refers to the last asbestos removal completion date on record. Where the notification project type indicates asbestos removal and demolition or demolition with no asbestos removal, the last completion date on record is 365 days from the earliest original notification start date.

a. Completion Date Extension.

Where the notification project type indicates asbestos removal only or asbestos removal and demolition, the last asbestos removal completion date on record has already passed, when an asbestos survey was performed that was designed to address the full scope of the renovation or demolition being performed, and when asbestos-containing materials are discovered unexpectedly prior to or during renovation or demolition and those materials were not identified in an asbestos survey, the owner or owner's agent may request that SRCAA accept an amendment under this section for removal of additional asbestos-containing material. In making the request, the owner or owner's agent shall submit a copy of the asbestos survey to SRCAA. If SRCAA does not approve an amendment under this section, a new notification must be submitted pursuant to Article IX and Section 10.09 for removal of additional asbestos-containing material.

6. Adding Structures.

Adding one or more structures to a previously submitted notification.

a. Amendments cannot be used to add structures to a previously submitted notification unless one or more of the following applies:

1) The structure(s) meet(s) the definition of an owner-occupied, single-family residence and the last completion date on record has not passed; or

2) The structure(s) is/are added prior to the earliest start date listed on the original notification.

b. If the addition of one or more structures will increase the original advance notification waiting period (e.g. 3 day to 10 day), a new notification is required.

c. The multiple asbestos project and demolition requirements in Section 9.04.A.3 and other applicable requirements apply.

((~~2. Opportunity for Amendment.~~

~~a. Start Date on Record.~~

~~An amendment must be submitted on or before the most current asbestos removal start date on record in order to change the asbestos removal start date or place a project "on hold".~~

~~b. Last Completion Date on Record.~~

~~In no case shall an amendment be accepted by the Agency if it is filed after the last completion date on record. Where the notification project type indicates asbestos removal only, the last completion date on record refers to the last asbestos removal completion date on record. Where the notification project type indicates asbestos removal and demolition or demolition with no asbestos removal, the last completion date on record is 365 days from the earliest original notification start date.~~

~~1) In the case of additional work to be performed after the last completion date on record, a new notification shall be submitted to the Agency and shall be accompanied by the appropriate nonrefundable fee as set forth in Section 10.09 of Article X of this Regulation.~~

~~2) Where the notification project type indicates asbestos removal and demolition, the last asbestos removal completion date on record has already passed, and when asbestos-containing materials are encountered prior to or during demolition that were not identified in the asbestos survey, SRCAA may accept an amendment for additional asbestos removal, provided the additional asbestos removal is complete within 365 days from the earliest original notification start date.~~

~~c. Canceled Notification.~~

~~Once a property owner or owner's agent cancels a notification, it shall be unlawful for any person to cause or allow any work on an asbestos project or demolition unless a new, complete notification, including the required fee and any additional information requested by the Control Officer, has been submitted to the Agency on approved forms through the Agency's website or in person at the Agency's place of business by the property owner or owner's agent, in accordance with the advance notification period requirements contained in Article X, Section 9.04.A and 10.09 of this Regulation).~~

~~d. Adding Structures.~~

~~Amendments may not be used to add structures to a previously submitted notification if the structure(s) meet(s) the definition of a facility in Section 9.02.~~))

Reviser's note: The typographical errors in the above material occurred in the copy filed by the Spokane Regional Clean Air Agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

SECTION 9.05 ASBESTOS DISTURBANCE ((~~REMOVAL REQUIREMENTS~~))

((~~A. Removal of Asbestos.~~

A. Removal to Prevent Disturbance.

((~~1.~~)) Except as provided in Sections 9.05.E and 9.08((~~.B-C~~)) of this Regulation, it shall be unlawful for any person to cause or allow any renovation, demolition, or other action or inaction that may:

1. ((~~a.~~)) Disturb asbestos-containing material without first removing all asbestos-containing material in accordance with the requirements of this Regulation; or

2. ((~~b.~~)) Damage a structure so as to preclude access to asbestos-containing material for future removal, without first removing all asbestos-containing material in accordance with the requirements of this Regulation.

B. Conditions that will Likely Result in Disturbance.

((~~2.~~)) Except as provided in Sections 9.05.E and 9.08((~~.A-C~~)) of this Regulation, it shall be unlawful for any person to create or allow a condition, involving an existing structure or component, that will likely result in the disturbance of asbestos-containing material (e.g., not removing all asbestos-containing material in a structure scheduled for demolition; not completely removing asbestos-containing material identified for removal by the last asbestos removal completion date on record; leaving asbestos-containing material in a state that makes it more susceptible to being disturbed; asbestos-containing material that is peeling, delaminating, crumbling, blistering, or other similar condition; etc.).

C. Reuse.

((~~3.~~)) Asbestos-containing material in good condition (as determined in Section 9.03.C.2.d when an asbestos survey is performed) ((~~need not be removed from a component if the component is~~)) may be removed for reuse, stored for reuse, or transported for reuse provided it is not disturbed or likely to be disturbed ((~~without disturbing or damaging the asbestos-containing material~~)). Asbestos-containing material that is damaged or likely to be disturbed shall not be removed for

reuse, stored for reuse or transported for reused. Asbestos-containing material which is stored or transported for reuse must be kept in a secure location and clearly labeled with asbestos warning signs until reuse occurs. If the asbestos-containing material will not be reused or is likely to be disturbed, it must be handled and disposed of in accordance with this Regulation.

D. If Disturbance Occurs.

((4.)) Suspect asbestos-containing material that has been disturbed must be removed as soon as possible and disposed of in accordance with this Regulation unless an asbestos survey, performed in accordance with Section 9.03 of this Regulation, demonstrates that suspect asbestos-containing materials are not asbestos-containing materials.

E. Vermiculite.

Except as provided in Sections 9.08.A and 9.08.C, it shall be unlawful for any person to cause or allow any renovation, demolition, or other action or inaction that may disturb loose vermiculite containing one percent or less asbestos, including damaging a structure so as to preclude access for future removal, without first removing it to the extent practicable in accordance with Section 9.06.C and other applicable requirements of this Regulation. Furthermore, it shall be unlawful for any person to create or allow a condition, involving an existing structure or component that will likely result in the disturbance of loose vermiculite containing one percent or less asbestos (e.g. not removing it to the extent practical in a structure scheduled for demolition; not removing visible vermiculite to the extent practical by the last asbestos removal completion date on record; leaving loose vermiculite containing one percent or less asbestos in a state that makes it more susceptible to being disturbed).

Reviser's note: The typographical errors in the above material occurred in the copy filed by the Spokane Regional Clean Air Agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

SECTION 9.06 PROCEDURES FOR ASBESTOS PROJECTS

A. Training Requirements.

It shall be unlawful for any person to cause or allow any work on an asbestos project unless it is performed by persons trained and certified in accordance with the standards established by the Washington State Department of Labor & Industries, the federal Occupational Safety & Health Administration, or the United States Environmental Protection Agency (whichever agency has jurisdiction) and whose certification is current. This certification requirement does not apply to asbestos projects conducted in an owner-occupied, single-family residence performed by the resident owner of the dwelling.

B. Standard Asbestos Project Work Practices.

Standard asbestos project work practices require manual removal methods unless otherwise approved by SRCAA. Examples of mechanical work practices approved by SRCAA include, but are not limited to, the use of a stationary fixed blade attached to a motorized vehicle for removal of asbestos-containing floor tile (see also WISHA Interim Interpretive Memorandum #97-7-G) and self-contained shot blasting equipment fitted and operated with HEPA filtration. Standard asbestos work practices require removal of asbestos-containing material using all procedures described in Section 9.06.B.1-6. Except as provided in Sections 9.08.A-C of this Regulation, it shall be unlawful for any person to cause or allow the removal or disturbance of asbestos-containing material unless all the following requirements are met:

1. Controlled Area.

The asbestos project shall be conducted and maintained in a controlled area, clearly marked by barriers and asbestos warning signs. Access to the controlled area shall be restricted to authorized personnel only, including occasions when asbestos abatement is not actively occurring (e.g.((,)) when workers are on break or off-site).

2. Negative Pressure Enclosure.

If a negative pressure enclosure is employed it shall be equipped with transparent viewing ports, if feasible, and shall be maintained in good working order.

3. Wetting Asbestos-Containing Material Prior to and During Removal.

a. Absorbent asbestos-containing materials, such as surfacing material and thermal system insulation, shall be saturated with a liquid wetting agent prior to removal. Wetting shall continue until all the material is permeated with the wetting agent. Any unsaturated absorbent asbestos-containing material exposed during removal shall be immediately saturated with a liquid wetting agent and kept wet until sealed in leak-tight containers.

b. Nonabsorbent asbestos-containing materials, such as cement asbestos board or vinyl asbestos tile, shall be continuously coated with a liquid wetting agent on any exposed surface prior to and during removal. Any dry surfaces of nonabsorbent asbestos-containing material exposed during removal shall be immediately coated with a liquid wetting agent and kept wet until sealed in leak-tight containers.

c. Metal components (such as valves, fire doors, and reactor vessels) that have internal asbestos-containing material do not require wetting of the asbestos-containing material if all access points to the asbestos-containing materials are welded shut or the component has mechanical seals, which cannot be removed by hand, that separate the asbestos-containing material from the environment.

4. Handling.

Except for surfacing material being removed inside a negative pressure enclosure, asbestos-containing material that is being removed, has been removed, or may have fallen off components during an asbestos project shall be carefully lowered to the ground or the floor, not dropped, thrown, slid, or otherwise damaged.

5. Asbestos-Containing Waste Material.

a. All absorbent, asbestos-containing waste material shall be kept saturated with a liquid wetting agent until sealed in leak-tight containers. All nonabsorbent, asbestos-containing waste material shall be kept coated with a liquid wetting agent until sealed in leak-tight containers.

b. All asbestos-containing waste material resulting from an asbestos project shall be sealed in leak-tight containers as soon as possible after removal, but no later than the end of each work shift.

c. The exterior of each leak-tight container shall be free of all asbestos residue and shall be permanently labeled with an asbestos warning sign as specified by the Washington

State Department of Labor and Industries or the federal Occupational Safety and Health Administration.

d. Immediately after sealing, each leak-tight container shall be permanently marked with the date the material was collected for disposal, the name of the waste generator, and the address at which the waste was generated. This marking must be made at the site where the waste was generated and must be readable without opening the container.

e. Leak-tight containers shall not be dropped, thrown, slid, or otherwise damaged.

f. Asbestos-containing waste material shall be stored in a controlled area until transported to, and disposed of at, a waste disposal site approved to accept asbestos-containing waste material.

6. Visible Emissions

No visible emissions shall result from an asbestos project.

C. Procedures for Loose Vermiculite Containing One Percent or Less Asbestos

Except as provided in Sections 9.08.A and 9.08.C, all of the following asbestos procedures shall be employed for removal or demolition of loose vermiculite containing one percent or less asbestos:

1. Removal

a. The asbestos project shall be conducted and maintained in a controlled area, clearly marked by barriers and asbestos warning signs. Access to the controlled area shall be restricted to authorized personnel only, including occasions when asbestos abatement is not actively occurring (e.g. when workers are on break or off-site).

b. Vermiculite shall be misted or wetted to the extent practicable with a liquid wetting agent prior to and during removal.

c. Vermiculite shall be removed using manual methods or using vacuum systems with HEPA filtered exhaust systems designed for the vacuum system on which it is used. The HEPA filtered exhaust system shall be operated and maintained according to manufacturer specifications.

d. Following vermiculite removal, the work space shall be treated with a post abatement encapsulant (e.g., lock-down encapsulant, penetrating encapsulant).

2. Handling & Disposal

a. After being removed, vermiculite shall immediately be transferred to a leak-tight container.

b. The exterior of each leak-tight container shall be free of all vermiculite residue and shall be permanently labeled with an asbestos warning sign as specified by the Washington State Department of Labor and Industries or the federal Occupational Safety and Health Administration.

c. Immediately after sealing, each leak-tight container shall be permanently marked with the date the material was collected for disposal, the name of the waste generator, and the address at which the waste was generated. This marking must be made at the site where the waste was generated and must be readable without opening the container.

d. Leak-tight containers shall not be dropped, thrown, slid, or otherwise damaged.

e. Asbestos-containing waste material shall be stored in a controlled area until transported to, and disposed of at, a waste disposal site approved to accept asbestos-containing waste material and in accordance with Section 9.09 of this Regulation.

3. Except as provided for in Section 9.06.C.1.b, no visible emissions shall result from an asbestos project.

Reviser's note: The typographical error in the above material occurred in the copy filed by the Spokane Regional Clean Air Agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

SECTION 9.07 PROCEDURES FOR NONFRIABLE ASBESTOS-CONTAINING ROOFING MATERIAL

((~~A. Method of Removal for Nonfriable Asbestos Containing Roofing Material.~~)) All of the following asbestos removal methods shall be employed for nonfriable asbestos-containing roofing material as defined in Section 9.02.S of this Regulation:

A. ((~~1.~~)) The nonfriable asbestos-containing roofing material shall be removed using methods, such as spud bar and knife, which do not render the material friable. Removal methods such as sanding, grinding, abrading, or sawing shall not be employed under this Section.

B. ((~~2.~~)) After being removed, nonfriable asbestos-containing roofing material shall be carefully lowered to the ground or the floor, not dropped, thrown, or otherwise damaged and transferred to a disposal container as soon as possible after removal. In no case shall the transfer occur later than the end of each work shift.

C. ((~~3.~~)) Each disposal container shall have a sign identifying the material as nonfriable asbestos-containing roofing material and shall be transported to, and disposed of at, an approved waste disposal site in compliance with Section 9.09 and applicable local, state, and federal regulations.

D. ((~~4. Appropriate dust control methods as provided in Article VI, Section 6.05 of this Regulation shall be used to control fugitive dust emissions~~)) No visible emissions shall result from an asbestos project.

SECTION 9.08 ALTERNATE MEANS OF COMPLIANCE

A. Alternate Asbestos Project Work Practices for Removing Asbestos-Containing Material Prior to Renovation or Demolition.

Unless otherwise approved by SRCAA in writing, alternate means of compliance must be used ((~~W~~))where standard asbestos project work practices in Section 9.06.B cannot be utilized to remove asbestos-containing material (financial considerations aside) prior to renovation or demolition((~~,~~)); when asbestos-containing material has been disturbed or is otherwise no longer intact (e.g., when demolition has already occurred or a similar situation exists, (((~~t~~))typically leaving a pile/area of debris, rubble, ash, ((~~and/~~))or soil)((,)); or when mechanical methods are used for removal ((~~an alternate asbestos removal method may be employed provided it complies~~)). Projects performed under this section must be performed under the alternate asbestos project work practice notification category and must comply with all of the following:

1. Qualifications of Person(s) Preparing an Alternate Work Plan (AWP).

An AHERA Project Designer ((~~and a Certified Industrial Hygienist (CIH) or an AHERA Project Designer and a~~

~~Licensed Professional Engineer (PE)~~)) must evaluate the work area, the type and quantity (known or estimated) of asbestos-containing material, the projected work practices, and the engineering controls and develop an AWP that ensures the planned control methods will be as effective as the work practices in Section 9.06.B of this Regulation.

2. AWP Contents.

The AWP must contain all of the following information:

a. Reason(s) why standard work practices cannot be utilized;

b. Date(s) the work area was evaluated by the person(s) that prepared the AWP;

c. Site address(es)/location(s) where the inspection was performed;

d. The purpose of the evaluation (e.g., asbestos removal from an electrical structure or component where standard wet methods cannot be utilized, removal and disposal of a debris pile resulting from a fire-damaged structure, etc.);

e. If an asbestos survey was performed, include a copy or incorporate it by reference;

f. All procedures that will be followed for controlling asbestos emissions during the asbestos project;

g. Procedures that will be followed for the final inspection of the property to ensure that asbestos-containing material has been removed and disposed of in accordance with applicable regulations;

h. A statement that the AWP will be as effective as the work practices in Section 9.06.B;

i. Signature(s) of the person(s) that prepared the AWP; and

j. Certification(s) and/or license number(s), and date(s) that certification(s) and/or license(s) expire(s), for the person(s) that prepared the AWP.

3. Asbestos Survey.

If an asbestos survey is not performed pursuant to Section 9.03 of this Regulation, it must be presumed that the asbestos project involves friable and nonfriable asbestos-containing material.

4. AWP Procedures.

The AWP must identify in detail all procedures that will be followed for controlling asbestos emissions during the asbestos project (e.g., during asbestos removal, when workers are off-site, etc.). All procedures and requirements in the AWP must be followed. Unless alternate procedures are specified in the AWP by an AHERA Project Designer ((~~and a Certified Industrial Hygienist or an AHERA Project Designer and a Licensed Professional Engineer~~)), the AWP shall include all of the ((~~following~~)) requirements in Section 9.08.A.4.a-f, below. ((~~of this Regulation:~~))

a. Controlled Area.

The asbestos project shall be conducted in a controlled area, clearly marked by barriers and asbestos warning signs. Access to the controlled area shall be restricted to authorized personnel only. The controlled area shall protect persons outside the controlled area from potential exposure to airborne asbestos.

b. Wetting.

All materials and debris shall be handled in a wet condition.

1) Absorbent materials shall be saturated with a liquid wetting agent prior to removal. Wetting shall continue until all the material is permeated with the wetting agent. Any unsaturated surfaces exposed during removal shall be wetted immediately.

2) Nonabsorbent materials shall be continuously coated with a liquid wetting agent on any exposed surface prior to and during the removal. They shall be wetted after removal, as necessary, to assure they are wet when sealed in leak-tight containers. Any dry surfaces exposed during removal shall be wetted immediately.

c. Asbestos-Containing Waste Materials.

1) All asbestos-containing waste material and/or asbestos contaminated waste material shall be kept wet and shall be sealed in leak-tight containers while still wet, as soon as possible after removal but no later than the end of each work shift.

2) The exterior of each leak-tight container shall be free of all asbestos residue and shall be permanently labeled with an asbestos warning sign as specified by the Washington State Department of Labor and Industries or the federal Occupational Safety and Health Administration.

3) Immediately after sealing, each leak-tight container shall be permanently marked with the date the material was collected for disposal, the name of the waste generator, and the address at which the waste was generated. This marking must be readable without opening the container.

4) Leak-tight containers shall be kept leak-tight.

5) The asbestos-containing waste material shall be stored in a controlled area until transported to an approved waste disposal site.

d. Air Monitoring.

Procedures that shall be followed for air monitoring at the outside perimeter of the controlled area, both upwind and downwind, to ensure that the asbestos fiber concentrations do not exceed a net difference (between concurrent upwind and downwind monitoring results) of 0.01 fibers per cubic centimeter (f/cc) as determined by the NIOSH Manual of Analytical Methods, Method 7400 (asbestos and other fibers by PCM).

1) The procedures shall require that any air sampling cassette(s) that become(s) overloaded with dust be immediately replaced. Work shall stop until an AHERA Project Designer ((~~and a Certified Industrial Hygienist or an AHERA Project Designer and a Licensed Professional Engineer~~)) has re-evaluated the engineering controls for dust control, revised the AWP as necessary, and the owner or owner's agent implements all revisions to the AWP.

2) The Agency shall immediately be notified by the owner or owner's agent if the airborne fiber concentrations exceed a net difference of 0.01 f/cc and work shall stop until an AHERA Project Designer ((~~and a Certified Industrial Hygienist or an AHERA Project Designer and a Licensed Professional Engineer~~)) has re-evaluated the engineering controls, revised the AWP as necessary, and the owner or owner's agent implements all revisions to the AWP.

e. Competent Person.

1) A competent person shall be present for the duration of the asbestos project (includes demolition) and shall observe work activities at the site.

2) The competent person shall stop work at the site to ensure that friable asbestos-containing material found in the debris, which can readily be separated, is removed from the main waste stream and is placed and maintained in leak-tight containers for disposal.

3) The competent person shall stop work if AWP procedures are not being followed and shall ensure that work does not resume until procedures in the AWP are followed.

f. Separation of Materials.

If the project involves separation of clean(ed) materials from debris piles (e.g., rubble, ash, soil, etc.) that contain or are contaminated with asbestos-containing materials, the material separation procedures shall be included in the AWP. In addition to these procedures, the following requirements apply:

1) The AWP shall identify what materials will be separated from the asbestos-containing material waste stream and shall describe the procedures that will be used for separating and cleaning the materials. All materials removed from the asbestos-containing waste material stream shall be free of asbestos-containing material.

2) A competent person shall ensure that materials being diverted from the asbestos-containing waste material stream are free of asbestos-containing material.

5. Visible Emissions.

No visible emissions shall result from an asbestos project.

6. Record Keeping.

a. The AWP shall be kept at the work site for the duration of the project and made available to the Agency upon request. The property owner or owner's agent and AHERA Project Designer that prepared the AWP shall retain a complete copy of the AWP for at least 24 months from the date it was prepared and make it available to the Agency upon request.

b. Complete copies of other asbestos-related test plans and reports (e.g., testing soil for asbestos, air monitoring for asbestos, etc.) associated with the project shall also be retained by the property owner or owner's agent for at least 24 months from the date it was performed and made available to the Agency upon request. The person(s) preparing and performing such tests shall also retain a complete copy of these records for at least 24 months from the date it was prepared and make it available to the Agency upon request.

7. Other Requirements.

All applicable local, state, and federal regulations must be complied with.

B. Leaving Nonfriable Asbestos-Containing Roofing Material in Place During Demolition.

Nonfriable asbestos-containing roofing material as defined in Section 9.02.S of this Regulation may be left in place during demolition, except for demolition by burning, if it remains nonfriable during all demolition activities (including handling and disposal) and all of the following are met:

1. A signed and dated written determination was made by an AHERA Project Designer that includes all of the following:

a. A summary of the evaluation performed within the past 12 months, including a description of the type and current condition of asbestos-containing roofing materials;

b. A summary of the work practices and engineering controls that will be used;

c. A determination that nonfriable asbestos-containing roofing material will remain nonfriable during all demolition activities and subsequent disposal of the debris; and

d. The property owner or owner's agent and the AHERA Project Designer that performed the determination shall retain a complete copy of the determination for at least 24 months from the date it was performed and make it available to the Agency upon request.

2. Appropriate dust control methods as provided in Article VI, Section 6.05 of this Regulation shall be used to control fugitive dust emissions.

3. Each disposal container shall have a sign identifying the material as nonfriable asbestos-containing roofing material and shall be transported to, and disposed of at, an approved waste disposal site in compliance with Section 9.09 and applicable local, state, and federal regulations.

C. Exception for Hazardous Conditions (((~~Leaving Friable and/or Nonfriable Asbestos-Containing Material in Place During Demolition~~))).

When the exception for hazardous conditions is being utilized, all of the following apply:

1. Friable and nonfriable asbestos-containing material need not be removed prior to demolition, if it is not accessible (e.g.((~~,~~)) asbestos cannot be removed prior to demolition) because of hazardous conditions such as structures or buildings that are structurally unsound, structures or buildings that are in danger of imminent collapse, or other conditions that are immediately dangerous to life and health. ((~~At a minimum, the owner and owner's agent must comply with all of the following:~~

2. An authorized government official or a licensed structural engineer must determine in writing that a hazard exists, which makes removal of asbestos-containing material dangerous to life or health. The determination must be retained for at least 24 months from the date it was prepared and made available to SRCAA by the property owner or owner's agent upon request.

~~1. Qualifications of Person(s) Preparing an Alternate Work Plan (AWP).~~))

3. An AHERA Project Designer ((~~and a Certified Industrial Hygienist or an AHERA Project Designer and a Licensed Professional Engineer~~)) must evaluate the work area, the type and quantity (known or estimated) of asbestos-containing material, the projected work practices, and the engineering controls and develop an ((~~Alternative Work Plan (~~))AWP((~~)~~)) that ensures the planned control methods will be protective of public health. The AWP must contain all of the following information:

((~~2. Determination of a Hazardous Condition.~~

~~An authorized government official or a licensed structural engineer must determine in writing that a hazard exists, which makes removal of asbestos-containing material dangerous to life or health.~~

~~3. AWP Contents.~~

~~The AWP must contain all of the following information~~))

a. Date(s) the work area was evaluated by the person(s) that prepared the AWP;

b. Site address(es)/location(s) where the inspection was performed;

c. A copy of the hazardous conditions determination from a government official or licensed structural engineer;

d. If an asbestos survey was performed, include a copy or incorporate it by reference;

e. All procedures that will be followed for controlling asbestos emissions during the asbestos project;

f. A statement that the AWP will be protective of public health;

g. Signature(s) of the person(s) that prepared the AWP; and

h. Certification(s) and/or license number(s), and date(s) that certification(s) and/or license(s) expire(s), for the person(s) that prepared the AWP.

4. AWP Procedures.

The requirements of Section 9.08.A.3-7 of this Regulation and all other applicable requirements, including those specified in the AWP, shall be complied with.

Reviser's note: The typographical errors in the above material occurred in the copy filed by the Spokane Regional Clean Air Agency and appear in the Register pursuant to the requirements of RCW 34.08.040.

SECTION 9.09 DISPOSAL OF ASBESTOS-CONTAINING WASTE MATERIAL

A. Disposal Within 10 Days of Removal.

Except as provided in Section 9.09.C (Temporary Storage Site) of this Regulation, it shall be unlawful for any person to cause or allow the disposal of asbestos-containing waste material unless it is deposited within 10 calendar days of removal at a waste disposal site authorized to accept such waste.

B. Waste Tracking Requirements.

It shall be unlawful for any person to cause or allow the disposal of asbestos-containing waste material unless all of the following requirements are met:

1. Maintain waste shipment records, beginning prior to transport, using a separate form for each waste generator that includes all of the following information:

a. The name, address, and telephone number of the waste generator.

b. The approximate quantity in cubic meters or cubic yards.

c. The name and telephone number of the disposal site operator.

d. The name and physical site location of the disposal site.

e. The date transported.

f. The name, address, and telephone number of the transporter.

g. Accurate detailed description of the type of asbestos-containing waste material being disposed of.

((g)) h. A certification that the contents of the consignment are fully and accurately described by proper shipping name and are classified, packed, marked, and labeled, and are in all respects in proper condition to transport by highway according to applicable waste transport regulations.

2. Provide a copy of the waste shipment record to the disposal site owner or operator at the same time the asbestos-containing waste material is delivered. If requested by the disposal site operator, a copy of the ((~~Alternate Work Plan~~)) AWP or written determination as specified pursuant to Sections 9.08.A-C of this Regulation shall also be provided to the disposal site owner or operator at the same time the asbestos-containing waste material is delivered.

3. If a copy of the waste shipment record, signed by the owner or operator of the disposal site, is not received by the waste generator within 35 calendar days of the date the waste was accepted by the initial transporter, contact the transporter and/or the owner or operator of the disposal site to determine the status of the waste shipment.

4. If a copy of the waste shipment record, signed by the owner or operator of the disposal site, is not received by the waste generator within 45 calendar days of the date the waste was accepted by the initial transporter, report in writing to the Control Officer. Include in the report, a copy of the waste shipment record and cover letter signed by the waste generator, explaining the efforts taken to locate the asbestos waste shipment and the results of those efforts.

5. Retain a copy of all waste shipment records for at least 24 months from the date it was generated, including a copy of the waste shipment record signed by the owner or operator of the designated waste disposal site. A copy of asbestos project notifications and corresponding waste shipment records shall be provided to the Agency upon request.

C. Temporary Storage Site.

A person may establish a ((~~facility~~)) temporary storage site for the purpose of collecting and temporarily storing asbestos-containing waste material if ((~~the facility~~)) it is approved by the Control Officer and all of the following conditions are met:

1. A complete application for Temporary Storage of asbestos containing waste material is submitted to and approved by the Agency.

2. The application must be accompanied by a non-refundable fee as set in the fee schedule.

3. Accumulated asbestos-containing waste material shall be kept in a controlled storage area posted with asbestos warning signs and accessible only to authorized persons, including Agency representatives and persons authorized by WISHA.

4. All asbestos-containing waste material shall be stored in leak-tight containers which are maintained in leak-tight condition.

5. The storage area must be locked except during transfer of asbestos-containing waste material.

6. Storage, transportation, disposal, and return of the waste shipment record to the waste generator shall not exceed 90 calendar days.

7. Asbestos-Containing Waste Material Temporary Storage Permits approved by the Agency are valid for one calendar year unless a different time frame is specified in the permit.

D. Disposal of Asbestos Cement Pipe.

Asbestos cement pipe used on public right-of-ways, public easements, and places receiving the prior written approval of the Control Officer may be buried in place if the pipe is left intact (e.g., not moved, broken or disturbed) and covered with at least 3 feet or more of non-asbestos fill material. All asbestos cement pipe fragments that are 1 linear foot or less

and other asbestos-containing waste material shall be disposed of at a waste disposal site authorized to accept such waste. Pipe bursting asbestos cement pipe or other asbestos-containing material is prohibited.

SECTION 9.10 COMPLIANCE WITH OTHER RULES

Other government agencies have adopted rules that may apply to asbestos regulated under these rules including, but not limited to, the U.S Environmental Protection Agency, the U.S. Occupational Safety and Health Administration, and the Washington State Department of Labor and Industries. Nothing in the Agency's rules shall be construed as excusing any person from complying with any other applicable local, state, or federal requirement.

Reviser's note: The typographical error in the above material occurred in the copy filed by the Spokane Regional Clean Air Agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

AMENDATORY SECTION

The following section of SRCAA Regulation I is amended:

Section 10.09 – Asbestos Project and Demolition Notification Waiting Period and Fees

SECTION 10.09 ASBESTOS PROJECT AND DEMOLITION NOTIFICATION WAITING PERIOD AND FEES

A. Written notification, as required in Article IX, Section 9.04, shall be in accordance with the waiting period in the tables that follow and shall be accompanied by the appropriate nonrefundable fee, as specified in the fee schedule. Refunds are allowable for overpayments which are identified within thirty days of the notification filing date.

Owner-occupied, single-family residence	Waiting Period
> 0 ln ft and/or > 0 sq ft asbestos performed by residing owner	Notification Not Required
< 10 ln ft and/or < 48 sq ft asbestos not performed by residing owner	Notification Not Required
≥ 10 ln ft and/or ≥ 48 sq ft asbestos not performed by residing owner	Prior Notice
All Demolition	3 Days

Not owner-occupied, single-family residence	Waiting Period
< 10 ln ft and/or < 48 sq ft asbestos, but asbestos removal threshold of ≥ 10 ln ft and/or ≥ 48 sq ft has not been exceeded for structure in calendar year and project WILL NOT exceed threshold of ≥ 10 ln ft and/or ≥ 48 sq ft asbestos removal from structure in calendar year	Notification Not Required
Project consists of < 10 ln ft and/or < 48 sq ft of asbestos removal, but ≥ 10 ln ft and/or ≥ 48 sq ft asbestos has already been removed from structure in calendar year or project WILL exceed threshold of ≥ 10 ln ft and/or ≥ 48 sq ft asbestos removal from structure in calendar year	Prior Notice
10-259 ln ft and/or 48-159 sq ft asbestos	3 Days
260-999 ln ft and/or 160-4,999 sq ft asbestos	10 Days
≥ 1,000 ln ft and/or ≥ 5,000 sq ft asbestos	10 Days
All Demolition	10 Days

Additional categories	Waiting Period	Reference
Emergency	Prior Notice*	Sect. 9.04.A.((~~6~~))7.h.
Annual Notification (≤ 259 ln ft and/or ≤ 159 sq ft)	Prior Notice	Sect. 9.04.A. ((~~6~~))7.j
Amendment	Prior Notice	Section 9.04.B.
Alternate Asbestos Project Work Practices	10 days	Section 9.08.A.
Demolition with Non-friable Asbestos Roofing	10 days	Section 9.08.B.
Exception for Hazardous Conditions	10 days	Section 9.08.C

* If prior notice isn't possible because of life endangerment or other serious consequences, the Agency may accept, at its discretion, a completed emergency notification if it is filed no later than the first regular Agency work day after the asbestos project and/or demolition commenced.

B. The Board shall periodically review the fee schedule for notifications submitted pursuant to Section 9.04 and determine if the total projected fee revenue to be collected pursuant to this Section is sufficient to fully recover program costs. Any proposed fee revisions shall include opportunity for public review and comment. Accordingly, the Agency shall account for program costs. If the Board determines that the total projected fee revenue is either significantly excessive or deficient for this purpose, then the Board may amend the fee schedule to more accurately recover program costs.

Reviser's note: The typographical error in the above material occurred in the copy filed by the Spokane Regional Clean Air Agency and appears in the Register pursuant to the requirements of RCW 34.08.040.

WSR 14-12-004
PERMANENT RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed May 21, 2014, 1:41 p.m., effective June 21, 2014]

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

Purpose: To establish rules behind the K-1 high poverty compliance calculations which begin in the 2014-15 school year.

Citation of Existing Rules Affected by this Order: Amending [new sections] WAC 392-140-921, 392-140-923, 392-140-932, and 392-140-933.

Statutory Authority for Adoption: RCW 28A.150.290 and 84.52.0531.

Adopted under notice filed as WSR 14-08-074 on March 31, 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 [4], Amended 4 [0], Repealed 0.

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

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

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

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

Date Adopted: May 14, 2014.

Randy Dorn
State Superintendent
of Public Instruction

NEW SECTION

WAC 392-140-921 K-1 high poverty class size compliance. The superintendent of public instruction shall determine which high poverty schools are eligible for enhanced funding for class size reduction per WAC 392-140-915. High poverty class size compliance will be measured at each eligible school independent of other eligible schools within a district. A demonstrated class size will be measured at each eligible school. That demonstrated class size will be converted to a funded class size, and a weighted average funded class size by district will be calculated and used for funding purposes.

Compliance calculations will be performed in January, March, and June of each school year. The most recent weighted average funded class size will be used for funding purposes. Districts will be funded based on their budgeted high poverty class size from September through December. Only districts with at least one high poverty eligible school may budget an enhanced class size.

NEW SECTION

WAC 392-140-923 K-1 high poverty class size—Enrollment. School level enrollment by grade at each of the high poverty eligible schools will be considered from the current school year October 1 CEDARS data inclusive of changes through the enrollment count day in January, March, and June. All students in ALE programs will be excluded from the compliance calculation. First grade and full day kindergarten students will be considered a 1.0 FTE, while half day kindergartners will be considered a 0.5 FTE.

NEW SECTION

WAC 392-140-932 K-1 high poverty class size—Teachers. The superintendent of public instruction shall include in the calculation of high poverty class size compliance those teachers reported on the S-275 at the eligible schools that are coded in programs 01 and 79 to grade group K or 1, and are reported in one of the following duty roots:

- Duty Root 31 – Elementary teacher
- Duty Root 33 – Other teacher
- Duty Root 52 – Substitute teacher
- Duty Root 63 – Contractor teacher

S-275 data as of the published apportionment cutoff dates in January, March, and June will be considered in the calculation.

Program 21 special education teachers coded to grade K or 1 at the eligible schools multiplied by the annual percentage of students in special education instruction used in determination of a district's 3121 revenue will be included.

Teachers coded to program 02 alternative learning experience shall be excluded.

NEW SECTION

WAC 392-140-933 K-1 demonstrated class size. Demonstrated class size at each school will be calculated by dividing the total teachers for that school as described in WAC 392-140-932 into the calculated total of K-1 student FTE for that school. Funded class size will equal the demonstrated class size to a maximum of 24.1 and a minimum of 20.3 students per teacher.

A weighted average of funded class sizes across all high poverty eligible schools will be calculated by multiplying eligible enrollment as defined in WAC 392-140-923 at each school by the funded class size at each school. The results of that calculation for each school will be summed and divided by the total K-1 calculate enrollment at all eligible schools to arrive at a district wide weighted average funded class size. This weighted average funded class size will be used for funding purposes.

WSR 14-12-007
PERMANENT RULES
OFFICE OF FINANCIAL MANAGEMENT

[Filed May 22, 2014, 9:56 a.m., effective June 22, 2014]

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

Purpose: To establish official pay dates for state officers and employees for calendar year 2015.

Citation of Existing Rules Affected by this Order: Amending WAC 82-50-021.

Statutory Authority for Adoption: RCW 42.16.010(1) and 42.16.017.

Adopted under notice filed as WSR 14-04-016 on January 24, 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 1, Repealed 0.

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

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

Date Adopted: May 22, 2014.

Roselyn Marcus
Assistant Director for Legal
and Legislative Affairs
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-08-078, filed 4/2/13, effective 5/3/13)

WAC 82-50-021 Official lagged, semimonthly pay dates established. Unless exempted otherwise under the provisions of WAC 82-50-031, the salaries of all state officers and employees are paid on a lagged, semimonthly basis for the official twice-a-month pay periods established in RCW 42.16.010(1). The following are the official lagged, semimonthly pay dates for calendar years ((~~2013 and~~)) 2014 and 2015:

((~~CALENDAR YEAR 2013~~	~~CALENDAR YEAR 2014~~
~~Thursday, January 10, 2013~~	~~Friday, January 10, 2014~~
~~Friday, January 25, 2013~~	~~Friday, January 24, 2014~~
~~Monday, February 11, 2013~~	~~Monday February 10, 2014~~
~~Monday, February 25, 2013~~	~~Tuesday, February 25, 2014~~
~~Monday, March 11, 2013~~	~~Monday, March 10, 2014~~
~~Monday, March 25, 2013~~	~~Tuesday, March 25, 2014~~
~~Wednesday, April 10, 2013~~	~~Thursday, April 10, 2014~~
~~Thursday, April 25, 2013~~	~~Friday, April 25, 2014~~
~~Friday, May 10, 2013~~	~~Friday, May 9, 2014~~
~~Friday, May 24, 2013~~	~~Friday, May 23, 2014~~
~~Monday, June 10, 2013~~	~~Tuesday, June 10, 2014~~
~~Tuesday, June 25, 2013~~	~~Wednesday, June 25, 2014~~
~~Wednesday, July 10, 2013~~	~~Thursday, July 10, 2014~~
~~Thursday, July 25, 2013~~	~~Friday, July 25, 2014~~
~~Friday, August 9, 2013~~	~~Monday, August 11, 2014~~
~~Monday, August 26, 2013~~	~~Monday, August 25, 2014~~
~~Tuesday, September 10, 2013~~	~~Wednesday, September 10, 2014~~
~~Wednesday, September 25, 2013~~	~~Thursday, September 25, 2014~~
~~Thursday, October 10, 2013~~	~~Friday, October 10, 2014~~
~~Friday, October 25, 2013~~	~~Friday, October 24, 2014~~
~~Friday, November 8, 2013~~	~~Monday, November 10, 2014~~
~~Monday, November 25, 2013~~	~~Tuesday, November 25, 2014~~
~~Tuesday, December 10, 2013~~	~~Wednesday, December 10, 2014~~
~~Tuesday, December 24, 2013~~	~~Wednesday, December 24, 2014~~))
CALENDAR YEAR 2014	CALENDAR YEAR 2015
Friday, January 10, 2014	Friday - January 9, 2015
Friday, January 24, 2014	Monday - January 26, 2015
Monday February 10, 2014	Tuesday - February 10, 2015
Tuesday, February 25, 2014	Wednesday - February 25, 2015
Monday, March 10, 2014	Tuesday - March 10, 2015
Tuesday, March 25, 2014	Wednesday - March 25, 2015
Thursday, April 10, 2014	Friday - April 10, 2015
Friday, April 25, 2014	Friday - April 24, 2015
Friday, May 9, 2014	Monday - May 11, 2015
Friday, May 23, 2014	Friday - May 22, 2015
Tuesday, June 10, 2014	Wednesday - June 10, 2015
Wednesday, June 25, 2014	Thursday - June 25, 2015
Thursday, July 10, 2014	Friday - July 10, 2015
Friday, July 25, 2014	Friday - July 24, 2015
Monday, August 11, 2014	Monday - August 10, 2015
Monday, August 25, 2014	Tuesday - August 25, 2015
Wednesday, September 10, 2014	Thursday - September 10, 2015
Thursday, September 25, 2014	Friday - September 25, 2015
Friday, October 10, 2014	Friday - October 9, 2015
Friday, October 24, 2014	Monday - October 26, 2015
Monday, November 10, 2014	Tuesday - November 10, 2015
Tuesday, November 25, 2014	Wednesday - November 25, 2015
Wednesday, December 10, 2014	Thursday - December 10, 2015
Wednesday, December 24, 2014	Thursday - December 24, 2015

WSR 14-12-008
PERMANENT RULES
UTILITIES AND TRANSPORTATION COMMISSION

[General Order R-575, Docket UT-131239—Filed May 22, 2014, 2:09 p.m., effective June 22, 2014]

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 14-13 issue of the Register.

WSR 14-12-010
PERMANENT RULES
PUBLIC DISCLOSURE COMMISSION

[Filed May 22, 2014, 4:04 p.m., effective June 22, 2014]

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

Purpose: To clarify that a candidate or political committee who registers a campaign and selects the mini reporting option must disclose contributions and expenditures as required by chapter 42.17A RCW upon failing to comply with the mini reporting eligibility criteria set out in the rule.

To allow the public disclosure commission staff to approve an application to change reporting options after the applicant has exceeded the mini reporting thresholds, provided the application is received by the proscribed deadline for switching reporting options, the applicant acknowledges a violation of WAC 390-16-105, and files disclosure reports.

To change the pregeneral election deadline for submitting an application to change from mini to full reporting options. Current deadline: Thirty business days for the election. New deadline: August 31.

Citation of Existing Rules Affected by this Order: Amending WAC 390-16-105 and 390-16-125.

Statutory Authority for Adoption: RCW 42.17A.110(8).

Adopted under notice filed as WSR 14-08-022 on March 21, 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 2, Repealed 0.

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

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

Date Adopted: May 22, 2014.

Lori Anderson
Communications and
Training Officer

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

WAC 390-16-105 Mini campaign reporting—Eligibility. (1) A candidate or candidate's authorized committee, as those terms are defined in RCW 42.17A.005, ((~~shall not be~~)) is not required to comply with the provisions of RCW 42.17A.225 through 42.17A.240 except as otherwise prescribed in WAC 390-16-038, 390-16-115, and 390-16-125 when both of the following conditions are present:

(a) Neither aggregate contributions nor aggregate expenditures exceed the amount of the candidate's filing fee provided by law plus a sum not to exceed five thousand dollars; and

(b) No contribution or contributions from any person other than the candidate ((~~within such aggregate~~)) exceed five hundred dollars in the aggregate. However, a bona fide political party may pay the candidate's filing fee provided by law without that payment disqualifying that candidate from eligibility under this section.

(2) A political committee, as that term is defined in RCW 42.17A.005, ((~~shall not be~~)) is not required to comply with the provisions of RCW 42.17A.225 through 42.17A.240 except as otherwise prescribed in WAC 390-16-038, 390-16-115, and 390-16-125 when both of the following conditions are present:

(a) Neither aggregate contributions nor aggregate expenditures exceed five thousand dollars; and

(b) No contribution or contributions from any person exceed five hundred dollars in the aggregate.

(3) A continuing political committee, as that term is defined in RCW 42.17A.005, ((~~shall not be~~)) is not required to comply with the provisions of RCW 42.17A.225 through 42.17A.240 except as otherwise prescribed in WAC 390-16-038, 390-16-115, and 390-16-125 when both of the following conditions are present:

(a) Neither aggregate contributions nor aggregate expenditures during a calendar year exceed five thousand dollars; and

(b) No contribution or contributions from any person exceed five hundred dollars in the aggregate.

(4) A candidate or political committee that exceeds one or both of the thresholds set out in this section after registering as a mini reporting campaign shall comply with the provisions of chapter 42.17A RCW, including, but not limited to, disclosure of contributions and expenditures, disclosure of last minute contributions, applicable contribution limits, false political advertising, sponsor identification and public inspection of campaign books of account.

(5) Candidates and political committees eligible for mini campaign reporting are required to comply with all applicable provisions of chapter 42.17A RCW including, but not limited to, false political advertising, sponsor identification and public inspection of campaign books of account unless specifically exempted under subsections (1) through (3) of this section.

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

WAC 390-16-125 Mini campaign reporting—Exceeding limitations. (1) A candidate or political committee ((~~shall~~)) wishing to change from mini to full reporting must apply in writing to the commission for authorization to change reporting options before the limitations specified in WAC 390-16-105 are exceeded. A complete application shall include all of the following documents:

(a) An amended registration statement (Form C-1 for candidates, Form C-1pc for political committees) selecting the full reporting option as provided in RCW 42.17A.225 through 42.17A.240;

(b) PDC forms C-3 and C-4 with relevant schedules and attachments disclosing all contributions and expenditures to date reportable under RCW 42.17A.240 for the election campaign, or in the case of continuing political committees, for the calendar year; and

(c)(i) If the applicant is a candidate, a statement affirming that all candidates registered with the commission for the office being sought have been notified personally in writing of the application, and the manner and date of such notification;

(ii) If the applicant is the treasurer of a political committee supporting or opposing a ballot proposition, a statement affirming that all treasurers of all political committees registered with the commission as supporting or opposing the proposition have been notified personally in writing of the application, and the manner and date of such notification; or

(iii) If the applicant is the treasurer of a county or legislative district party committee, a statement affirming that the treasurer of that party committee's counterpart in any other major political party has been notified personally in writing of the application, and the manner and date of such notification.

(2) An application that is submitted without the required documents described in subsection (1) of this section is incomplete and will not be processed or approved. If the applicant provides the missing documents, the application will be determined to be complete on the date the documents are ((~~postmarked or delivered to~~)) received by the commission.

(3) If a complete application is ((~~postmarked or delivered to~~)) received by the commission on or before thirty business days prior to the date of ((~~the~~)) an election other than the general election, the executive director will approve the application ((~~shall be approved by the executive director~~)). An application to change reporting options before the general election must be received by the commission on or before August 31.

(4) If a complete application is ((~~postmarked or delivered to~~)) received by the commission on or after ((~~twenty-nine business days prior to the election~~)) the deadlines set out in subsection (3) of this section, the executive director will approve the application ((~~shall be approved by the executive director~~)) only if one or more of the following factors are present:

(a) The applicant's campaign had its respective C-1 or C-1pc on file with the commission ((~~forty-one or more days before the election~~)) when notice of the upcoming application deadline to change reporting options was sent and the commission staff did not send to the applicant's campaign in a timely and proper manner, either electronically or by other mail delivery service, a notice that the ((~~thirtieth business day~~)) deadline for unrestricted changes in reporting options is approaching. To be timely and proper, this notice must be sent at least ((~~forty business days~~)) two weeks before the ((~~election~~)) application deadline to the campaign's electronic mail address or postal service mailing address specified on the registration statement;

(b) The applicant is a candidate and, ((~~within thirty business days of the election~~)) after the application deadline, a write-in opponent has filed for office in accordance with chapter 29A.24 RCW;

(c) ((~~Within thirty business days of the election~~)) After the application deadline, an independent expenditure as defined in RCW 42.17A.005 is made in support of the applicant's opponent or in opposition to the applicant; or

(d) When a candidate or political committee on one side of an election campaign or proposition has been approved to change reporting options under this section, each opponent of that candidate or political committee is approved to change options as of the date that ((~~opponent postmarks or delivers a~~)) opponent's complete application ((~~is~~)) is received by the commission.

(5) Exceeding the aggregate contributions or aggregate expenditures specified in WAC 390-16-105 without complying with the provisions of this section ((~~shall~~)) constitutes one or more violations of chapter 42.17A RCW or 390-17 WAC.

(6) The executive director may approve an application to change reporting options after the aggregate contributions or aggregate expenditures specified in WAC 390-16-105 have been exceeded only if the applicant (a) meets the deadlines provided in subsection (3) of this section; and (b) acknowledges the violation and demonstrates compliance with WAC 390-16-105(4). Approval of an application under this subsection does not absolve a candidate or political committee from liability for any violation or violations of subsection (5) of this section.

WSR 14-12-012
PERMANENT RULES
PUBLIC DISCLOSURE COMMISSION

[Filed May 22, 2014, 4:57 p.m., effective June 22, 2014]

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

Purpose: Converting PDC Interpretation 07-01, Computing Thresholds for Independent Expenditures (adopted March 22, 2007) to rule.

Rule amendments provide guidance to filers by explaining how to prorate and attribute independent expenditures supporting or opposing more than one candidate or ballot measure for the purposes of determining when disclosure is required and whether special sponsor identification is required for independent expenditure political advertising.

Citation of Existing Rules Affected by this Order: WAC 390-16-063.

Statutory Authority for Adoption: RCW 42.17A.110(1).

Adopted under notice filed as WSR 14-08-015 on March 21, 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 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: May 22, 2014.

Lori Anderson
Communications and
Training Officer

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

WAC 390-16-063 Additional information regarding independent expenditures and C-6 report filing. (1) RCW 42.17A.255 requires a person not otherwise subject to the disclosure requirements of Chapter 42.17A RCW to disclose an independent expenditure of one hundred dollars or more that supports or opposes a candidate or ballot measure. RCW 42.17A.260 requires the disclosure of political advertising with a fair market value of one thousand dollars or more that is presented to the public within twenty-one days of an election, that supports or opposes a candidate or ballot measure, and that qualifies as an independent expenditure.

(a) **Prorating and attributing independent expenditures that support or oppose multiple candidates or ballot measures.** Whether to disclose an independent expenditure that supports or opposes multiple candidates or ballot measures is determined by prorating and attributing the cost of the expenditure among all candidates or ballot measures that are the subject of the expenditure. Disclosure is required when:

(i) The pro rata cost for a single candidate or ballot measure reaches or exceeds the statutory threshold and none of the subject candidates are seeking election to the same office and none of the subject ballot measures are competing measures; or

(ii) The sum of the pro rata costs attributable to all candidates seeking election to the same office or the sum of the pro rata costs attributable to competing ballot measures reaches or exceeds the statutory threshold.

Example 1 (prorating): A mailer/postcard supports one candidate and one ballot measure at a total cost of $3,200. One side of the postcard is entirely devoted to the ballot measure. The other side is split evenly between the candidate and the ballot measure. The ballot measure's pro rata share is $2,400 (75%) and the candidate's pro rata share is $800 (25%).

Example 2 (prorating and attributing): An independent expenditure ad appears in the newspaper two weeks before the election. The ad costs $1,000; 50% of the ad supports a candidate and the other 50% opposes the candidate's opponent. The independent expenditure is disclosed under RCW 42.17A.260 because the sum of the pro rata share for the two candidates who seek the same office is $1,000.

(b) **Disclosing independent expenditures that support or oppose multiple candidates or ballot measures.** When a pro rata, attributable cost reaches or exceeds the statutory threshold, the entire independent expenditure must be disclosed. Include the amounts attributable to all candidates and ballot propositions supported or opposed by the expenditure.

(c) **Other applications of prorating and attributing independent expenditures.** Use the prorating and attribution steps explained in (a)(i) and (ii) of this section to determine when an independent expenditure as defined in RCW 42.17A.005(26) must comply with the "no candidate authorized this ad" sponsor identification and, if applicable, the "top 5" contributors required by RCW 42.17A.320(2) and WAC 390-18-010.

(2) A political committee reporting pursuant to RCW 42.17A.225, 42.17A.235 and 42.17A.240 is exempt from providing on a C-6 form itemized information concerning its sources of funds giving in excess of two hundred fifty dollars for an electioneering communication, unless the committee received funds that were requested or designated for the communication.

((~~(2)~~)) (3) An out-of-state political committee shall report pursuant to RCW 42.17A.305 if it sponsors an electioneering communication defined in RCW 42.17A.005.

((~~(3)~~)) (4) The sponsor of an electioneering communication shall report pursuant to RCW 42.17A.305 and commission rules regarding electioneering communications, even if the expenditure also satisfies the definition of independent expenditure in RCW 42.17A.005 or 42.17A.255. Persons in compliance with this subsection are deemed in compliance with RCW 42.17A.255 or 42.17A.260.

((~~(4)~~)) (5) Any person making an expenditure that is reportable under RCW 42.17A.640, grass roots lobbying campaigns, that also satisfies the definition of electioneering communication in RCW 42.17A.005 shall file pursuant to RCW 42.17A.305 and commission rules regarding electioneering communications.

WSR 14-12-013
PERMANENT RULES
PUBLIC DISCLOSURE COMMISSION
[Filed May 22, 2014, 5:07 p.m., effective June 22, 2014]

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

Purpose: Converting PDC Interpretation 04-01, Contribution Limits: Impact When a Candidate Subject to Limit Does Not Have a Primary Election (adopted 2/242/04 [February 24, 2004]) to rule.

New rule clarifies that only candidates who appear on the primary election ballot or as write-in candidates in the primary election may receive primary election contributions under the limits imposed by RCW 42.17A.405 and 42.17A.-

410. The rule informs candidates how refunds are to be made when contributions are received that a candidate is not eligible to receive.

Statutory Authority for Adoption: RCW 42.17A.110(1).

Adopted under notice filed as WSR 14-08-021 on March 21, 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 1, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0 [1], Amended 1 [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 22, 2014.

Lori Anderson
Communications and
Training Officer

NEW SECTION

WAC 390-17-301 Eligibility to receive primary election contributions. (1) Candidates for state and certain local offices are subject to the contribution limits in RCW 42.17A.405. Judicial candidates are subject to the contribution limits in RCW 42.17A.410. Only candidates who appear on the primary election ballot or as write-in candidates in the primary election may receive primary election contributions.

(2) Once the appropriate elections official determines that no primary election for a particular office will be held, a declared candidate for that office must refund any contributions received in excess of the general election contribution limit. The candidate or the candidate's authorized committee must make the refunds within two weeks of the election's official's determination, and must disclose the refunds on the appropriate report.

(3) Failure by a candidate or a candidate's authorized committee to make refunds as required by subsection (2) of this section is a violation of RCW 42.17A.405 or 42.17A.410 by the candidate, but not by the contributors who made primary election contributions before a determination was made that no primary election would be held.

(4) WAC 390-17-303 sets out additional eligibility criteria for superior court candidates.

WSR 14-12-018
PERMANENT RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed May 23, 2014, 1:12 p.m., effective June 23, 2014]

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

Purpose: Amends WAC 181-78A-100 on the requirements for the site team chair for review of preparation programs. Current requirements are for a professional educator standards board staff person. Change would require the team chair to have completed specific training.

Citation of Existing Rules Affected by this Order: Amending WAC 181-78A-100.

Statutory Authority for Adoption: RCW 28A.410.210.

Adopted under notice filed as WSR 14-08-028 on March 24, 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: May 15, 2014.

David Brenna
Senior Policy Analyst

AMENDATORY SECTION (Amending WSR 13-20-028, filed 9/23/13, effective 10/24/13)

WAC 181-78A-100 Existing approved programs. Chapter 181-78A WAC rules shall govern all policies related to programs upon adoption by the professional educator standards board, which shall provide assistance to programs in the revision of their existing programs.

(1) The professional educator standards board shall determine the schedule for such approval reviews and whether an on-site visit or other forms of documentation and validation shall be used for the purposes of granting approval under program approval standards. In determining the schedule for site visits, the board shall take into consideration the partnership agreement between the state and national accreditation organizations as such agreement relates to the accreditation cycle and allow CAEP accredited ((~~colleges/universities~~)) programs to follow the CAEP schedule for their review. Non-CAEP accredited ((~~colleges/universities~~)) programs shall have a review every five years. The professional educa-

tor standards board may require more frequent site visits at their discretion pursuant to WAC 181-78A-110(2). The professional educator standards board will not consider requests for site visit delays.

(2) Each institution shall submit its program for review when requested by the professional educator standards board to ensure that the program meets the state's program approval standards as follows:

(a) At least six months prior to a scheduled on-site visit, the institution shall submit an institutional report that provides evidence and narrative, as needed, that addresses how the program approval standards are met for each preparation program undergoing review. Evidence shall include such data and information from the annual data submissions required per WAC 181-78A-255(2) as have been designated by the professional educator standards board as evidence pertinent to the program approval process.

(b) The institutional report shall be reviewed by a team whose membership is composed of:

(i) One member of the professional educator standards board;

(ii) One peer institution representative;

(iii) One individual with assessment expertise;

(iv) Two K-12 practitioners with expertise related to the programs scheduled for review; and

(v) A ((~~designated professional educator standards board staff member who shall serve as team leader~~)) site team chair who has completed state site chair training.

(c) Substitutions, drawn from (b)(i) through (iv) of this subsection, may be assigned when individuals are not available. Additions to the team shall be drawn from (b)(i) through (iv) of this subsection when necessary. The professional educator standards board liaison for that institution may be present, but shall not serve in an evaluative role. All members, including substitutes, shall be trained.

(d) Team membership may be reduced for regular continuing visits in which fewer than five standards are being reviewed, initial visits, and focus visits. At a minimum, the team must consist of two members of which one must be a member of the professional educator standards board.

(e) Members of a focus visit team shall, at a minimum, be comprised of one member who served on the on-site team and one member of the professional educator standards board.

(f) The review of the off-site team shall identify additional evidence and clarifications that may be needed to provide adequate support for the institutional report.

(g) The report of the off-site team shall be submitted to the institution, which shall provide an addendum to the institutional report no later than five weeks preceding the on-site review.

(h) The on-site visit shall be conducted in compliance with the protocol and process adopted and published by the professional educator standards board. The team shall be comprised of members of the off-site review team whenever possible.

(i) The final site visit report and other appropriate documentation will be submitted to the professional educator standards board.

(j) Institutions may submit a reply to the report within two weeks following receipt of the report. The reply may address issues for consideration, including a request for appeal per this subsection (g), limited to evidence that the review disregarded state standards, failed to follow state procedures for review, or failed to consider evidence that was available at the time of the review.

(k) In considering the report, the professional educator standards board may grant approval according to WAC 181-78A-110 and 181-78A-100(1).

(l) Institutions may request a hearing in instances where it disagrees with the professional educator standards board's decision. The hearing will be conducted through the office of administrative hearings by an administrative law judge per chapter 34.05 RCW. The institution seeking a hearing will provide a written request to the professional educator standards board in accordance with WAC 10-08-035.

(3) Institutions seeking Council for the Accreditation of Educator Preparation, Council for Accreditation of Counseling and Related Education Programs, and National Association of School Psychologist accreditation may request from the professional educator standards board approval for concurrent site visits which would utilize the same documentation with the exception of material submitted by the institution to the state for the professional education advisory boards and the accountability standards.

WSR 14-12-024
PERMANENT RULES
CLARK COLLEGE

[Filed May 27, 2014, 11:43 a.m., effective July 7, 2014]

Effective Date of Rule: July 7, 2014.

Purpose: To bring the code of student conduct into alignment with the federal Violence Against Women Act, reflect online, virtual environments and relevant issues (cyberstalking, cyberbullying and online harassment), and create a consistent process for ensuring due process.

Citation of Existing Rules Affected by this Order: Repealing chapter 132N-121 WAC, Code of student conduct.

Statutory Authority for Adoption: RCW 28B.50.140(3).

Adopted under notice filed as WSR 14-07-121 on March 19, 2014.

Number of Sections Adopted in Order to Comply with Federal Statute: New 4, Amended 1, 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 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 17, 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 25, 2014.

Bob Williamson
Vice-President of
Administrative Services

Chapter 132N-125 WAC

CODE OF STUDENT CONDUCT

NEW SECTION

WAC 132N-125-005 Student responsibilities. (1) Clark College provides its community and students with education and services of the highest quality. We do this in a manner which exhibits concern and sensitivity to students, faculty, staff, and others who utilize our services and facilities. It is essential that members of Clark College exhibit appropriate and conscientious behavior in dealing with others.

(2) Clark College expects all students to conduct themselves in a manner consistent with its high standards of scholarship and conduct. Student conduct, which distracts from or interferes with accomplishment of these purposes, is not acceptable. Students are expected to comply with these standards of conduct for students both on and off campus and acknowledge the college's authority to take disciplinary action.

(3) Admission to Clark College carries with it the presumption that students will conduct themselves as responsible members of the college community. This includes an expectation that students will obey the law, comply with policies, procedures and rules of the college and its departments, maintain a high standard of integrity and honesty, and respect the rights, privileges and property of other members of Clark College.

(4) It is assumed that students are and wish to be treated as adults. As such, students are responsible for their conduct. These standards of conduct for students promote Clark College's educational purposes and provide students a full understanding of their rights and responsibilities. Sanctions for violations of the standards of conduct for students will be administered under this chapter. When violations of laws of the state of Washington and/or the United States are also involved, the college may refer such matters to proper authorities and in the case of minors, this conduct may be referred to parents or legal guardians.

NEW SECTION

WAC 132N-125-010 Authority. The board of trustees, acting pursuant to RCW 28B.50.140(14), delegates to the president of the college the authority to administer disciplinary action. Administration of the disciplinary procedures is the responsibility of the vice-president of student affairs or designee. The student conduct officer shall serve as the principal investigator and administrator for alleged violations of this code.

NEW SECTION

WAC 132N-125-015 Definitions. The following definitions shall apply for the purposes of this student conduct code:

(1) "ASCC" means the associated students of Clark College as defined in the constitution of that body.

(2) "Assembly" means any overt activity engaged in by one or more persons, the object of which is to gain publicity, advocate a view, petition for a cause, or disseminate information to any person, persons, or group of persons.

(3) "Board" means the board of trustees of Community College District No. 14, state of Washington.

(4) "College" means Clark College and any other community college centers or facilities established within Washington state Community College District No. 14.

(5) "College community" means trustees, students, staff, faculty, and visitors on college-owned or controlled facilities.

(6) "College facilities" and "college facility" means and includes any and all real and personal property owned, rented, leased, or operated by the board of trustees of Washington state Community College District No. 14, and shall include all buildings and appurtenances attached thereto and all parking lots and other grounds. College facilities extend to distance education classroom environments, and agencies or institutions that have educational agreement with the college.

(7) "College official" includes any person employed by the college performing assigned duties.

(8) "College premises" shall include all campuses of the college, wherever located, and includes all land, buildings, facilities, vehicles, equipment, and other property owned, used, or controlled by the college.

(9) "Complainant" means any person who submits a charge alleging that a student violated the code of student conduct.

(10) "Conduct review officer" is the vice-president of student affairs or other college administrator designated by the president to be responsible for receiving and for reviewing or referring appeals of student disciplinary actions in accordance with the procedures of this code. The president is authorized to reassign any and all of the conduct review officer's duties or responsibilities as set forth in this chapter as may be reasonably necessary.

(11) "Controlled substance" means and includes any drug or substance as defined in chapter 69.50 RCW as now law or hereafter amended.

(12) "Day" means a weekday, excluding weekends and college holidays.

(13) "Disciplinary action" is the process by which the student conduct officer imposes discipline against a student for a violation of the student conduct code.

(14) "Disciplinary appeal" is the process by which an aggrieved student can appeal the discipline imposed by the student conduct officer. Disciplinary appeals from a suspension in excess of ten days or an expulsion are heard by the student conduct committee. Appeals of all other appealable disciplinary action shall be reviewed through brief adjudicative proceedings.

(15) "Faculty member" and "instructor" means any employee of Community College District No. 14 who is

employed on a full-time or part-time basis as a teacher, instructor, counselor, or librarian.

(16) "Filing" is the process by which a document is officially delivered to a college official responsible for facilitating a disciplinary review. Unless otherwise provided, filing shall be accomplished by:

(a) Hand delivery of the document to the specified college official or college official's assistant; or

(b) By sending the document by e-mail and first class mail to the specified college official's office and college e-mail address.

Papers required to be filed shall be deemed filed upon actual receipt during office hours at the office of the specified college official.

(17) "The president" is the president of the college. The president is authorized to delegate any and all of his or her responsibilities as set forth in the chapter as may be reasonably necessary.

(18) "RCW" means Revised Code of Washington which can be accessed at http://apps.leg.wa.gov/rcw/.

(19) "Respondent" is the student against whom disciplinary action is initiated.

(20) "Service" is the process by which a document is officially delivered to a party. Unless otherwise provided, service upon a party shall be accomplished by:

(a) Hand delivery of the document to the party; or

(b) By sending the document by e-mail and by certified mail or first class mail to the party's last known address. It is the responsibility of each student to regularly check their official Clark College e-mail address.

Service is deemed complete upon hand delivery of the document or upon the date the document is e-mailed and deposited in the mail.

(21) "Student" includes all persons taking courses at or through the college, whether on a full-time or part-time basis, and whether such courses are credit courses, noncredit courses, online courses, or otherwise. Persons who have been notified of their acceptance for admission, persons who withdraw after allegedly violating the code, or persons who are not officially enrolled for a particular term but who have a continuing relationship with the college, are considered "students."

(22) "Student conduct officer" is a college administrator designated by the president or vice-president of student affairs to be responsible for implementing and enforcing the student conduct code. The president or vice-president of student affairs is authorized to reassign any and all of the student conduct officer's duties or responsibilities as set forth in this chapter as may be reasonably necessary.

(23) "Student organization" means any number of students who have met the formal requirements of clubs and organizations.

NEW SECTION

WAC 132N-125-020 Statement of jurisdiction. The student conduct code shall apply to student conduct that occurs on college premises, to conduct that occurs at or in connection with college-sponsored activities, or to off-campus conduct that in the judgment of the college adversely affects the college community or the pursuit of its objectives. Jurisdiction extends to, but is not limited to, locations in which students are engaged in official college activities including, but not limited to, foreign or domestic travel, activities funded by the associated students, athletic events, training internships, cooperative and distance education, online education, practicums, supervised work experiences or any other college-sanctioned social or club activities. Students are responsible for their conduct from the time of application for admission through the actual receipt of a degree, even though conduct may occur before classes begin or after classes end, as well as during the academic year and during periods between terms of actual enrollment. These standards shall apply to a student's conduct even if the student withdraws from college while a disciplinary matter is pending.

NEW SECTION

WAC 132N-125-025 Students studying abroad. Students who participate in any college-sponsored or sanctioned international study program shall observe the following:

(1) The laws of the host country;

(2) The academic and disciplinary regulations of the educational institution or residential housing program where the student is studying;

(3) Any other agreements related to the student's study program in another country; and

(4) Clark College's standards of conduct for students.

NEW SECTION

WAC 132N-125-030 Statement of student rights. As members of the academic community, students are encouraged to develop the capacity for critical judgment and to engage in an independent search for truth. Freedom to teach and freedom to learn are inseparable facets of academic freedom. The freedom to learn depends upon appropriate opportunities and conditions in the classroom, on the campus, and in the larger community. Students should exercise their freedom with responsibility. The responsibility to secure and to respect general conditions conducive to the freedom to learn is shared by all members of the college community.

The following enumerated rights are guaranteed to each student within the limitations of statutory law and college policy which are deemed necessary to achieve the educational goals of the college:

(1) **Academic freedom.**

(a) Students are guaranteed the rights of free inquiry, expression, and assembly upon and within college facilities that are generally open and available to the public.

(b) Students are free to pursue appropriate educational objectives from among the college's curricula, programs, and services, subject to the limitations of RCW 28B.50.090 (3)(b).

(c) Students shall be protected from academic evaluation which is arbitrary, prejudiced, or capricious, but are responsible for meeting the standards of academic performance established by each of their instructors.

(d) Students have the right to a learning environment which is free from unlawful discrimination, inappropriate

and disrespectful conduct, and any and all harassment, including sexual harassment.

(2) **Due process.**

(a) The rights of students to be secure in their persons, quarters, papers, and effects against unreasonable searches and seizures is guaranteed.

(b) No disciplinary sanction may be imposed on any student without notice to the accused of the nature of the charges.

(c) A student accused of violating this code of student conduct is entitled, upon request, to procedural due process as set forth in this chapter.

NEW SECTION

WAC 132N-125-035 Prohibited student conduct. The college may impose disciplinary sanctions against a student who commits, or aids, abets, incites, encourages or assists another person to commit, an act(s) of misconduct which include, but are not limited to, the following:

(1) **Academic dishonesty.** Any act of academic dishonesty including, but not limited to, cheating, plagiarism, and fabrication.

(a) Cheating includes using or any attempt to use, give or obtain unauthorized assistance relating to the completion of an academic assignment.

(b) Plagiarism includes taking and using as one's own, without proper attribution, the ideas, writings, or work of another person in completing an academic assignment.

(c) Self-plagiarism may also include the unauthorized submission for credit of academic work that has been submitted for credit in another course.

(d) Fabrication includes falsifying data, information, or citations in completing an academic assignment and also includes providing false or deceptive information to an instructor concerning the completion of an assignment.

(e) No student shall be allowed to withdraw from a course or from the college to avoid the consequences of academic dishonesty.

(2) **Other dishonesty.** Any other acts of dishonesty, such acts include, but are not limited to:

(a) Forgery, alteration, submission of falsified documents or misuse of any college document, record, or instrument of identification;

(b) Tampering with an election conducted by or for college students; or

(c) Furnishing false information, or failing to furnish correct information, in response to the request or requirement of a college officer or employee.

(3) **Obstruction or disruption.** Obstruction or disruption of:

(a) Any instruction, research, administration, disciplinary proceeding, or other college activity, including the obstruction of the free flow of pedestrian or vehicular movement on college property or at a college activity; or

(b) Any activity that is authorized to occur on college property, whether or not actually conducted or sponsored by the college. Participation in any activity which unreasonably disrupts the operations of the college or infringes on the rights of another member of the college community, or leads or incites another person to engage in such an activity.

(4) Assault, physical abuse, verbal abuse, threat(s), intimidation, harassment, bullying, stalking or other conduct which harms, threatens, or is reasonably perceived as threatening the health or safety of another person or another person's property. For purposes of this subsection:

(a) Bullying is physical or verbal abuse, repeated over time, and involving a power imbalance between the aggressor and victim.

(b) Stalking is intentional and repeated following of another person, which places that person in reasonable fear that the perpetrator intends to injure, intimidate, or harass that person. Stalking also includes instances where the perpetrator knows or reasonably should know that the person is frightened, intimidated, or harassed, even if the perpetrator lacks such an intent.

(5) **Cyber misconduct.** Cyberstalking, cyberbullying, or online harassment. Use of electronic communications including, but not limited to, electronic mail, instant messaging, electronic bulletin boards, and social media sites to harass, abuse, bully, or engage in other conduct which harms, threatens, or is reasonably perceived as threatening the health or safety of another person. Prohibited activities include, but are not limited to, unauthorized monitoring of another's e-mail communications directly or through spyware, sending threatening e-mails, disrupting electronic communications with spam or by sending a computer virus, sending false messages to third parties using another's e-mail identity, nonconsensual recording of sexual activity, and nonconsensual distribution of a recording of sexual activity.

(6) **Property violation.** Attempted or actual damage to, or theft or misuse of, real or personal property or money of:

(a) The college or state;

(b) Any student or college officer, employee, or organization;

(c) Any other member of the college community or organization; or

(d) Possession of such property or money after it has been stolen.

(7) **Failure to comply with directive.** Failure to comply with the direction of a college officer or employee who is acting in the legitimate performance of his or her duties, including failure to properly identify oneself to such a person when requested to do so.

(8) **Weapons.** Possession or use of firearms, explosives, dangerous chemicals, or other dangerous weapons, which can be used to inflict bodily harm or to damage real or personal property is prohibited on the college campus, at any other facilities leased or operated by the college, or at any activity under the administration or sponsorship of the college. Exceptions to this policy are permitted when the weapon is used in conjunction with an approved college instructional program, is carried by duly constituted law enforcement officer, or is otherwise permitted by law.

(9) **Hazing.** Hazing includes, but is not limited to, any initiation into a student organization or any pastime or amusement engaged in with respect to such an organization that causes, or is likely to cause, bodily danger or physical harm, or serious mental or emotional harm to any student.

(10) **Alcohol, drug, and tobacco violations.**

(a) **Alcohol.** The use, possession, delivery, sale, or being visibly under the influence of any alcoholic beverage, except as permitted by law and applicable college policies.

(b) **Marijuana.** The use, possession, delivery, sale, or being visibly under the influence of marijuana or the psychoactive compounds found in marijuana and intended for human consumption, regardless of form. While state law permits the recreational use of marijuana, federal law prohibits such use on college premises or in connection with college activities.

(c) **Drugs.** The use, possession, delivery, sale, or being under the influence of any legend drug, including anabolic steroids, androgens, or human growth hormones as defined in chapter 69.41 RCW, or any other controlled substance under chapter 69.50 RCW, except as prescribed for a student's use by a licensed practitioner.

(d) **Tobacco, electronic cigarettes, and related products.** Consistent with its efforts to promote wellness, fitness, and a campus environment conducive to work, study, and activities for staff, students, and the public, Clark College maintains a tobacco-free campus. The use of tobacco, electronic cigarettes, and related products in any building owned, leased, or operated by the college or in any location is prohibited. "Related products" include, but are not limited to, cigarettes, pipes, bidi, clove cigarettes, waterpipes, hookahs, chewing tobacco, and snuff.

(11) **Lewd conduct.** Conduct which is obscene, lewd, or indecent.

(12) **Disorderly conduct.** Conduct which disrupts campus operations or the educational environment, is disturbing the peace, or assisting or encouraging another person to disturb the peace.

(13) **Discriminatory conduct.** Discriminatory conduct which harms or adversely affects any member of the college community because of her/his race; color; national origin; sensory, mental or physical disability; use of a service animal; gender, including pregnancy; marital status; age (40+); religion; creed; genetic information; sexual orientation; gender identity; veteran's status; or any other legally protected classification. Such finding is considered an aggravating factor in determining a sanction for such conduct.

(14) **Sexual misconduct.** The term "sexual misconduct" includes sexual harassment, sexual intimidation, and sexual violence.

(a) **Sexual harassment.** The term "sexual harassment" means unwelcome conduct of a sexual nature, including unwelcome sexual advances, requests for sexual favors, and other verbal, nonverbal, or physical conduct of a sexual nature that is sufficiently serious as to deny or limit, and that does deny or limit, based on sex, the ability of a student to participate in or benefit from the college's educational program or that creates an intimidating, hostile, or offensive environment for other campus community members.

(b) **Sexual intimidation.** The term "sexual intimidation" incorporates the definition of "sexual harassment" and means threatening or emotionally distressing conduct based on sex including, but not limited to, nonconsensual recording of sexual activity or the distribution of such recording.

(c) **Sexual violence.** The term "sexual violence" incorporates the definition of "sexual harassment" and means a physical sexual act perpetrated without clear, knowing, and voluntary consent, such as committing a sexual act against a person's will, exceeding the scope of consent, or where the person is incapable of giving consent including rape, sexual assault, sexual battery, sexual coercion, sexual exploitation, gender- or sex-based stalking. The term further includes acts of dating or domestic violence. A person may be incapable of giving consent by reason of age, threat or intimidation, lack of opportunity to object, disability, drug or alcohol consumption, or other cause.

(15) **Harassment.** Unwelcome and offensive conduct including verbal, nonverbal, or physical conduct, that is directed at a person because of such person's protected status and that is sufficiently serious as to deny or limit, and that does deny or limit, the ability of a student to participate in or benefit from the college's educational program or that creates an intimidating, hostile, or offensive environment for other campus community members. Protected status includes a person's race; color; national origin; sensory, mental or physical disability; use of a service animal; gender, including pregnancy; marital status; age (40+); religion; creed; genetic information; sexual orientation; gender identity; veteran's status; or any other legally protected classification. See "Sexual misconduct" for the definition of "sexual harassment." Harassing conduct may include, but is not limited to, physical conduct, verbal, written, social media, and electronic communications.

(16) **Retaliation.** Retaliation, intimidation, threats, or coercion against anyone who asserts a right protected by federal, state, or local law, or college policies including, but not limited to, student conduct code provisions prohibiting discrimination and harassment, or who cooperates in an investigation.

(17) **Theft or misuse of electronic resources.** Theft or other misuse of computer time or other electronic information resources of the college. Such misuse includes, but is not limited to:

(a) Unauthorized use of such resources or opening of a file, message, or other item;

(b) Unauthorized duplication, transfer, or distribution of a computer program, file, message, or other item;

(c) Unauthorized use or distribution of someone else's password or other identification;

(d) Use of such time or resources to interfere with someone else's work;

(e) Use of such time or resources to send, display, or print an obscene or abusive message, text, or image;

(f) Use of such time or resources to interfere with normal operation of the college's computing system or other electronic information resources;

(g) Use of such time or resources in violation of applicable copyright or other law;

(h) Adding to or otherwise altering the infrastructure of the college's electronic information resources without authorization; or

(i) Failure to comply with the student computing resources policy. http://www.clark.edu/student_services/computing_resources/policy.php

(18) **Unauthorized access.** Unauthorized possession, duplication, or other use of a key, keycard, or other restricted means of access to college property, or unauthorized entry onto or into college property.

(19) **Safety violations.** Safety violations include any nonaccidental conduct that interferes with or otherwise compromises any college policy, equipment, or procedure relating to the safety and security of the campus community, including tampering with fire safety equipment and triggering false alarms or other emergency response systems.

(20) **Abuse or misuse of any procedures.** Abuse or misuse of any of the procedures relating to student complaints or misconduct including, but not limited to:

(a) Failure to obey a subpoena;

(b) Falsification or misrepresentation of information;

(c) Disruption or interference with the orderly conduct of a proceeding.

(d) Interfering with someone else's proper participation in a proceeding;

(e) Destroying or altering potential evidence or attempting to intimidate or otherwise improperly pressure a witness or potential witness;

(f) Attempting to influence the impartiality of, or harassing or intimidating, a student conduct committee member; or

(g) Failure to comply with any disciplinary sanction(s) imposed under this student conduct code.

(21) **Motor vehicles.** Operation of any motor vehicle on college property in an unsafe manner or in a manner which is reasonably perceived as threatening the health or safety of another person.

(22) **Violation of other laws or policies.** Violation of any federal, state, or local law, rule, or regulation or other college rules or policies, including college traffic and parking rules.

(23) **Ethical violation.** The breach of any generally recognized and published code of ethics or standards of professional practice that governs the conduct of a particular profession for which the student is taking a course or is pursuing as an educational goal or major.

In addition to initiating discipline proceedings for violation of the student conduct code, the college may refer any violations of federal, state, or local laws to civil and criminal authorities for disposition. The college shall proceed with student disciplinary proceedings regardless of whether the underlying conduct is subject to civil or criminal prosecution.

NEW SECTION

WAC 132N-125-040 Trespass. The vice-president of student affairs or designee shall have the authority and power to:

(1) Prohibit the entry, or withdraw the license or privilege of any person or group of persons to enter onto or remain on any college premises or facility; or

(2) Give notice against trespass by any manner provided by law, to any person, persons, or group of persons against whom the license or privilege has been withdrawn or who have been prohibited from entering onto or remaining upon all or any portion of college premises or a college facility; or

(3) Order any person, persons, or group of persons to leave or vacate all or any portion of the college premises or facility. Such power and authority may be exercised to halt any event which is deemed to be unreasonably disruptive of order or impedes the movement of persons or vehicles or which disrupts or threatens to disrupt the ingress and/or egress of persons from facilities owned and/or operated by the college. Any individual remaining on or reentering the college premises or facility after receiving notice that his or her license or privilege to be on that property has been revoked shall be subject to disciplinary action and/or charges of criminal trespass.

NEW SECTION

WAC 132N-125-045 Disciplinary sanctions—Terms—Conditions. The following disciplinary sanctions may be imposed upon students found to have violated the student conduct code. Depending upon the misconduct, more than one sanction may be required. Other than college expulsion or revocation or withholding of a degree, disciplinary sanctions are not made part of the student's academic record, but are part of the student's disciplinary record. Violation of any term or condition of any disciplinary sanction constitutes a new violation and may subject the student to additional sanctions.

(1) **Disciplinary warning.** A verbal statement to a student that there is a violation and that continued violation may be cause for further disciplinary action.

(2) **Written reprimand.** Notice in writing that the student has violated one or more terms of this code of conduct and that continuation of the same or similar behavior may result in more severe disciplinary action.

(3) **Disciplinary probation.** Formal action placing specific conditions and restrictions upon the student's continued attendance depending upon the seriousness of the violation and which may include a deferred disciplinary sanction. If the student subject to a deferred disciplinary sanction is found in violation of any college rule during the time of disciplinary probation, the deferred disciplinary sanction, which may include, but is not limited to, a suspension or a dismissal from the college, shall take effect immediately without further review. Any such sanction shall be in addition to any sanction or conditions arising from the new violation. Probation may be for a limited period of time or may be for the duration of the student's attendance at the college.

(4) **Disciplinary suspension.** Dismissal from the college and from the student status for a stated period of time. There will be no refund of tuition or fees for the quarter in which the action is taken.

(5) **Dismissal.** The revocation of all rights and privileges of membership in the college community and exclusion from the campus and college-owned or controlled facilities without any possibility of return. There will be no refund of tuition or fees for the quarter in which the action is taken.

(6) Disciplinary terms and conditions that may be imposed in conjunction with the imposition of a disciplinary sanction include, but are not limited to, the following:

(a) Educational sanction. The college may require the student to complete an educational activity or experience

directly related to the violation committed, at the student's expense.

(b) Professional evaluation. Referral for drug, alcohol, psychological, or medical evaluation by an appropriately certified or licensed professional may be required. The student may choose the professional within the scope of practice and with the professional credentials as defined by the college. The student will sign all necessary releases to allow the college access to any such evaluation. The student's return to college may be conditioned upon compliance with recommendations set forth in such a professional evaluation. If the evaluation indicates that the student is not capable of functioning within the college community, the student will remain suspended until future evaluation recommends that the student is capable of reentering the college and complying with the rules of conduct.

(c) Not in good standing. A student may be deemed "not in good standing" with the college. If so, the student shall be subject to the following restrictions:

(i) Ineligible to hold an office in any student organization recognized by the college or to hold any elected or appointed office of the college.

(ii) Ineligible to represent the college to anyone outside the college community in any way, including representing the college at any official function, or any forms of intercollegiate competition or representation.

(d) Restitution or monetary fine. Reimbursement for damage to or misappropriation of property, or for injury to persons, or for reasonable costs incurred by the college in pursuing an investigation or disciplinary proceeding. This may take the form of monetary reimbursement, appropriate service, monetary fine, or other compensation.

(e) Hold on transcript or registration. This is a temporary measure restricting release of a student's transcript or access to registration. Upon satisfactory completion of the conditions of the sanction, the hold is released.

(f) Revocation of admission or degree. Admission to or a degree awarded from the college may be revoked for fraud, misrepresentation, or other violation of standards of conduct for students in obtaining the degree, or for other serious violations committed by a student prior to graduation.

(g) Withholding degree. The college may withhold awarding a degree otherwise earned until the completion of the process set forth in this chapter, including the completion of all sanctions imposed.

(h) No trespass order. A student may be restricted from college property based on his/her misconduct.

(i) No contact order. A prohibition of direct or indirect physical, verbal, or written contact (to include electronic) with another individual or group.

HEARING PROCEDURES

NEW SECTION

WAC 132N-125-100 Initiation of disciplinary action. (1) All disciplinary actions will be initiated by the student conduct officer. If that officer is the subject of a complaint initiated by the respondent, the president shall, upon request and when feasible, designate another person to fulfill any such disciplinary responsibilities relative to the complainant.

(2) The student conduct officer shall initiate disciplinary action by serving the respondent with written notice directing him or her to attend a disciplinary meeting. The notice shall briefly describe the factual allegations, the provision(s) of the conduct code the respondent is alleged to have violated, the range of possible sanctions for the alleged violation(s), and specify the time and location of the meeting. At the meeting, the student conduct officer will present the allegations to the respondent and the respondent shall be afforded an opportunity to explain what took place. If the respondent fails to attend the meeting, the student conduct officer may take disciplinary action based upon the available information.

(3) Within ten days of the initial disciplinary meeting and after considering the evidence in the case, including any facts or argument presented by the respondent, the student conduct officer shall serve the respondent with a written decision setting forth the facts and conclusions supporting his or her decision, the specific student conduct code provisions found to have been violated, the discipline imposed, if any, and a notice of any appeal rights with an explanation of the consequences of failing to file a timely appeal.

(4) The student conduct officer may take any of the following disciplinary actions:

(a) Exonerate the respondent and terminate the proceedings.

(b) Impose a disciplinary sanction(s) as described in WAC 132N-125-045.

(c) Refer the matter directly to the student conduct committee for such disciplinary action as the committee deems appropriate. Such referral shall be in writing, to the attention of the chair of the student conduct committee, with a copy served on the respondent.

NEW SECTION

WAC 132N-125-105 Appeal from disciplinary action. (1) The respondent may appeal a disciplinary action by filing a written notice of appeal with the conduct review officer within twenty-one days of the student conduct officer's decision. Failure to timely file a notice of appeal constitutes a waiver of the right to appeal and the student conduct officer's decision shall be deemed final.

(2) The notice of appeal must include a brief statement explaining why the respondent is seeking review.

(3) The parties to an appeal shall be the respondent and the conduct review officer.

(4) A respondent, who timely appeals a disciplinary action or whose case is referred to the student conduct committee, has a right to a prompt, fair, and impartial hearing as provided for in these procedures.

(5) On appeal, the college bears the burden of establishing the evidentiary facts underlying the imposition of a disciplinary sanction by a preponderance of the evidence.

(6) Imposition of disciplinary action for violation of the student conduct code shall be stayed pending appeal, unless respondent has been summarily suspended.

(7) The student conduct committee shall hear appeals from:

(a) The imposition of disciplinary suspensions in excess of ten days;

(b) Dismissals; and

(c) Discipline cases referred to the committee by the student conduct officer, the conduct review officer, or the president.

(8) Student conduct appeals from the imposition of the following disciplinary sanctions shall be reviewed through a brief adjudicative proceeding;

(a) Suspensions of ten days or less;

(b) Disciplinary probation;

(c) Written reprimands; and

(d) Any conditions or terms imposed in conjunction with one of the foregoing disciplinary actions.

(9) Except as provided elsewhere in these rules, disciplinary warnings and dismissals of disciplinary actions are final action and are not subject to appeal.

NEW SECTION

WAC 132N-125-110 Brief adjudicative proceedings—Initial hearing. (1) Brief adjudicative proceedings shall be conducted by a conduct review officer designated by the president. The conduct review officer shall not participate in any case in which he or she is a complainant or witness, or in which they have direct or personal interest, prejudice, or bias, or in which they have acted previously in an advisory capacity.

(2) Before taking action, the conduct review officer shall conduct an informal hearing and provide each party:

(a) An opportunity to be informed of the college's view of the matter; and

(b) An opportunity to explain the party's view of the matter.

(3) The conduct review officer shall serve an initial decision upon both parties within ten days of the appeal. The initial decision shall contain a brief written statement of the reasons for the decision and information about how to seek administrative review of the initial decision. If no request for review is filed within twenty-one days of the initial decision, the initial decision shall be deemed the final decision.

(4) If the conduct review officer, upon review, determines that the respondent's conduct may warrant imposition of a disciplinary suspension of more than ten days or expulsion, the matter shall be referred to the student conduct committee for a disciplinary hearing.

NEW SECTION

WAC 132N-125-115 Brief adjudicative proceedings—Review of an initial decision. (1) An initial decision is subject to review by the president, provided the respondent files a written request for review with the conduct review officer within twenty-one days of the initial decision.

(2) The president shall not participate in any case in which he or she is a complainant or witness, or in which they have direct or personal interest, prejudice, or bias, or in which they have acted previously in an advisory capacity.

(3) During the review, the president shall give each party an opportunity to file written responses explaining their view of the matter and shall make any inquiries necessary to ascertain whether the sanctions should be modified or whether the proceedings should be referred to the student conduct committee for a formal adjudicative hearing.

(4) The decision on review must be in writing and must include a brief statement of the reason for the decision and must be served on the parties within twenty-one days of the initial decision or of the request for review, whichever is later. The decision on review will contain a notice that judicial review may be available. A request for review may be deemed to have been denied if the president does not make a disposition of the matter within twenty-one days after the request is submitted.

(5) If the president, upon review, determines that the respondent's conduct may warrant imposition of a disciplinary suspension of more than ten days or expulsion, the matter shall be referred to the student conduct committee for a disciplinary hearing.

NEW SECTION

WAC 132N-125-120 Student conduct committee. (1) The student conduct committee consists of five members:

(a) Two full-time students appointed by the student government;

(b) Two faculty members appointed by the president;

(c) One administrative staff member, other than an administrator serving as a student conduct or conduct review officer, appointed by the president at the beginning of the academic year.

(2) The administrative staff member shall serve as the chair of the committee and may take action on preliminary hearing matters prior to convening the committee. The chair shall receive annual training on protecting victims and promoting accountability in cases involving allegations of sexual misconduct.

(3) Hearings may be heard by a quorum of three members of the committee, so long as a faculty member and one student are included on the hearing panel. Committee action may be taken upon a majority vote of all committee members attending the hearing.

(4) Members of the student conduct committee shall not participate in any case in which they are a party, complainant, or witness, in which they have direct or personal interest, prejudice, or bias, or in which they have acted previously in an advisory capacity. Any party may petition for disqualification of a committee member pursuant to RCW 34.05.425(4).

NEW SECTION

WAC 132N-125-125 Appeal—Student conduct committee. (1) Proceedings of the student conduct committee shall be governed by the Administrative Procedure Act, chapter 34.05 RCW, and by the Model Rules of Procedure, chapter 10-08 WAC. To the extent there is a conflict between these rules and chapter 10-08 WAC, these rules shall control.

(2) The student conduct committee chair shall serve all parties with written notice of the hearing not less than seven days in advance of the hearing date, as further specified in RCW 34.05.434 and WAC 10-08-040 and 10-08-045. The chair may shorten this notice period if both parties agree, and

also may continue the hearing to a later time for good cause shown.

(3) The committee chair is authorized to conduct prehearing conferences and/or to make prehearing decisions concerning the extent and form of any discovery, issuance of protective decisions, and similar procedural matters.

(4) Upon request, filed at least five days before the hearing by any party or at the direction of the committee chair, the parties shall exchange, no later than the third day prior to the hearing, lists of potential witnesses and copies of potential exhibits that they reasonably expect to present to the committee. Failure to participate in good faith in such a requested exchange may be cause for exclusion from the hearing of any witness or exhibit not disclosed, absent a showing of good cause for such failure.

(5) The committee chair may provide to the committee members in advance of the hearing copies of (a) the conduct officer's notification of the imposition of discipline, or referral to the committee, and (b) the notice of appeal, or any response to referral, by the respondent. If doing so, however, the chair should remind the members that these "pleadings" are not evidence of any facts they may allege.

(6) The parties may agree before the hearing to designate specific exhibits as admissible without objection and, if they do so, whether the committee chair may provide copies of these admissible exhibits to the committee members before the hearing.

(7) The student conduct officer, upon request, shall provide reasonable assistance to the respondent in obtaining relevant and admissible evidence that is within the college's control.

(8) Communications between committee members and other hearing participants regarding any issue in the proceeding, other than procedural communications that are necessary to maintain an orderly process, are generally prohibited without notice and opportunity for all parties to participate, and any improper "ex parte" communication shall be placed on the record, as further provided in RCW 34.05.455.

(9) Each party may be accompanied at the hearing by a nonattorney assistant of his/her choice. A respondent may elect to be represented by an attorney at his or her own cost, but will be deemed to have waived that right unless at least four days before the hearing, written notice of the attorney's identity and participation is filed with the committee chair with a copy to the student conduct officer. The committee will ordinarily be advised by an assistant attorney general. If the respondent is represented by an attorney, the student conduct officer may also be represented by a second, appropriately screened assistant attorney general.

NEW SECTION

WAC 132N-125-130 Student conduct committee hearings—Presentation of evidence. (1) Upon the failure of any party to attend or participate in a hearing, the student conduct committee may either:

(a) Proceed with the hearing and issuance of its decision; or

(b) Serve a decision of default in accordance with RCW 34.05.440.

(2) The hearing will ordinarily be closed to the public. However, if all parties agree on the record that some or all of the proceedings be open, the chair shall determine any extent to which the hearing will be open. If any person disrupts the proceedings, the chair may exclude that person from the hearing room.

(3) The chair shall cause the hearing to be recorded by a method that he/she selects, in accordance with RCW 34.05.449. That recording, or a copy, shall be made available to any party upon request. The chair shall assure maintenance of the record of the proceeding that is required by RCW 34.05.476, which shall also be available upon request for inspection and copying by any party. Other recording shall also be permitted, in accordance with WAC 10-08-190.

(4) The chair shall preside at the hearing and decide procedural questions that arise during the hearing, except as overridden by majority vote of the committee.

(5) The student conduct officer, unless represented by an assistant attorney general, shall present the case for imposing disciplinary sanctions.

(6) All testimony shall be given under oath or affirmation. Evidence shall be admitted or excluded in accordance with RCW 34.05.452.

NEW SECTION

WAC 132N-125-135 Student conduct committee—Initial decision. (1) At the conclusion of the hearing, the student conduct committee shall permit the parties to make closing arguments in whatever form it wishes to receive them. The committee also may permit each party to propose findings, conclusions, and/or a proposed decision for its consideration.

(2) Within twenty-one days following the later of the conclusion of the hearing, or the committee's receipt of closing arguments, the committee shall issue an initial decision in accordance with RCW 34.05.461 and WAC 10-08-210. The initial decision shall include findings on all material issues of fact and conclusions on all material issues of law, including which, if any, provisions of the student conduct code were violated. Any findings based substantially on the credibility of evidence or the demeanor of witnesses shall be so identified.

(3) The committee's initial order shall also include a determination on appropriate discipline, if any. If the matter was referred to the committee by the student conduct officer, the committee shall identify and impose disciplinary sanction(s) or conditions, if any, as authorized in the student code. If the matter is an appeal by the respondent, the committee may affirm, reverse, or modify the disciplinary sanction and/or conditions imposed by the student conduct officer and/or impose additional disciplinary sanction(s) or conditions as authorized herein.

(4) The committee chair shall cause copies of the initial decision to be served on the parties and their legal counsel of record. The committee chair shall also promptly transmit a copy of the decision and the record of the committee's proceedings to the president.

NEW SECTION

WAC 132N-125-140 Appeal from student conduct committee initial decision. (1) A respondent who is aggrieved by the findings or conclusions issued by the student conduct committee may appeal the committee's initial decision to the president by filing a notice of appeal with the president's office within twenty-one days of the committee's initial decision. Failure to file a timely appeal constitutes a waiver of the right and the initial decision shall be deemed final.

(2) The notice of appeal must identify the specific findings of fact and/or conclusions of law in the initial decision that are challenged and must contain argument why the appeal should be granted. The president's review shall be restricted to the hearing record made before the student conduct committee and will normally be limited to a review of those issues and arguments raised in the notice of appeal.

(3) The president shall provide a written decision to all parties within forty-five days after receipt of the notice of appeal. The president's decision shall be final and shall include a notice of any rights to request reconsideration and/or judicial review.

(4) The president may, at his or her discretion, suspend any disciplinary action pending review of the merits of the findings, conclusions, and disciplinary actions imposed.

(5) The president shall not engage in an ex parte communication with any of the parties regarding an appeal.

NEW SECTION

WAC 132N-125-145 Summary suspension. (1) Summary suspension is a temporary exclusion from specified college premises or denial of access to all activities or privileges for which a respondent might otherwise be eligible, while an investigation and/or formal disciplinary procedures are pending.

(2) The student conduct officer may impose a summary suspension if there is probable cause to believe that the respondent:

(a) Has violated any provision of the code of conduct; and

(b) Presents an immediate danger to the health, safety, or welfare of members of the college community; or

(c) Poses an ongoing threat of substantial disruption of, or interference with, the operations of the college.

(3) Notice. Any respondent who has been summarily suspended shall be served with oral or written notice of the summary suspension. If oral notice is given, a written notification shall be served on the respondent within two days of the oral notice.

(4) The written notification shall be entitled "Notice of Summary Suspension" and shall include:

(a) The reasons for imposing the summary suspension, including a description of the conduct giving rise to the summary suspension and reference to the provisions of the student conduct code or the law allegedly violated;

(b) The date, time, and location when the respondent must appear before the conduct review officer for a hearing on the summary suspension; and

(c) The conditions, if any, under which the respondent may physically access the campus or communicate with members of the campus community. If the respondent has been trespassed from the campus, a notice against trespass shall be included that warns the student that his or her privilege to enter into or remain on college premises has been withdrawn, that the respondent shall be considered trespassing and subject to arrest for criminal trespass if the respondent enters the college campus other than to meet with the student conduct officer or conduct review officer, or to attend a disciplinary hearing.

(5)(a) The conduct review officer shall conduct a hearing on the summary suspension as soon as practicable after imposition of the summary suspension.

(b) During the summary suspension hearing, the issue before the conduct review officer is whether there is probable cause to believe that summary suspension should be continued pending the conclusion of disciplinary proceedings and/or whether the summary suspension should be less restrictive in scope.

(c) The respondent shall be afforded an opportunity to explain why summary suspension should not be continued while disciplinary proceedings are pending or why the summary suspension should be less restrictive in scope.

(d) If the student fails to appear at the designated hearing time, the conduct review officer may order that the summary suspension remain in place pending the conclusion of the disciplinary proceedings.

(e) As soon as practicable following the hearing, the conduct review officer shall issue a written decision which shall include a brief explanation for any decision continuing and/or modifying the summary suspension and notice of any right to appeal.

(f) To the extent permissible under applicable law, the conduct review officer shall provide a copy of the decision to all persons or offices who may be bound or protected by it.

NEW SECTION

WAC 132N-125-150 Classroom misconduct and authority to suspend for no more than one day. (1) Faculty members have the authority to take appropriate action to maintain order and proper conduct in the classroom and to maintain the effective cooperation of students in fulfilling the objectives of the course.

(2) Bringing any person, thing, or object to a teaching and learning environment that may disrupt the environment or cause a safety or health hazard, without the express approval of the faculty member is expressly prohibited.

(3) Faculty members or college administrators have the right to suspend any student from any single class or related activity for no more than one instructional day, if the student's misconduct creates disruption to the point that it is difficult or impossible to maintain the decorum of the class, related activity, or the learning and teaching environment. The faculty member or college administrator shall report this suspension to the student conduct officer or designee on the same day of the suspension. In consultation with the faculty member, the student conduct officer may set conditions for the student upon return to the class or activity.

DISCIPLINE PROCEDURES FOR CASES INVOLVING ALLEGATIONS OF SEXUAL MISCONDUCT

NEW SECTION

WAC 132N-125-200 Supplemental sexual misconduct procedures. Both the respondent and the complainant in cases involving allegations of sexual misconduct shall be provided the same procedural rights to participate in student discipline matters, including the right to participate in the initial disciplinary decision-making process and to appeal any disciplinary decision.

Application of the following procedures is limited to student conduct code proceedings involving allegations of sexual misconduct by a student. In such cases, these procedures shall supplement the student disciplinary procedures in WAC 132N-125-005 through 132N-125-145. In the event of conflict between the sexual misconduct procedures and the student disciplinary procedures, the sexual misconduct procedures shall prevail.

NEW SECTION

WAC 132N-125-205 Supplemental definitions. The following supplemental definitions shall apply for purposes of student conduct code proceedings involving allegations of sexual misconduct by a student:

(1) A "complainant" is an alleged victim of sexual misconduct, as defined in subsection (2) of this section.

(2) "Sexual misconduct" is prohibited sexual- or gender-based conduct by a student including, but not limited to:

(a) Sexual activity for which clear and voluntary consent has not been given in advance;

(b) Sexual activity with someone who is incapable of giving valid consent because, for example, she or he is underage, sleeping, or otherwise incapacitated due to alcohol or drugs;

(c) Sexual harassment;

(d) Sexual violence which includes, but is not limited to, sexual assault, domestic violence, intimate violence, and sexual- or gender-based stalking; and

(e) Nonphysical conduct such as sexual- or gender-based digital media stalking, sexual- or gender-based online harassment, sexual- or gender-based cyberbullying, nonconsensual recording of a sexual activity, and nonconsensual distribution of a recording of a sexual activity.

NEW SECTION

WAC 132N-125-210 Supplemental complaint process. The following supplemental procedures shall apply with respect to complaints or other reports of alleged sexual misconduct by a student:

(1) The college's Title IX compliance officer or designee shall investigate complaints or other reports of alleged sexual misconduct by a student. Investigations will be completed in a timely manner and the results of the investigation shall be referred to the student conduct officer for disciplinary action.

(2) Informal dispute resolution shall not be used to resolve sexual misconduct complaints without written permission from both the complainant and the respondent. If the parties elect to mediate a dispute, either party shall be free to discontinue mediation at any time. In no event shall mediation be used to resolve complaints involving allegations of sexual violence.

(3) College personnel will honor requests to keep sexual misconduct complaints confidential to the extent this can be done without unreasonably risking the health, safety, and welfare of the complainant or other members of the college community or compromising the college's duty to investigate and process sexual harassment and sexual violence complaints.

(4) The student conduct officer, prior to initiating disciplinary action, will make a reasonable effort to contact the complainant to discuss the results of the investigation and possible disciplinary sanctions and/or conditions, if any, that may be imposed upon the respondent if the allegations of sexual misconduct are found to have merit.

(5) The student conduct officer, on the same date that a disciplinary decision is served on the respondent, will serve a written notice informing the complainant whether the allegations of sexual misconduct were found to have merit and describing any disciplinary sanctions and/or conditions imposed upon the respondent for the complainant's protection, including disciplinary suspension or dismissal of the respondent. The notice will also inform the complainant and respondent of their appeal rights. If protective sanctions and/or conditions are imposed, the student conduct officer shall make a reasonable effort to contact the complainant to ensure prompt notice of the protective disciplinary sanctions and/or conditions imposed upon the respondent for the complainant's protection is given.

NEW SECTION

WAC 132N-125-215 Supplemental appeal rights. (1) The following actions by the student conduct officer may be appealed by the complainant:

(a) The dismissal of a sexual misconduct complaint; or

(b) Any disciplinary sanction(s) and conditions imposed against a respondent for a sexual misconduct violation, including a disciplinary warning.

(2) A complainant may appeal a disciplinary decision by filing a notice of appeal with the conduct review officer within twenty-one days of the notice of the discipline decision provided for in WAC 132N-125-210(5). The notice of appeal may include a written statement setting forth the grounds of appeal. Failure to file a timely notice of appeal constitutes a waiver of this right and the disciplinary decision shall be deemed final.

(3) If the respondent timely appeals a decision imposing discipline for a sexual misconduct violation, the college shall notify the complainant of the appeal and provide the complainant an opportunity to intervene as a party to the appeal.

(4) Except as otherwise specified in this supplemental procedure, a complainant who timely appeals a disciplinary decision or who intervenes as a part to the respondent's appeal of a disciplinary decision shall be afforded the same procedural rights as are afforded the respondent.

(5) An appeal by a complainant from the following disciplinary actions involving allegations of sexual misconduct against a student shall be handled as a brief adjudicative proceeding:

(a) Exoneration and dismissal of the proceedings;

(b) A disciplinary warning;

(c) A written reprimand;

(d) Disciplinary probation;

(e) Suspensions of ten days or less; and/or

(f) Any conditions or terms imposed in conjunction with one of the foregoing disciplinary actions.

(6) An appeal by a complainant from disciplinary action imposing a suspension in excess of ten days or an expulsion shall be reviewed by the student conduct committee.

(7) In proceedings before the student conduct committee, respondent and complainant shall have the right to be accompanied by a nonattorney assistant of their choosing during the appeal process. Complainant may choose to be represented at the hearing by an attorney at his or her own expense, but will be deemed to have waived that right unless, at least four days before the hearing, he or she files a written notice of the attorney's identity and participation with the committee chair, and with copies to the respondent and the student conduct officer.

(8) In proceedings before the student conduct committee, complainant and respondent shall not directly question or cross examine one another. All questions shall be directed to the committee chair, who will act as an intermediary and pose questions on the parties' behalf.

(9) Student conduct hearings involving sexual misconduct allegations shall be closed to the public, unless respondent and complainant both waive this requirement in writing and request that the hearing be open to the public. Complainant, respondent, and their respective nonattorney assistants and/or attorneys may attend portions of the hearing where argument, testimony, and/or evidence are presented to the student conduct committee.

(10) The chair of the student conduct committee, on the same date as the initial decision is served on the respondent, will serve a written notice upon complainant informing the complainant whether the allegations of sexual misconduct were found to have merit and describing any disciplinary sanctions and/or conditions imposed upon the respondent for the complainant's protection, including suspension or dismissal of the respondent. The notice will also inform the complainant of his or her appeal rights.

(11) Complainant may appeal the student conduct committee's initial decision to the president subject to the same procedures and deadlines applicable to other parties.

(12) The president, on the same date that the final decision is served upon the respondent, shall serve a written notice informing the complainant of the final decision. This notice shall inform the complainant whether the sexual misconduct allegation was found to have merit and describe any disciplinary sanctions and/or conditions imposed upon the respondent for the complainant's protection, including suspension or dismissal of the respondent.

NEW SECTION

WAC 132N-125-220 Brief adjudicative proceedings —College record. The college record for brief adjudicative proceedings shall consist of any documents regarding the matter that were considered or prepared by the presiding officer for the brief adjudicative proceeding or by the reviewing officer for any review. These records shall be maintained as the official record of the proceedings.

NEW SECTION

WAC 132N-125-225 Recordkeeping. (1) The record in a brief adjudicative proceeding shall consist of all documents as required by law and as specified in RCW 34.05.476.

(2) The office of the vice-president of student affairs shall maintain records of student grievance and disciplinary proceedings for at least six years.

(3) The disciplinary record is confidential.

(4) Students may request a copy of their own disciplinary record at their own reasonable expense by making a written request to the vice-president of student affairs. Personally identifiable student information is redacted to protect another student's privacy.

(5) Students may authorize release of their own disciplinary record to a third party in compliance with FERPA, 20 U.S.C. Sec. 1232g, by making a written request to the vice-president of student affairs.

(6) The college may inform the complainant of the outcome of any disciplinary proceeding involving a crime of violence or nonforcible sex offense, as permitted by FERPA, 20 U.S.C. Sec. 1232g; 34 C.F.R. Part 99.

(7) The college may not communicate a student's disciplinary record to any person or agency outside the college without the prior written consent of the student, except as required or permitted by law. Exceptions include, but are not limited to:

(a) The student's parents or legal guardians may review these records if the student is a minor or a dependent, if the student is a minor and disciplinary action involves the use or possession of alcohol or controlled substance, or in connection with a health or safety emergency regardless if the student is a dependent or a minor, as permitted by FERPA, 20 U.S.C. Sec. 1232g; 34 C.F.R. Part 99.

(b) To another educational institution, upon request, where the student seeks to, intends to, or has enrolled.

(c) Information concerning registered sex offenders.

REPEALER

The following chapter of the Washington Administrative Code is repealed:

WAC 132N-121-010 Code of student conduct.

WAC 132N-121-020 Authority.

WAC 132N-121-030 Definitions.

WAC 132N-121-040 Jurisdiction.

WAC 132N-121-045 Students studying abroad.

WAC 132N-121-050 Student rights.

WAC 132N-121-060 Grounds for discipline.
WAC 132N-121-062 Academic dishonesty.
WAC 132N-121-065 Trespass.
WAC 132N-121-070 Disciplinary sanction.
WAC 132N-121-080 Initial disciplinary proceedings.
WAC 132N-121-090 Appeals.
WAC 132N-121-100 Committee on student conduct.
WAC 132N-121-110 Hearing procedures before the committee on student conduct.
WAC 132N-121-112 Decision by the committee on student conduct and notification.
WAC 132N-121-120 Recordkeeping.
WAC 132N-121-150 Summary suspension proceedings.
WAC 132N-121-151 Appeals from summary suspension hearing.
WAC 132N-121-500 Classroom misconduct and authority to suspend for no more than one day.

WSR 14-12-035

PERMANENT RULES

SECRETARY OF STATE

(Archives Division)

[Filed May 28, 2014, 12:24 p.m., effective June 28, 2014]

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

Purpose: The purpose of the proposed rule is to allow electronically recorded documents that require notarization to be notarized by any authorized notary, and to eliminate the requirement that the notary be appointed by the Washington state department of licensing.

Citation of Existing Rules Affected by this Order: Amending WAC 434-661-020 and 434-661-030.

Statutory Authority for Adoption: RCW 65.24.040.

Adopted under notice filed as WSR 14-09-014 on April 4, 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 2, Repealed 0.

Number of Sections Adopted Using Negotiated Rule Making: New 0, Amended 2, 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 28, 2014.

Ken Raske
Assistant Secretary
of State

AMENDATORY SECTION (Amending WSR 13-03-070, filed 1/14/13, effective 2/14/13)

WAC 434-661-020 Definitions. For the purpose of this chapter:

(1) "Delivery package" means a document, group of documents, related or unrelated, bundled into a single entity for electronic transfer.

(2) "Document" means information that is inscribed on a tangible medium or that is stored in an electronic or other medium, is retrievable in perceivable form, and is eligible to be recorded in the land records maintained by the county recording officer.

(3) "Electronic" means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

(4) "Electronic document" means a document that is received or sent by the recording officer in an electronic form.

(5) "Electronic signature" means an electronic sound, symbol or process attached to or logically associated with a document and executed or adopted by a person with the intent to sign the document.

(6) "Electronic notarization" means a notarial act performed in accordance with chapter 42.44 RCW and chapter 308-30 WAC by a notary public((~~, appointed by the Washington state department of licensing,~~)) who provides notarial acts using electronic interface.

(7) "Electronic recording standards commission" or "eRecording standards commission" or "ERSC" means the body of stakeholders appointed by the secretary of state to review electronic recording standards and make recommendations to the secretary in accordance with RCW 65.24.040.

(8) "eRecording" means electronic recording of real property documents.

(9) "Metadata" means data describing other data to facilitate the understanding, use, and management of that data.

(10) "Open architecture" means computer architecture or software architecture that employs specifications that are open to the public to allow for adding, upgrading and exchange of components produced by a broad range of manufacturers.

(11) "PDF (portable document format)" means the file format originally created by Adobe Systems for document exchange allowing documents to be viewed as they were intended to appear. PDFs are a common format for image exchange or world wide web presentation.

(12) "Recording" means making a matter of record in the office of the recording officer in accordance with RCW 65.04.030.

(13) "Recording officer" means the county auditor or other official county recording officer.

(14) "TIFF" (tagged image file format) means the variable-resolution bitmapped image format originally developed by the Aldus Corporation (now part of Adobe Systems) and

published as ISO 12639:2004, Graphic technology-Prepress digital data exchange-Tag image file format for image technology (TIFF/IT). TIFF is a common format for high-quality black and white, gray-scaled, or color graphics of any resolution and is made up of individual dots or pixels.

(15) "URPERA (Uniform Real Property Electronic Recording Act)" means the body of recommended legislation released in 2004 by the National Conference of Commissioners on Uniform State Laws (NCCUSL) for adoption by state legislatures. URPERA authorizes recording officers to accept electronic documents for recording in accordance with established standards. Washington state adopted a modified version of URPERA in 2008 (chapter 65.24 RCW).

(16) "Washington state archives" means the office of the secretary of state, division of archives and records management.

(17) "Web portal (gateway)" means a site that functions as a point of access to information or services on the world wide web.

(18) "XML (extensible markup language)" means an extensible document language for specifying document content. XML is not a predefined markup language but a metalanguage (a language for describing other languages) allowing the user to specify a document type definition (DTD) and design customized markup languages for different classes of documents.

AMENDATORY SECTION (Amending WSR 13-03-070, filed 1/14/13, effective 2/14/13)

WAC 434-661-030 Washington real property electronic recording standards. (1) **Technical standards and implementation guidelines.**

(a) Electronic recording of real property documents shall meet technical standards for document formatting and document data fields and follow implementation guidelines as prescribed by the Property Records Industry Association (PRIA) which are hereby incorporated by reference, made a part of this rule, and listed below:

(i) PRIA Request Version 2.4.2, August 2007;

(ii) PRIA Response Version 2.4.2, August 2007;

(iii) Document Version 2.4.1, October 2007;

(iv) Notary Version 2.4.1, October 2007;

(v) eRecording XML Implementation Guide for Version 2.4.1, Revision 2, March 2007;

(vi) URPERA Enactment and eRecording Standards Implementation Guide, December 2005.

These standards are available from the Property Records Industry Association, 2501 Aerial Center Parkway, Ste. 103, Morrisville, NC 27560, and at http://www.pria.us/.

(b) eRecording shall be offered and conducted in accordance with the models of submission described in the URPERA Enactment and eRecording Standards Implementation Guide, Section 2.3, eRecording Models.

(c) Each recording officer who accepts documents for eRecording shall provide open architecture for reception of electronic documents. All reception software, including web portals, must support PRIA eRecording SML Implementation Guide for Version 2.4.1 standards.

(2) **Web portals.**

(a) The world wide web will be the most common delivery medium for electronic documents.

(b) A document delivered over the web should provide a minimum amount of information in the delivery package sufficient to identify and authenticate the sender to the recording officer, while also itemizing the contents of the package.

(c) Payment processing, if supplied at the portal, shall comply with the 2012 NACHA Operating Rules & Guidelines, which is hereby incorporated by reference and made a part of this rule. This publication is available from NACHA: The Electronic Payments Association, 13450 Sunrise Valley Drive, Suite 100, Herndon, VA 20171, and at http://www.nacha.org/. The recording officer and portal provider shall determine the portal's payment processing capabilities, and each recording officer shall designate approved methods of payment, which may include credit cards, ACH (automated clearing house), escrow accounts, electronic checks, or other methods.

(3) **Business rules.** Recording officers shall establish and publish business rules that govern how eRecording will be conducted. The business rules may be in electronic or hard copy format and may appear on a portal or the recording officer web site. The transmitting parties' electronic acknowledgment of acceptance of the terms of the business rules is acceptable. The business rules must cover the following items:

(a) Memorandum of understanding or contract;

(b) Defined technical specifications;

(c) Document formatting and indexing specifications;

(d) Hours of operations and processing schedules;

(e) Payment options;

(f) Termination terms;

(g) Document rejection rights;

(h) Statement that any amendments and/or alterations to the business rules will be published with adequate notice before taking effect;

(i) Statement clarifying the liability of the recording offices.

(4) **Security.**

(a) All electronic documents must be secured in such a way that both the transmitting and receiving parties are assured of each other's identity and that no unauthorized party can view or alter the electronic document during transmission, processing, and delivery. If followed through the entire electronic document process of execution through recording, the security measures identified in chapter 6 of the eRecording XML Implementation Guide for Version 2.4.1, Revision 2, March 2007, satisfy this requirement.

(b) Each recording officer who elects to accept electronic real property documents for recordation shall implement reasonable measures such that each electronic document accepted for recordation is protected from alteration and unauthorized access.

(5) **Electronic signatures.** Recording officers are only required to accept electronic signatures that they have the technology to support. Recording officers have no responsibility to authenticate electronic signatures embedded within the body of the document.

(6) **Notarizations.** Pursuant to chapter 65.24 RCW, notarizations must:

(a) Be performed by a notary public who has been appointed by the Washington state department of licensing, or a person authorized by the laws of another jurisdiction outside the state of Washington, in accordance with chapter ((~~43.44~~)) 42.44 RCW; and

(b) Comply with all applicable requirements for performing a notarial act as found in chapter 42.44 RCW and chapter 308-30 WAC, as amended from time to time, except that in the case of ((~~an electronic~~)) notarizations performed electronically, an impression of the official seal or stamp is not required.

Recording officers have no responsibility for verifying or authenticating notary signatures and acknowledgments.

(7) **File formats for eRecording.** The electronic recording standards commission recommends that electronic recordings be converted to (if necessary) and preserved as image files along with their associated metadata. If submissions are accepted in XHTML (extensible hypertext markup language) format, they shall be converted to a digital image until the viability of preserving these eRecordings in their native format has been demonstrated. Document images should be submitted as defined in WAC 434-663-305 and meet all state requirements for recorded instruments as defined in RCW 65.04.045.

(8) **Records retention and preservation.** Recording officers must not destroy public records, including electronic records, without the approval of the local records committee, in accordance with RCW 40.14.070.

Recording officers must retain electronic public records in electronic format such that the records remain usable, searchable, retrievable, and authentic for the length of the designated retention period in accordance with WAC 434-662-040.

The local records committee has approved the local government common records retention schedule (CORE) and the county auditor records retention schedule authorizing the minimum retention periods for recording officer records, and designating those records with enduring value as "archival."

Recording officers may transfer public records designated as "archival," including electronic records, to Washington state archives for preservation and for facilitating public access to the records.

(9) **Payment of recording fees.** Electronic payment of recording fees and excise tax, where applicable, shall be collected by the county agency responsible for such as prescribed in accordance with Washington state law and accepted industry standards without incurring unreasonable electronic processing fees.

WSR 14-12-038
PERMANENT RULES
DEPARTMENT OF ECOLOGY

[Order 13-03—Filed May 28, 2014, 3:59 p.m., effective June 28, 2014]

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

Purpose: The purpose of this rule making is to adopt new chapter 173-485 WAC, Petroleum refinery greenhouse gas emission requirements. This rule establishes reasonably available control technology (RACT) to limit greenhouse gas (GHG) emissions from petroleum refineries in Washington state.

Statutory Authority for Adoption: Chapter 70.94 RCW provides statutory authority to adopt rule changes.

Adopted under notice filed as WSR 14-01-115 on December 18, 2013.

Changes Other than Editing from Proposed to Adopted Version: RCW 34.05.325 (6)(a)(ii) requires ecology to describe the differences between the text of the proposed rule as published in the *Washington State Register* and the text of the rule as adopted, other than editing changes, stating the reasons for the differences.

There are some differences between the proposed rule filed on December 18, 2013, and the adopted rule. Ecology made these changes for all or some of the following reasons:

- In response to comments we received.
- To ensure clarity and consistency.
- To meet the intent of the authorizing statue [statute].

The following content describes the changes and ecology's reasons for making them:

Section	Change(s)	Purpose/Effect
010	No change.	
020(2)	Rephrased first part of subsection (2) and changed "adopted as they exist" to "to the version in effect."	Improve usability for reader and clarification.
030	Changed CO_{2e} to CO_2e throughout section.	Formatting consistency.
030	Made minor changes to definition for "Baseline greenhouse gas emissions."	Combined definition of "baseline greenhouse gas emissions" and "typical refinery operation," simplifying the definition and eliminating a definition used only once.
030	Deleted definition for "typical refinery operation."	Not needed because of revision to "baseline greenhouse gas emissions."
040	Changed CO_{2e} to CO_2e.	Formatting consistency.
050 (1)(c)	Changed "was" to "were."	Corrected grammar.
060 (1)(b)	Changed CO_{2e} to CO_2e.	Formatting consistency.
060 (2)(c)	Added words "for credit" into second sentence.	Clarification of intent.
060(3)	Added words "at the refinery."	Clarifies that the electrical equipment upgrade is at the refinery and not some distant power plant. This is consistent with original intent.
060(5)	Changed "occurred" to "completed."	Clarification that the reduction projects must have been completed after 2010 for GHG reductions to count.
070(1)	Added clarifying language to first part of sentence.	Improve usability for reader.

Section	Change(s)	Purpose/Effect
080(1)	Added clarifying language to first sentence.	Clarifies what submittal information is required to be retained in recordkeeping.
090	No changes.	

A final cost-benefit analysis is available by contacting Margo Thompson, Department of Ecology, P.O. Box 47600, Olympia, WA 98504-7600, phone (360) 407-6827, fax (360) 407-7534, e-mail margo.thompson@ecy.wa.gov.

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

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

Number of Sections Adopted on the Agency's Own Initiative: New 9, Amended 0, Repealed 0.

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

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

Date Adopted: May 28, 2014.

Maia D. Bellon
Director

Chapter 173-485 WAC

PETROLEUM REFINERY GREENHOUSE GAS EMISSION REQUIREMENTS

NEW SECTION

WAC 173-485-010 Policy and purpose. The purpose of this rule is to determine reasonably available control technology for emissions of greenhouse gases emitted by petroleum refineries located in Washington state. The emission standards in this rule were developed under the requirements of RCW 70.94.154.

NEW SECTION

WAC 173-485-020 Applicability. (1) This chapter applies to all petroleum refineries in Washington state identified in WAC 173-485-030.

(2) All references to federal regulations in this regulation are to the version in effect on July 1, 2013.

NEW SECTION

WAC 173-485-030 Definitions. Definitions in chapter 173-400 WAC apply to this chapter. Definitions specific to this chapter include:

"Baseline greenhouse gas emissions" means greenhouse gas emissions, reported to the United States Environmental Protection Agency (EPA) to comply with 40 C.F.R. Part 98. The baseline greenhouse gas emissions are for calendar year 2010 or calendar year 2011 as determined by the refinery. The selected year must not include more than thirty days of outage in the refinery's crude unit. Emissions attributable to the production of electricity from on-site cogeneration equipment are not included in the baseline emissions. Emissions attributable to the production of steam by the cogeneration equipment are included in the baseline emissions.

"Carbon dioxide equivalent" or **"CO_2e"** means the number of metric tons of carbon dioxide emissions with the same global warming potential as one metric ton of another greenhouse gas. CO_2e is calculated using Equation A-1 of 40 C.F.R. Part 98.2 and the global warming potential values contained in Table A-1 of 40 C.F.R. Part 98, Subpart A.

"Credit" means the reduction of CO_2e emitted resulting from one or more projects performed at a petroleum refinery during or prior to a reporting year. A credit is established according to WAC 173-485-060.

"**Energy efficiency standard**" means the EII® value representing the fiftieth percentile EII® of similar sized United States refineries, using the EPA EnergyStar® calculation methodology, which is based on the United States refineries participating in the EII® process in 2006.

"Energy Intensity Index®" or **"EII®"** means the Solomon Associates proprietary petroleum refinery energy efficiency metric that compares actual energy consumption for a petroleum refinery with the standard energy consumption for a petroleum refinery of similar size. The standard energy consumption is based on an analysis of refining capacity as contained in the data base maintained by Solomon Associates. The ratio of a facility's actual energy consumption to the standard energy consumption is multiplied by one hundred to arrive at the EII® for a refinery.

"Greenhouse gases (GHGs)" include carbon dioxide, methane, nitrous oxide, hydrofluorocarbons, perfluorocarbons, and sulfur hexafluoride.

"Petroleum refinery" or **"petroleum refineries"** means the following facilities, regardless of future changes in ownership or name:

(a) BP Cherry Point Refinery in Blaine, WA;

(b) Phillips 66 Company Refinery in Ferndale, WA;

(c) Shell Oil Company Refinery in Anacortes, WA;

(d) Tesoro Refining & Marketing Company, LLC Anacortes Refinery in Anacortes, WA; and

(e) U.S. Oil & Refining Co. Tacoma Refinery in Tacoma, WA.

"RACT" means reasonably available control technology.

"Similar sized United States refineries" means refineries determined to be of similar size using the petroleum refinery capacity categories established for EPA's EnergyStar® program.

NEW SECTION

WAC 173-485-040 Greenhouse gas reasonably available control technology emission standard. (1) **Energy efficiency standard.** The owner/operator of each petroleum refinery subject to this rule shall meet the requirement to use reasonably available control technology (RACT) for greenhouse gas emissions by demonstrating the petroleum refinery

has a calculated EII® equal to or more efficient than the EII® value representing the fiftieth percentile EII® of similar sized United States refineries, based on 2006 data and the EPA EnergyStar® calculation methodology. The petroleum refinery must demonstrate compliance with WAC 173-485-050 in the annual report required in WAC 173-485-090 using any EII® report issued between 2006 and the first annual report. If a petroleum refinery is unable to or chooses not to demonstrate compliance with the energy efficiency standard in the first annual report required in WAC 173-485-090, the petroleum refinery shall document that it has met the requirements of subsection (2) of this section no later than October 1, 2025.

(2) **Emission reduction requirement.** A petroleum refinery that does not meet the requirements of subsection (1) of this section, must:

(a) No later than October 1, 2025, have implemented greenhouse gas reduction projects that:

(i) Result in cumulative annual emissions reduction(s) equivalent to ten percent of the facility's baseline greenhouse gas emissions (as CO_2e); or

(ii) Result in the petroleum refinery meeting the energy efficiency standard in subsection (1) of this section.

(b) Demonstrate compliance with the emission reduction requirement in WAC 173-485-060.

NEW SECTION

WAC 173-485-050 Demonstrating compliance with the energy efficiency standard. (1) Owners/operators of a petroleum refinery demonstrating compliance with the energy efficiency standard shall as part of the annual report required in WAC 173-485-090(1) submit the following information:

(a) The letter from Solomon Associates certifying that the petroleum refinery has a calculated EII® for the refinery that meets the requirements in WAC 173-485-040(1);

(b) Identification of the calendar year of the petroleum refinery's operational data submitted to Solomon Associates to reach that conclusion. The calendar year used may be any year between 2006 through 2024; and

(c) Confirmation that the operational data submitted to Solomon Associates for these calculations were reviewed and certified by a professional engineer licensed in the state of Washington, including the date the operational data were certified and the name and license number of the professional engineer who made the certification.

(2) According to WAC 173-485-090, once this certification has been made, no additional annual reports are required.

NEW SECTION

WAC 173-485-060 Demonstrating compliance with the emission reduction requirement. (1) **Requesting credit.** Owners/operators of a petroleum refinery demonstrating compliance through the emission reduction requirement in WAC 173-485-040(2) shall submit, as part of each annual report required in WAC 173-485-090(1), requests for a credit against the greenhouse gas emission reduction requirement. A credit request must be based on specific projects that have been completed at the petroleum refinery since the previous annual report. Each request must include the following information:

(a) An engineering description and analysis of the project, including the emission reduction and energy efficiency objectives for the project.

(b) A quantitative analysis of the project documenting the annual metric tons of CO_2e emission reductions achieved as a result of completing the project.

(c) Information supporting the quantitative analysis including engineering assumptions, measurements, or monitoring data.

(d) Requests for credits shall be submitted as part of the first annual report submitted after the petroleum refinery project has been completed.

(2) **Processing a credit request.**

(a) Each request for credit shall be reviewed and certified by a professional engineer licensed in the state of Washington. The certification must contain the name and license number of the professional engineer who performed the review and certified the submittal.

(b) Within thirty days after the receipt of a request for credit, the permitting authority may require the submission of additional information needed to review the request.

(c) Within thirty days after all required information has been received, the permitting authority shall propose to approve or deny the request for credit. Final approval or denial of a request for credit shall be established through the issuance of a regulatory order. The regulatory order must be issued in accordance with the procedures of the permitting authority for issuing such orders. Each regulatory order issued to approve a request shall include both the quantity of greenhouse gas reduction credit awarded and any conditions necessary to support the validity of the credit award.

(3) Improvements in the efficiency of existing electrical equipment or electrical equipment upgrades at the refinery are not eligible for credits.

(4) Greenhouse gas reductions for the replacement of direct fired or steam-driven equipment with electrical equipment will be credited based on the calculated difference between the greenhouse gas emissions reduced at the refinery and the greenhouse gas emissions calculated for the electricity required. The greenhouse gas emissions for electricity used will be the greenhouse gas emissions specific to the petroleum refinery's source of electricity.

(5) Greenhouse gas emission reductions at the petroleum refinery occurring as a result of projects completed prior to January 1, 2010, are not eligible for credits.

NEW SECTION

WAC 173-485-070 Monitoring. (1) To demonstrate compliance with the emission reduction requirement, each petroleum refinery must use monitoring measures that satisfy requirements for petroleum refinery owners/operators reporting greenhouse gas emissions to EPA under 40 C.F.R. Part 98. Unless additional monitoring is required by the credit order issued under WAC 173-485-060 (2)(c), the 40 C.F.R. Part 98 monitoring is considered sufficient for quantifying annual emissions for this regulation.

(2) The permitting authority may require additional monitoring, recordkeeping, and reporting to document compliance with a credit established through this regulation. The additional monitoring, recordkeeping, and reporting must be identified in the credit order issued under WAC 173-485-060 (2)(c).

NEW SECTION

WAC 173-485-080 Recordkeeping. (1) All records used for preparing submittals to Solomon Associates to support a determination of compliance with the energy efficiency standard or for preparing reports to the permitting authority shall be retained at least five years beyond the date of the last annual report required by WAC 173-485-090(2).

(2) Records related to emission calculations and reports shall be provided to the permitting authority upon request. The petroleum refinery owner/operator retains the rights to keep specified records and information confidential as provided in RCW 70.94.205.

NEW SECTION

WAC 173-485-090 Reporting. (1) **Annual reports**. Starting on October 1, 2014, and by October 1 of each year until October 1, 2025, unless compliance has been demonstrated on an earlier date, the owners/operators of a petroleum refinery subject to this standard shall submit reports to their permitting authority that include the following information:

(a) Identification of the option the petroleum refinery intends to use to demonstrate compliance with this standard, including the baseline greenhouse gas emissions year the refinery has selected and justification to utilize that year.

(b) Activities completed since the last annual report to reduce greenhouse gas emissions.

(c) Any changes since the last annual report regarding the compliance option utilized by the petroleum refinery.

(d) Baseline greenhouse gas emissions for the petroleum refinery, actual greenhouse gas emissions for the previous calendar year, total greenhouse gas emission reductions already credited to the petroleum refinery, and any emission reductions previously approved through regulatory order to comply with WAC 173-485-040(3), since the effective date of this regulation.

(e) All compliance documentation submittals required in WAC 173-485-050 or 173-485-060(1), as applicable.

(f) If the first annual report does not indicate compliance with the requirements in WAC 173-485-040, the first report must contain an overview plan of how the refinery intends to comply with the requirements of WAC 173-485-040.

(2) Annual reports must be submitted to the permitting authority until compliance has been demonstrated with either WAC 173-485-040 (2) or (3). The owner/operator of a petroleum refinery shall identify in the annual report that the report is the final report that will be submitted to the authority.

WSR 14-12-040
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)
[Filed May 29, 2014, 7:19 a.m., effective June 29, 2014]

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

Purpose: The department is amending these rules to comply with changes to state law made by the 2013 legislature in SB [SSB] 5077 Gender-neutral terms and SB 5510 Vulnerable adults—Abuse.

Changes related to SB [SSB] 5077 include changing the term "ombudsman" to "ombuds" in multiple sections.

Changes related to SB 5510 include amending the definition of the term "neglect."

Citation of Existing Rules Affected by this Order: Amending WAC 388-97-0001, 388-97-0300, 388-97-0460, 388-97-0520, 388-97-1640, 388-97-1840, and 388-97-4480.

Statutory Authority for Adoption: Chapters 18.51 and 74.42 RCW.

Adopted under notice filed as WSR 13-23-098 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 7, 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 7, Repealed 0.

Date Adopted: May 15, 2014.

Katherine I. Vasquez
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 14-13 issue of the Register.

WSR 14-12-046
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Developmental Disabilities Administration)
[Filed May 29, 2014, 11:20 a.m., effective July 1, 2014]

Effective Date of Rule: July 1, 2014.

Purpose: The primary purposes for these changes are to clarify rules which determine whether an individual meets the requirements for developmental disabilities administration (DDA) eligibility. Overall changes in organization and

language have been made to reduce confusion for DDA, applicants and DDA clients. Amendments align eligibility requirements for autism with the Diagnostic and Statistical Manual – Fifth Edition (DSM-5). Furthermore, combining the categories of "another neurological" and "other condition" eliminate confusion between the WAC and RCW language.

Amendments to this chapter may change eligibility requirements for some individuals applying for services from DDA. In addition, housekeeping changes were made such as WAC and RCW references, [changing] division of developmental disabilities to DDA, and mental retardation to intellectual disability.

Citation of Existing Rules Affected by this Order: Repealing WAC 388-823-0030, 388-823-0040, 388-823-0060, 388-823-0070, 388-823-0110, 388-823-0120, 388-823-0130, 388-823-0140, 388-823-0150, 388-823-0160, 388-823-0170, 388-823-0215, 388-823-0220, 388-823-0230, 388-823-0320, 388-823-0330, 388-823-0420, 388-823-0515, 388-823-0615, 388-823-0700, 388-823-0710, 388-823-0800, 388-823-0810, 388-823-0820, 388-823-0830, 388-823-0840, 388-823-0850, 388-823-0900, 388-823-1040 and 388-823-1050; and amending WAC 388-823-0010, 388-823-0020, 388-823-0050, 388-823-0080, 388-823-0090, 388-823-0100, 388-823-0105, 388-823-0200, 388-823-0210, 388-823-0300, 388-823-0310, 388-823-0400, 388-823-0410, 388-823-0500, 388-823-0510, 388-823-0600, 388-823-0610, 388-823-0920, 388-823-0930, 388-823-0940, 388-823-1000, 388-823-1005, 388-823-1010, 388-823-1015, 388-823-1020, 388-823-1030, 388-823-1060, 388-823-1070, 388-823-1080, 388-823-1090, 388-823-1095, and 388-823-1100.

Statutory Authority for Adoption: RCW 71A.12.030, 71A.12.120.

Other Authority: RCW 71A.12.030, 74.08.090.

Adopted under notice filed as WSR 14-05-071 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 11, Amended 30, Repealed 32; 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 11, Amended 30, Repealed 32.

Date Adopted: May 27, 2014.

Katherine I. Vasquez
Rules Coordinator

Reviser's note: The material contained in this filing exceeded the page-count limitations of WAC 1-21-040 for appearance in this issue of the Register. It will appear in the 14-13 issue of the Register.

WSR 14-12-047

PERMANENT RULES

HEALTH CARE AUTHORITY

(Washington Apple Health)

[Filed May 29, 2014, 1:50 p.m., effective July 1, 2014]

Effective Date of Rule: July 1, 2014.

Purpose: Revising the outlier rules is an integral part of updating inpatient hospital payment rates to reflect changes in hospital industry practices and state medicaid payment policies as requested by the legislature. The update called "rebasing" is completed by a consultant hired by the state of Washington in coordination with stakeholders including hospitals, the Washington State Hospital Association, office of financial management, legislative staff and others. During the rebasing of inpatient and outpatient rates, the agency along with consultants and stakeholders, reviews and revises how the agency pays hospitals for caring for agency clients. During this process, payment methods and rates change. These changes must be reflected in rule.

The agency is also updating WAC 182-550-1050 with new and revised definitions pertaining to chapter 182-550 WAC.

Citation of Existing Rules Affected by this Order: Repealing WAC 182-550-2511, 182-550-2570, 182-550-2800, 182-550-3010, 182-550-3020, 182-550-3100, 182-550-3150, 182-550-3200, 182-550-3250, 182-550-3300, 182-550-3350, 182-550-3450, 182-550-3460, 182-550-3500, 182-550-4600 and 182-550-7050; and amending WAC 182-550-1050, 182-550-2900, 182-550-3000, 182-550-3381, 182-550-3400, 182-550-3600, 182-550-3700, 182-550-3800, 182-550-3900, 182-550-4000, 182-550-4100, 182-550-4300, 182-550-4400, 182-550-4500, and 182-550-4800.

Statutory Authority for Adoption: RCW 41.05.021.

Other Authority: Chapter 74.60 RCW.

Adopted under notice filed as WSR 14-08-059 on March 28, 2014, and WSR 14-09-100 on April 22, 2014.

Changes Other than Editing from Proposed to Adopted Version: As a result of stakeholder comments, the agency added the following sentence to WAC 182-550-3800(4): "The agency ensures that base DRG conversion factors and per diem rates are sufficient to support economy, efficiency, and access to services for medicaid recipients."

In WAC 182-550-3800(4), the agency added the following underlined text:

(4) Calculates base payment factors. The agency calculates the average, or base, DRG conversion factor and per diem rates. The base is calculated as the maximum amount that can be used, along with all other payment factors and adjustments described in this chapter, to maintain aggregate payments across the system. <u>The agency ensures that base DRG conversion factors and per diem rates are sufficient to support economy, efficiency, and access to services for medicaid recipients. The agency will publish base rate factors on its web site.</u>

The changes were made because:

SUMMARY OF COMMENTS RECEIVED	THE AGENCY CONSIDERED ALL THE COMMENTS. THE ACTIONS TAKEN IN RESPONSE TO THE COMMENTS, OR THE REASONS NO ACTIONS WERE TAKEN, FOLLOW.
We are still concerned that the rule-making communication process followed by the health care authority (HCA) limits stakeholder involvement, since the existence of and copies of stakeholder drafts are only known and provided to those who knew to respond to the CR-101 for the specific WACs. We have initiated steps to ensure we respond to any relevant CR-101 notices and are advising our members to do the same, but we believe the process does exclude many from being aware of, or commenting on, exposure drafts. In addition, we find it very difficult to comment on changes in proposed rules when changes are done on a piecemeal basis. We think the agency should release and allow comment on all the rules that impact the new inpatient and outpatient system as a complete entity, rather than releasing parts that may relate to each other on an individual basis.	The agency follows the rule-making process dictated by chapter 34.05 RCW, Administrative Procedure Act (APA). The agency solicits comments from those individuals and organizations that have previously indicated a desire to participate in rule making concerning a particular subject (e.g., hospital rules). The agency will continue following the APA; however, it will also continue to find ways to improve how it communicates with stakeholders during the rule-making process. The agency attempted to partition the rule-making process into logical groups. The agency thought that distribution in this manner would make the review process more manageable. The agency will consider your comments for future rule-making projects.
Aside from the budget neutrality adjustment, our largest concern is the absence of an independent base rate calculation methodology in the rule, other than that the payments will fit a fixed expenditure level determined by past payments or a fixed appropriation target. The new rate calculation language replaces existing language that sets rates that bore some relationship to average costs. Instead, the "budget target" and "budget target adjustor" language in WAC 182-550-3800 calibrates them to a level "to maintain aggregate payments across the system." While the current rebasing is intended to maintain the current expenditure level based on state fiscal year 2011 claims data, the "budget target "definition in the rule does not require that a specific expenditure level be maintained going forward, and inappropriately puts hospitals at risk for increases in caseload, utilization, and acuity.	The agency added the following sentence to WAC 182-550-3800(4): "The agency ensures that base DRG conversion factors and per diem rates are sufficient to support economy, efficiency, and access to services for medicaid recipients."
It also grants HCA a wide degree of latitude in setting base rates that may bear little relationship to what is needed to support economy, efficiency, and access to services for medicaid recipients. While the current "budget target adjustor" language may support its application at specific times, the absence of separate language to ensure the adequacy of base rates detaches the process in a way that isolates the legislature from their federal requirements to fund the medicaid program at appropriate levels.	

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 15, Repealed 16.

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 15, Repealed 16.

Kevin M. Sullivan
Rules Coordinator

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

WAC 182-550-1050 Hospital services definitions. The following definitions and abbreviations, those found in ((~~WAC 388-500-0005~~)) chapter 182-500 WAC, Medical definitions, and definitions and abbreviations found in other sections of this chapter((~~,~~)) apply to this chapter. When a term is not defined in this chapter, other agency or agency's designee WAC, or state or federal law, the medical definitions found in *Taber's Cyclopedic Medical Dictionary* apply.

"Accommodation costs" ((~~means~~)) - The expenses incurred by a hospital to provide its patients services for which a separate charge is not customarily made. These expenses include, but are not limited to, room and board, medical social services, psychiatric social services, and the use of certain hospital equipment and facilities.

((~~**"Acquisition cost (AC)"** means the cost of an item excluding shipping, handling, and any applicable taxes as indicated by a manufacturer's invoice.~~))

"Accredited" or **"accreditation"** - A term used by nationally recognized health organizations, such as the commission on accreditation of rehabilitation facilities (CARF), to indicate a facility meets both professional and community standards of medical care.

"Acute" ((~~means~~)) - A medical condition of severe intensity with sudden onset. ((~~See WAC 388-550-2511 for the definition of "acute"~~)) For the purposes of the acute physical medicine and rehabilitation (Acute PM&R) program, acute means an intense medical episode, not longer than three months.

"Acute care" ((~~means~~)) - Care provided for patients who are not medically stable or have not attained a satisfactory level of rehabilitation. These patients require frequent monitoring by a health care professional in order to maintain their health status (((~~see WAC 248-27-015~~))).

"Acute physical medicine and rehabilitation (Acute PM&R)" ((~~means~~)) - A comprehensive inpatient rehabilitative program coordinated by an interdisciplinary team at ((~~a department approved~~)) an agency-approved rehabilitation facility. The program provides twenty-four-hour specialized nursing services and an intense level of therapy for specific medical conditions for which the client shows significant potential for functional improvement. Acute PM&R is a twenty-four hour inpatient comprehensive program of integrated medical and rehabilitative services provided during the acute phase of a client's rehabilitation.

((~~**"ADATSA/DASA assessment center"** means an agency contracted by the division of alcohol and substance abuse (DASA) to provide chemical dependency assessment for clients and pregnant women in accordance with the Alcoholism and Drug Addiction Treatment and Support Act (ADATSA). Full plans for a continuum of drug and alcohol treatment services for pregnant women are also developed in ADATSA/DASA assessment centers.~~

~~**"Add-on procedure(s)"** means secondary procedure(s) that are performed in addition to another procedure.~~))

"Administrative day" ((~~means a day~~)) or **"administrative days"** - One or more days of a hospital stay in which an acute inpatient or observation level of care is ((~~no longer~~)) not medically necessary, and ((~~noninpatient hospital placement~~)) a lower level of care is appropriate.

"Administrative day rate" ((~~means~~)) - The agency's statewide medicaid average daily nursing facility rate ((~~as determined by the department.~~

~~**"Admitting diagnosis"** means the medical condition before study, which is initially responsible for the client's admission to the hospital, as defined by the international classification of diseases, 9th revision, clinical modification (ICD-9-CM) diagnostic code, or with the current published ICD-CM coding guidelines used by the department.~~

~~**"Advance directive"** means a document, recognized under state law, such as a living will, executed by a client, that tells the client's health care providers and others about the client's decisions regarding his or her health care in the event the client should become incapacitated. (See WAC 388-501-0125.)~~

~~**"Aggregate capital cost"** means the total cost or the sum of all capital costs~~)).

"Aggregate cost" ((~~means~~)) - The total cost or the sum of all constituent costs.

"Aggregate operating cost" ((~~means~~)) - The total cost or the sum of all operating costs.

((~~**"Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)"** means the law and the state-administered program it established which provides medical services for persons who are incapable of gainful employment due to alcoholism or substance addiction.~~

~~**"Alcoholism and/or alcohol abuse treatment"** means the provision of medical social services to an eligible client designed to mitigate or reverse the effects of alcoholism or alcohol abuse and to reduce or eliminate alcoholism or alcohol abuse behaviors and restore normal social, physical, and psychological functioning. Alcoholism or alcohol abuse treatment is characterized by the provision of a combination of alcohol education sessions, individual therapy, group therapy, and related activities to detoxified alcoholics and their families.~~))

"All-patient DRG grouper (AP-DRG)" ((~~means~~)) - A computer software program that determines the medical and surgical diagnosis-related group (DRG) assignments used by the agency for inpatient admissions between August 1, 2007, and June 30, 2014.

"All-patient refined DRG grouper (APR-DRG)" - A computer software program that determines the medical and surgical diagnosis-related group (DRG) assignments used by the agency for inpatient admissions on and after July 1, 2014.

"Allowable" ((~~means~~)) - The calculated amount for payment, after exclusion of any "nonallowed service or charge," based on the applicable payment method before final adjustments, deductions, and add-ons.

"Allowed amount" ((~~means~~)) - The initial calculated amount for any procedure or service, after exclusion of any "nonallowed service or charge," that the ((~~department~~)) agency allows as the basis for payment computation before final adjustments, deductions, and add-ons.

"Allowed charges" ((~~means the maximum amount for any procedure or service that the department allows as the basis for payment computation~~)) - The total billed charges for allowable services.

"Allowed covered charges" ((~~means the maximum amount of charges on a hospital claim recognized by the department as charges for "hospital covered service" and payment computation, after exclusion of any "nonallowed service or charge," and before final adjustments, deductions, and add-ons~~)) - The total billed charges for services minus the billed charges for noncovered and/or denied services.

"Ambulatory payment classification (APC)" - A grouping that categorizes outpatient visits according to the clinical characteristics, the typical resource use, and the costs associated with the diagnoses and the procedures performed.

"Ambulatory surgery" ((~~means~~)) - A surgical procedure that is not expected to require an inpatient hospital admission.

((~~**"Ancillary hospital costs"** means the expenses incurred by a hospital to provide additional or supporting services to its patients during their hospital stay. See **"ancillary services."**~~))

"Ancillary services" ((~~means~~)) - Additional or supporting services provided by a hospital to a ((~~patient~~)) client during the ((~~patient's~~)) client's hospital stay. These services include, but are not limited to((~~,~~)): Laboratory, radiology, drugs, delivery room, operating room, postoperative recovery rooms, and other special items and services.

"Appropriate level of care" ((~~means~~)) - The level of care required to best manage a client's illness or injury based on:

(1) The severity of illness ((~~presentation~~)) and the intensity of services ((~~received~~)) required to treat the illness or injury; or

(2) A condition-specific episode of care.

((~~**"Approved treatment facility"** means a treatment facility, either public or private, profit or nonprofit, approved by DSHS.~~))

"Audit" ((~~means~~)) - An assessment, evaluation, examination, or investigation of a health care provider's accounts, books, and records, including:

(1) Health, financial, and billing records pertaining to billed services paid by the ((~~department~~)) agency through ((~~medicaid, SCHIP, or other state programs~~)) Washington apple health, by a person not employed or affiliated with the provider, for the purpose of verifying the service was provided as billed and was allowable under program regulations; and

(2) Financial, statistical, and health records, including mathematical computations and special studies conducted supporting the medicare cost report (Form 2552-96 and 2552-10 or successor form), submitted to the ((~~department~~)) agency for the purpose of establishing program rates for payment to hospital providers.

((~~**"Audit claims sample"** means a selection of claims reviewed under a defined audit process.~~))

"Authorization" - See **"prior authorization"** and **"expedited prior authorization (EPA)."**

((~~**"Average hospital rate"** means an average of hospital rates for any particular type of rate that the department uses.~~))

"Bad debt" ((~~means~~)) - An operating expense or loss incurred by a hospital because of uncollectible accounts receivables.

((~~**"Beneficiary"** means a recipient of Social Security benefits, or a person designated by an insuring organization as eligible to receive benefits.~~))

"Bedside nursing services" - Services included under the room and board services paid to the facility and provided by nursing service personnel. These services include, but are not limited to: Medication administration, IV hydration and IV medication administration, vaccine administration, dressing applications, therapies, glucometry testing and other point of care testing, catheterizations, tube feedings and irrigations, and equipment monitoring services.

"Billed charge" ((~~means~~)) - The charge submitted to the ((~~department~~)) agency by the provider.

((~~**"Blended rate"** means a mathematically weighted average rate.~~))

"Bordering city hospital" ((~~means~~)) - A hospital located ((~~outside Washington state and located~~)) in one of the ((~~bordering~~)) cities listed in WAC ((~~388-501-0175~~)) 182-501-0175.

((~~**"BR" -** See **"by report."**~~))

"Budget ((~~neutrality~~)) neutral" ((~~is a concept that means that hospital payments resulting from payment methodology changes and rate changes should be equal to what payments would have been if the payment methodology changes and rate changes were not implemented~~)) - A condition in which a claims model produces aggregate payments to hospitals that are the same under two separate payment systems. ((~~(~~))See also **"budget neutrality factor."**((~~)~~))

"Budget neutrality factor" ((~~is a factor~~)) - A multiplier used by the ((~~department~~)) agency to ((~~adjust conversion factors, per diem rates, and per case rates in order~~)) ensure that modifications to the payment ((~~methodology~~)) method and rates are budget neutral. ((~~(~~))See also **"budget ((~~neutrality~~)) neutral."**((~~)~~))

"Budget target" - Funds appropriated by the legislature or through the agency's budget process to pay for a specific group of services, including anticipated caseload changes or vendor rate increases.

"Budget target adjuster" - A multiplier applied to the outpatient prospective payment system (OPPS) payment to ensure aggregate payments do not exceed the established budget target.

"Bundled services" ((~~means~~)) - Interventions ((~~that are~~)) integral to or related to the major procedure ((~~and are not paid separately.~~)

"Buy-in premium" means a monthly premium the state pays so a client is enrolled in part A and/or part B medicare.

"By report (BR)" means a method of payment in which the department determines the amount it will pay for a service when the rate for that service is not included in the department's published fee schedules. Upon request the provider must submit a "report" which describes the nature, extent, time, effort and/or equipment necessary to deliver the service.

"Callback" means keeping hospital staff members on duty beyond their regularly scheduled hours, or having them return to the facility after hours to provide unscheduled services which are usually associated with hospital emergency room, surgery, laboratory and radiology services.

"Capital-related costs" or **"capital costs"** means the component of operating costs related to capital assets, including, but not limited to:

(1) Net adjusted depreciation expenses;

(2) Lease and rentals for the use of depreciable assets;

(3) The costs for betterment and improvements;

(4) The cost of minor equipment;

(5) Insurance expenses on depreciable assets;

(6) Interest expense; and

(7) Capital-related costs of related organizations that provide services to the hospital.

Capital costs due solely to changes in ownership of the provider's capital assets are excluded.

"CARF" is the official name for commission on accreditation of rehabilitation facilities. CARF is an international, independent, nonprofit accreditor of human service providers and networks in the areas of aging services, behavioral health, child and youth services, employment and community services, and medical rehabilitation)). The agency does not pay separately for these services.

"Case mix" ((~~means, from the clinical perspective, the condition of the treated patients and the difficulty associated with providing care. Administratively, it means the resource intensity demands that patients place on an institution~~)) - A relative value assigned to a DRG or classification of patients in a medical care environment representing the resource intensity demands placed on an institution.

"Case mix index (CMI)" ((~~means the arithmetical index that measures~~)) - The average relative weight of all cases treated in a hospital during a defined period.

"Centers for Medicare and Medicaid Services (CMS)" – See WAC 182-500-0020.

"Charity care" - See chapter 70.170 RCW.

"Chemical dependency" ((~~means~~)) - An ((~~alcohol or drug~~)) addiction((~~,~~)) or dependence on ((~~alcohol and one or more other psychoactive chemicals~~)) alcohol or drugs, or both.

"Children's health insurance program (CHIP)" - The federal Title XXI program under which medical care is provided to uninsured children younger than age nineteen. Part of Washington apple health.

"Children's hospital" ((~~means~~)) - A hospital primarily serving children.

"Client" ((~~means~~)) - A person who receives or is eligible to receive services through ((~~department of social and health services (DSHS)~~)) agency programs.

((~~**"CMS"** means Centers for Medicare and Medicaid Services.~~))

"Commission on accreditation of rehabilitation facilities (CARF)" - See http://www.carf.org/home/.

"CMS PPS input price index" ((~~means~~)) - A measure, expressed as a percentage, of the annual inflationary costs for hospital services((~~, measured by Global Insight's Data Resources, Inc. (DRI).~~

~~**"Comorbidity"** means of, relating to, or caused by a disease other than the principal disease.~~

~~**"Complication"** means a disease or condition occurring subsequent to or concurrent with another condition and aggravating it~~)).

"Comprehensive hospital abstract reporting system (CHARS)" ((~~means~~)) - The department of health's (DOH's) inpatient hospital data collection, tracking, and reporting system.

((~~**"Contract hospital selective contracting"** means for dates of admission before July 1, 2007, a licensed hospital located in a selective contracting area, which is awarded a contract to participate in the department's hospital selective contracting program. The department's hospital selective contracting program no longer exists for admissions on and after July 1, 2007.~~))

"Condition-specific episode of care" - Care provided to a client based on the client's primary condition, complications, comorbidities, standard treatments, and response to treatments.

"Contract hospital" ((~~means~~)) - A hospital contracted by the ((~~department~~)) agency to provide specific services.

((~~**"Contractual adjustment"** means the difference between the amount billed at established charges for the services provided and the amount received or due from a third-party payer under a contract agreement. A contractual adjustment is similar to a trade discount.~~

~~**"Cost proxy"** means an average ratio of costs to charges for ancillary charges or per diem for accommodation cost centers used to determine a hospital's cost for the services where the hospital has medicaid claim charges for the services, but does not report costs in corresponding centers in its medicare cost report.~~))

"Conversion factor" - A hospital-specific dollar amount that is used in calculating inpatient payments.

"Core provider agreement (CPA)" - The basic contract the agency holds with providers serving Washington apple health clients.

"Cost report" - See **"medicare cost report."**

"Costs" ((~~mean department-approved~~)) - Agency-approved operating, medical education, and capital-related costs (capital costs) as reported and identified on the "cost report."

((~~**"Cost based conversion factor (CBCF)"** means for dates of admission before August 1, 2007, a hospital-specific dollar amount that reflects a hospital's average cost of treating medicaid and SCHIP clients. It is calculated from the hospital's cost report by dividing the hospital's costs for treating medicaid and SCHIP clients during a base period by the number of medicaid and SCHIP discharges during that same period and adjusting for the hospital's case mix. See also "hospital conversion factor" and "negotiated conversion factor."~~

~~**"County hospital"** means a hospital established under the provisions of chapter 36.62 RCW.~~))

"Covered charges" ((~~means~~)) - Billed charges submitted to the ((~~department~~)) agency on a claim by the provider, less the noncovered charges indicated on the claim.

"Covered services" - See **"hospital covered service"** and WAC ((~~388-501-0060~~)) 182-501-0050.

"Critical border hospital" ((~~means, on and after August 1, 2007,~~)) - An acute care hospital located in a bordering city (see WAC 182-501-0175 for list) that the ((~~department~~)) agency has, through analysis of admissions and hospital days, designated as critical to provide ((~~elective~~)) health care for ((~~the department's medical assistance~~)) Washington apple health clients.

"Current procedural terminology (CPT)" ((~~means~~)) - A systematic listing of descriptive terms and identifying codes for reporting medical services, procedures, and interventions performed by physicians. CPT is copyrighted and published annually by the American Medical Association (AMA).

((~~**"Customary charge payment limit"** means the limit placed by the department on aggregate DRG payments to a hospital during a given year to assure that DRG payments do not exceed the hospital's charges to the general public for the same services.~~

~~**"Day outlier"** means an inpatient case with a date of admission before August 1, 2007, that requires the department to make additional payment to the hospital provider but which does not qualify as a high-cost outlier. See **"day outlier payment"** and **"day outlier threshold."** The department's day outlier policy no longer exists for dates of admission on and after August 1, 2007.~~

~~**"Day outlier payment"** means the additional amount paid to a disproportionate share hospital for inpatient claims with dates of admission before August 1, 2007, for a client five years old or younger who has a prolonged inpatient stay which exceeds the day outlier threshold but whose covered charges for care fall short of the high cost outlier threshold. The amount is determined by multiplying the number of days in excess of the day outlier threshold and the administrative day rate.~~

~~**"Day outlier threshold"** means for inpatient claims with dates of admission before August 1, 2007, the average number of days a client stays in the hospital for an applicable DRG before being discharged, plus twenty days.~~))

"Deductible" ((~~means~~)) - The dollar amount a ((~~beneficiary~~)) client is responsible for((~~,~~)) before ((~~medicare~~)) an insurer, such as medicare, starts paying((~~,~~)) or the initial specific dollar amount for which the ((~~applicant or~~)) client is responsible.

"Department of social and health services (DSHS)" ((~~means the state department of social and health services (DSHS). As used in this chapter, department also means MAA, HRSA, or a successor administration that administers the state's medicaid, SCHIP, and other medical assistance programs.~~

~~**"Detoxification"** means treatment provided to persons who are recovering from the effects of acute or chronic intoxication or withdrawal from alcohol or other drugs~~)) - The Washington state agency that provides food assistance, financial aid, medical and behavioral health care, and other services to eligible children, families, and vulnerable adults and seniors of Washington state.

"Diabetes education program" ((~~means~~)) - A comprehensive, multidisciplinary program of instruction offered by a ((~~department of health (DOH) approved~~)) DOH-approved diabetes education provider to diabetic clients ((~~on dealing with~~)) for managing diabetes. This includes instruction on nutrition, foot care, medication and insulin administration, skin care, glucose monitoring, and recognition of signs/symptoms of diabetes with appropriate treatment of problems or complications.

"Diagnosis code" ((~~means~~)) - A set of numeric or alphanumeric characters assigned by the ((~~ICD-9-CM, or successor document,~~)) current published ICD-CM coding guidelines used by the agency as a shorthand symbol to represent the nature of a disease or condition.

"Diagnosis-related group (DRG)" ((~~means~~)) - A classification system that categorizes hospital patients into clinically coherent and homogenous groups with respect to resource use((~~, i.e., similar treatments and statistically similar lengths of stay for patients with related medical conditions~~)). Classification of patients is based on the ((~~International Classification of Diseases (ICD-9)~~)) current published ICD-CM coding guidelines used by the agency, the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria.

"Direct medical education costs" ((~~means~~)) - The direct costs of providing an approved medical residency program as recognized by medicare.

"Discharging hospital" ((~~means~~)) - The institution releasing a client from the acute care hospital setting.

"Discount factor" - The percentage applied to additional significant procedures when a claim has multiple significant procedures or when the same procedure is performed multiple times on the same day. Not all significant procedures are subject to a discount factor.

"Disproportionate share hospital (DSH) payment" ((~~means~~)) - A supplemental ((~~payment(s)~~)) payment made by the ((~~department~~)) agency to a hospital that qualifies for one or more of the disproportionate share hospital programs identified in the state plan. See WAC 182-550-4900.

"Disproportionate share hospital (DSH) program" ((~~is~~)) - A program through which the ((~~department gives consideration to hospitals~~)) agency makes payment adjustments to eligible hospitals that serve a disproportionate number of low-income ((~~patients with special needs by making payment adjustment to eligible hospitals~~)) clients in accordance with legislative direction and established payment methods. See 1902 (a)(13)(A)(iv) of the Social Security Act. See also WAC ((~~388-550-4900 through 388-550-5400~~)) 182-550-4900 through 182-550-5400.

"Dispute conference" - See **"hospital dispute conference."**

"Distinct unit" ((~~means medicare-certified~~)) - A distinct area for psychiatric ((~~or~~)), rehabilitation, or detox services which has been certified by medicare within an acute care hospital or ((~~a department-designated unit in~~)) approved by the agency within a children's hospital.

"Division of ((~~alcohol and substance abuse (DASA)" is~~)) behavioral health and recovery services (DBHR)" - The division within DSHS ((~~responsible for providing alcohol and drug-related services to help clients recover from alcoholism and drug addiction~~)) that administers mental health, problem gambling, and substance abuse programs authorized by chapters 43.20A, 71.05, 71.24, 71.34, and 70.96A RCW.

"DRG" - See **"diagnosis-related group."**

"DRG allowed amount" - The DRG relative weight multiplied by the conversion factor.

"DRG average length-of-stay" ((~~means for dates of admission on and after July 1, 2007, the department's~~)) - The agency's average length-of-stay for a DRG classification established during ((~~a department~~)) an agency DRG rebasing and recalibration project.

"DRG-exempt services" ((~~means services which are~~)) - Services paid through ((~~other methodologies than those using inpatient medicaid conversion factors, inpatient state-administered program conversion factors, cost-based conversion factors (CBCF) or negotiated conversion factors (NCF). Some examples are services paid using a~~)) methods other than DRG, such as per diem rate, ((~~a~~)) per case rate, or ((~~a~~)) ratio of costs-to-charges (RCC) ((~~rate~~)).

"DRG payment" ((~~means~~)) - The total payment made by the ((~~department~~)) agency for a client's inpatient hospital stay. ((~~This~~)) The DRG payment ((~~allowed amount is calculated by multiplying the conversion factor by the DRG relative weight assigned by the department to provider's inpatient claim before any outlier payment calculation~~)) is the DRG allowed amount plus the high outlier minus any third-party

liability, client participation, medicare payment, and any other adjustments applied by the agency.

"DRG relative weight" ((~~means the average cost or charge of a certain DRG classification divided by the average cost or charge, respectively, for all cases in the entire data base for all DRG classifications.~~

~~**"Drug addiction and/or drug abuse treatment"** means the provision of medical and rehabilitative social services to an eligible client designed to mitigate or reverse the effects of drug addiction or drug abuse and to reduce or eliminate drug addiction or drug abuse behaviors and restore normal physical and psychological functioning. Drug addiction or drug abuse treatment is characterized by the provision of a combination of drug and alcohol education sessions, individual therapy, group therapy and related activities to detoxified addicts and their families.~~

~~**"DSHS"** means the department of social and health services.~~

~~**"Elective procedure or surgery"** means a nonemergency procedure or surgery that can be scheduled at the client's and provider's convenience.~~)) - A factor used in the calculation of DRG payments. As of July 1, 2014, the medicaid agency uses the 3M™ Corporation's national weights developed for the all-patient refined-diagnosis-related group (APR-DRG) software.

"Enhanced ambulatory patient groupings (EAPG)" - The payment system used by the agency to calculate reimbursement to hospitals for the facility component of outpatient services on and after July 1, 2014. This system uses 3M's EAPGs as the primary basis for payment.

"Emergency medical condition" ((~~see WAC 388-500-0005~~)) - See WAC 182-500-0030.

((~~**"Emergency medical expense requirement (EMER)"** means a specified amount of expenses for ambulance, emergency room or hospital services, including physician services in a hospital, incurred for an emergency medical condition that a client must incur prior to certification for the psychiatric indigent inpatient (PHI) program.~~))

"Emergency room" or **"emergency facility"** or **"emergency department"** ((~~means an organized, distinct hospital-based facility available twenty-four hours a day for the provision of unscheduled episodic services to patients who present for immediate medical attention, and is capable of providing emergency services including trauma care~~)) - A distinct hospital-based facility which provides unscheduled services to clients who require immediate medical attention. An emergency department must be capable of providing emergency medical, surgical, and trauma care services twenty-four hours a day, seven days a week. A physically separate extension of an existing hospital emergency department may be considered a freestanding emergency department as long as the extension provides comprehensive emergency medical, surgical, and trauma care services twenty-four hours a day, seven days a week.

"Emergency services" ((~~means~~)) - Health care services required by and provided to a ((~~patient~~)) client after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in placing the ((~~patient's~~)) client's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. ((~~For department payment to a hospital,~~)) Inpatient maternity services are ((~~treated as~~)) considered emergency services by the agency.

"Equivalency factor (EF)" ((~~means~~)) - A factor that may be used by the ((~~department~~)) agency in conjunction with other factors to determine the level of a state-administered program payment. See WAC ((~~388-550-4800~~)) 182-550-4800.

"Exempt hospital((—)) - DRG payment method" ((~~means~~)) - A hospital that for a certain ((~~patient~~)) client category is reimbursed for services to ((~~medical assistance~~)) Washington apple health clients through methodologies other than those using DRG conversion factors.

((~~**"Exempt hospital - Hospital selective contracting program"** means a hospital that is either not located in a selective contracting area or is exempted by the department from the selective contracting program. The department's hospital selective contracting program no longer exists for admissions on and after July 1, 2007.~~))

"Expedited prior authorization (EPA)" ((~~means the department-delegated process of creating an authorization number for selected medical/dental procedures and related supplies and services in which providers use a set of numeric codes to indicate which department-acceptable indications, conditions, diagnoses, and/or department-defined criteria are applicable to a particular request for service.~~

~~**"Expedited prior authorization (EPA) number"** means an authorization number created by the provider that certifies that the department-published criteria for the medical/dental procedure or supply or services have been met~~)) - See WAC 182-500-0030.

"Experimental service" ((~~means~~)) - A procedure, course of treatment, drug, or piece of medical equipment, which lacks scientific evidence of safety and effectiveness. See WAC ((~~388-531-0050~~)) 182-531-0050. A service is not "experimental" if the service:

(1) Is generally accepted by the medical profession as effective and appropriate; and

(2) Has been approved by the federal Food and Drug Administration (FDA) or other requisite government body if such approval is required.

"Fee-for-service" ((~~means the general payment process the department uses to pay a hospital provider's claim for covered medical services provided to medical assistance clients when the payment for these services is through direct payment to the hospital provider, and is not the responsibility of one of the department's managed care organization (MCO) plans, or a mental health division designee~~)) - See WAC 182-500-0035.

"Fiscal intermediary" ((~~means~~)) - Medicare's designated fiscal intermediary for a region ((~~and/or~~)) or category of service, or both.

"Fixed per diem rate" ((~~means~~)) - A daily amount used to determine payment for specific services provided in long-term acute care (LTAC) hospitals.

"Formal release" - When a client:

(1) Discharges from a hospital or distinct unit;

(2) Dies in a hospital or distinct unit;

(3) Transfers from a hospital or distinct unit as an acute care transfer; or

(4) Transfers from the hospital or distinct unit to a designated psychiatric unit or facility, or a designated acute rehabilitation unit or facility.

"Global surgery days" ((~~means~~)) - The number of preoperative and follow-up days that are included in the payment to the physician for the major surgical procedure.

"Graduate medical education costs" ((~~means~~)) - The direct and indirect costs of providing medical education in teaching hospitals. See "direct medical education costs" and "indirect medical education costs."

"Grouper" - See **"all-patient DRG grouper (APDRG)"** and **"all-patient refined DRG grouper (APR-DRG)."**

"Health ((~~**and recovery services administration (HRSA)"** means the successor administration to the medical assistance administration within the department, authorized by the department secretary to administer the acute care portion of Title XIX medicaid, Title XXI SCHIP, and other medical assistance programs, with the exception of certain nonmedical services for persons with chronic disabilities~~)) **care authority (medicaid agency)" -** The Washington state agency that administers Washington apple health.

((~~**"Health care team"** means a group of health care providers involved in the care of a client.~~

~~**"High-cost outlier"** means, for dates of admission before August 1, 2007, a claim paid under the DRG payment method that did not meet the definition of "administrative day," and has extraordinarily high costs when compared to other claims in the same DRG. For dates of admission on and after January 1, 2001, to qualify as a high-cost outlier, the billed charges, minus the noncovered charges reported on the claim, must exceed three times the applicable DRG payment and exceed thirty-three thousand dollars. The department's high-cost outliers are not applicable for dates of admission on and after July 1, 2007.~~

~~**"High outlier claim Medicaid/SCHIP DRG"** means, for dates of admission on and after August 1, 2007, a claim paid under the DRG payment method that does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the department. See WAC 388-550-3700.~~))

"High outlier ((~~claim Medicaid/SCHIP per diem~~))" ((~~means, for dates of admission on and after August 1, 2007,~~)) - A DRG claim ((~~that is~~)) classified by the ((~~department~~)) agency as being allowed a high outlier payment that is paid under the ((~~per diem~~)) DRG payment method, does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the ((~~department~~)) agency. See WAC ((~~388-550-3700~~)) 182-550-3700.

((~~**"High outlier claim State-administered program DRG"** means, for dates of admission on and after August 1, 2007, claim paid under the DRG payment method that does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the department. See WAC 388-550-3700.~~

~~**"High outlier claim State-administered program per diem"** means, for dates of admission on or after August 1, 2007, claim that is classified by the department as being allowed as a high outlier payment, that is paid under the per diem payment method, does not meet the definition of "administrative day," and has extraordinarily high costs as determined by the department. See WAC 388-550-3700.~~))

"Hospice" ((~~means~~)) - A medically directed, interdisciplinary program of palliative services for terminally ill clients and the clients' families. Hospice is provided under arrangement with a Washington state-licensed and Title XVIII-certified Washington state hospice.

"Hospital" ((~~means~~)) - An entity that is licensed as an acute care hospital in accordance with applicable state laws and regulations, or the applicable state laws and regulations of the state in which the entity is located when the entity is out-of-state, and is certified under Title XVIII of the federal Social Security Act. The term "hospital" includes a medicare or state-certified distinct rehabilitation unit ((~~or~~)), a "psychiatric hospital" as defined in this section, or any other distinct unit of the hospital.

((~~**"Hospital base period"** means, for purposes of establishing a provider rate, a specific period or timespan used as a reference point or basis for comparison.~~

~~**"Hospital base period costs"** means costs incurred in, or associated with, a specified base period.~~

~~**"Hospital conversion factor"** means a hospital-specific dollar amount that reflects the average cost for a DRG paid case of treating medicaid and SCHIP clients in a given hospital. See cost-based conversion factor (CBCF) and negotiated conversion factor (NCF).~~))

"Hospital covered service" ((~~means a~~)) - Any service ((~~that is~~)), treatment, equipment, procedure, or supply provided by a hospital, covered under a ((~~medical assistance~~)) Washington apple health program, and ((~~is~~)) within the scope of an eligible client's ((~~medical assistance~~)) Washington apple health program.

"Hospital cost report" - See **"cost report."**

((~~**"Hospital dispute resolution conference"** means an informal meeting for deliberation during a provider administrative appeal. For provider audit appeals, see chapter 388-502A WAC. For provider rate appeals, see WAC 388-501-0220.~~

~~**"Hospital market basket index"** means a measure, expressed as a percentage, of the annual inflationary costs for hospital services measured by Global Insight's Data Resources, Inc. (DRI) and identified as the CMS PPS input price index.~~

~~**"Hospital peer group"** means the peer group categories established by the department for classification of hospitals:~~

~~(1) Peer Group A - Hospitals identified by the department as rural hospitals (excludes all rural hospitals paid by the certified public expenditure (CPE) payment method and critical access hospital (CAH) payment method);~~

~~(2) Peer Group B - Hospitals identified by the department as urban hospitals without medical education programs (excludes all hospitals paid by the CPE payment method and CAH payment method);~~

~~(3) Peer Group C - Hospitals identified by the department as urban hospitals with medical education programs (excludes all hospitals paid by the CPE payment method and CAH payment method);~~

(4) Peer Group D - Hospitals identified by the department as specialty hospitals and/or hospitals not easily assignable to the other five peer groups;

(5) Peer Group E - Hospitals identified by the department as public hospitals participating in the "full cost" public hospital certified public expenditure (CPE) payment program; and

(6) Peer Group F - Hospitals identified by the department of health (DOH) as CAHs, and paid by the department using the CAH payment method.

"Hospital selective contracting program" or **"selective contracting"** means for dates of admission before July 1, 2007, a negotiated bidding program for hospitals within specified geographic areas to provide inpatient hospital services to medical assistance clients. The department's hospital selective contracting program no longer exists for dates of admission on and after July 1, 2007.))

"Hospital readmission" - A situation in which a client who was admitted as an inpatient and discharged from the hospital has returned to inpatient status to the same or a different hospital.

"Indirect medical education costs" ((means)) **-** The indirect costs of providing an approved medical residency program as recognized by medicare.

"Inflation adjustment" ((means,)) **-** For cost inflation, this is the hospital inflation adjustment. This adjustment is determined by using the inflation factor method ((supported)) approved by the legislature. For charge inflation, ((it means)) this is the inflation factor determined by comparing average discharge charges for the industry from one year to the next, as found in the comprehensive hospital abstract reporting system (CHARS) ((standard reports three and four)) Hospital Census and Charges by Payer report.

((**"Informed consent"** means that an individual consents to a procedure after the provider who obtained a properly completed consent form has done all of the following:

(1) Disclosed and discussed the patient's diagnosis;

(2) Offered the patient an opportunity to ask questions about the procedure and to request information in writing;

(3) Given the patient a copy of the consent form;

(4) Communicated effectively using any language interpretation or special communication device necessary per 42 C.F.R. 441.257; and

(5) Given the patient oral information about all of the following:

(a) The patient's right to not obtain the procedure, including potential risks, benefits, and the consequences of not obtaining the procedure;

(b) Alternatives to the procedure including potential risks, benefits, and consequences; and

(c) The procedure itself, including potential risks, benefits, and consequences.

"Inpatient hospital" means a hospital authorized by the department of health to provide inpatient services.))

"Inpatient hospital admission" ((means an)) **-** A formal admission to a hospital based on an evaluation of the client using objective clinical indicators for the purpose of providing medically necessary, acute inpatient care((, including)). These indicators include assessment, monitoring, and therapeutic services as required to best manage the client's illness or injury((, and that is)). All applicable indicators must be documented in the client's health record. The decision to admit a client to inpatient status should be based on the condition-specific episode of care, severity of illness presented, and the intensity of services rendered. The agency does not deem inpatient hospital admissions as covered or noncovered solely on the basis of the length of time the client actually spends in the hospital. Generally, a client remains overnight and occupies a bed. Inpatient status can apply even if the client is discharged or transferred to another acute hospital and does not actually use a hospital bed overnight. For the agency to recognize a stay as inpatient there must be a physician admission order in the client's medical record indicating the status as inpatient.

"Inpatient medicaid DRG conversion factor" ((means)) **-** A dollar amount that represents selected hospitals' average costs of treating medicaid and ((SCHIP)) CHIP clients. The conversion factor is a rate that is multiplied by a DRG relative weight to pay medicaid and ((SCHIP)) CHIP claims under the DRG payment method. See WAC ((388-550-3450)) 182-550-3800 for how this conversion factor is calculated.

"Inpatient services" ((means)) **-** Health care services provided ((directly or indirectly)) to a client ((subsequent to the client's inpatient hospital admission and prior to discharge)) during hospitalization whose condition warrants formal admission and treatment in a hospital.

((("))"Inpatient state-administered program conversion factor" ((means a dollar amount used as a rate)) **-** A DRG conversion factor reduced from the inpatient medicaid DRG conversion factor to pay a hospital for inpatient services provided to a client eligible under a state-administered program. The conversion factor is multiplied by a DRG relative weight to pay claims under the DRG payment method.

"Intermediary" - See **"fiscal intermediary."**

"International Classification of Diseases((, 9th Revision, Clinical Modification (ICD-9-CM) Edition" means)) **(ICD-9-CM and ICD-10-CM)" -** The systematic listing ((that transforms verbal descriptions)) of diseases, injuries, conditions, and procedures ((into)) as numerical or alpha numerical designations (coding).

"Length of stay (LOS)" ((means)) **-** The number of days of inpatient hospitalization, calculated by adding the total number of days from the admission date to the discharge date, and subtracting one day.

((**"Length of stay extension request"** means a request from a hospital provider for the department, or in the case of psychiatric admission, the appropriate mental health division designee, to approve a client's hospital stay exceeding the average length of stay for the client's diagnosis and age.

"Lifetime hospitalization reserve" means, under the medicare Part A benefit, the nonrenewable sixty hospital days that a beneficiary is entitled to use during his or her lifetime for hospital stays extending beyond ninety days per benefit period. See also **"reserve days."**))

"Long-term acute care (LTAC) services" ((means)) **-** Inpatient intensive long-term care services provided in ((department-approved)) agency-approved LTAC hospitals to eligible ((medical assistance)) Washington apple health clients who meet criteria for level 1 or level 2 services. See

WAC ((~~388-550-2565 through 388-550-2596~~)) 182-550-2565 through 182-550-2596.

((~~**"Low-cost outlier"** means a case having a date of admission before August 1, 2007, with extraordinarily low costs when compared to other cases in the same DRG. For dates of admission on and after January 1, 2001, to qualify as a low-cost outlier, the allowed charges must be less than the greater of ten percent of the applicable DRG payment or four hundred and fifty dollars. The department's low-cost outliers are not applicable for dates of admission on and after August 1, 2007.~~

~~**"Low-income utilization rate (LIUR)"** means a rate determined by a formula represented as (A/B)+(C/D) in the same period in which:~~

~~(1) The numerator A is the hospital's total patient services revenue under the state plan, plus the amount of cash subsidies for patient services received directly from state and local governments;~~

~~(2) The denominator B is the hospital's total patient services revenue (including the amount of such cash subsidies);~~

~~(3) The numerator C is the hospital's total inpatient service charge attributable to charity care, less the portion of cash subsidies described in (1) of this definition in the period reasonably attributable to inpatient hospital services. The amount shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under the state plan); and~~

~~(4) The denominator D is the hospital's total charge for inpatient hospital services.~~))

"LTAC level 1 services" - LTAC services provided to a client who requires eight or more hours of direct skilled nursing care per day and the client's medical needs cannot be met at a lower level of care due to clinical complexity. Level 1 services include one of the following:

(1) Ventilator weaning care; or

(2) Care for a client who has:

(a) Chronic open wounds that require on-site wound care specialty services and daily assessments and/or interventions; and

(b) At least one comorbid condition (such as chronic renal failure requiring hemodialysis).

"LTAC level 2 services" - LTAC services provided to a client who requires four or more hours of direct skilled nursing care per day, and the clients' medical needs cannot be met at a lower level of care due to clinical complexity. Level 2 services include at least one of the following:

(1) Ventilator care for a client who is ventilator-dependent and is not weanable and has complex medical needs; or

(2) Care for a client who:

(a) Has a tracheostomy;

(b) Requires frequent respiratory therapy services for complex airway management and has the potential for decannulation; and

(c) Has at least one comorbid condition (such as quadriplegia).

"Major diagnostic category (MDC)" ((~~means~~)) - One of the mutually exclusive groupings of principal diagnosis areas in the AP-DRG and APR-DRG classification systems. ((~~The diagnoses in each MDC correspond to a single major organ system or etiology and, in general, are associated with a particular medical specialty.~~

~~**"Market basket index" -** See **"hospital market basket index."**~~

~~**"MDC" -** See **"major diagnostic category."**~~

~~**"Medicaid cost proxy"** means a figure developed to approximate or represent a missing cost figure.~~

~~**"Medicaid inpatient utilization rate (MIPUR)"** means a ratio expressed by the following formula represented as X/Y in which:~~

~~(1) The numerator X is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the state plan in a period.~~

~~(2) The denominator Y is the hospital's total number of inpatient days in the same period as the numerator's. Inpatient day includes each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.~~

~~**"Medical assistance administration (MAA)"** means the health and recovery services administration (HRSA), or a successor administration, within the department authorized by the department's secretary to administer the acute care portion of the Title XIX medicaid, Title XXI state children's health insurance program (SCHIP), and other medical assistance programs, with the exception of certain nonmedical services for persons with chronic disabilities.~~

~~**"Medical assistance program"** means any health care program administered through HRSA.~~))

"Medical care services (MCS)" ((~~means the state-administered limited scope of care provided to general assistance-unemployable (GAU) recipients, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW~~)) - See WAC 182-500-0070.

"Medical education costs" ((~~means~~)) - The expenses incurred by a hospital to operate and maintain a formally organized graduate medical education program.

((~~**"Medical screening evaluation"** means the service(s) provided by a physician or other practitioner to determine whether an emergent medical condition exists.~~

~~**"Medical stabilization"** means a return to a state of constant and steady function. It is commonly used to mean the patient is adequately supported to prevent further deterioration.~~))

"Medical visit" - Diagnostic, therapeutic, or consultative services provided to a client by a health care professional in an outpatient setting.

"Medicare cost report" ((~~means~~)) - The medicare cost report (Form 2552-96 or Form 2552-10), or successor document, completed and submitted annually by a hospital provider((~~:~~

~~(1) To medicare intermediaries at the end of a provider's selected fiscal accounting period to establish hospital reimbursable costs for per diem and ancillary services; and~~

~~(2) To medicaid to establish appropriate DRG and other rates for payment of services rendered~~)).

"Medicare crossover" ((~~means~~)) - A claim involving a client who is eligible for both medicare benefits and medicaid.

"Medicare physician fee schedule (((~~(MFS)~~))) (MPFS)" ((~~means~~)) - The official CMS publication of relative value units and medicare ((~~policies and relative value units~~)) payment policy indicators for the resource-based relative value scale (RBRVS) payment program.

"Medicare Part A" - See WAC ((~~388-500-0005~~)) 182-500-0070.

"Medicare Part B" - See WAC ((~~388-500-0005~~)) 182-500-0070.

((~~**"Medicare buy-in premium"** - See **"buy-in premium."**~~))

"Medicare payment principles" ((~~means~~)) - The rules published in the federal register regarding payment for services provided to medicare clients.

"Mental health ((~~division~~)) designee" ((~~or **"MHD designee"** means~~)) - A professional contact person authorized by ((~~MHD~~)) the division of behavioral health and recovery (DBHR) of DSHS, who operates under the direction of a regional support network (RSN) or a prepaid inpatient health plan (PIHP). See WAC ((~~388-550-2600~~)) 182-550-2600.

((~~**"Mentally incompetent"** means a person who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction.~~

~~**"Multiple occupancy rate"** means the rate customarily charged for a hospital room with two to four patient beds.~~))

"Military hospital" - A hospital reserved for the use of military personnel, their dependents, and other authorized users.

"Modifier" - A two-digit alphabetic and/or numeric identifier added to the procedure code to indicate the type of service performed. The modifier provides the means by which the reporting hospital can describe or indicate that a performed service or procedure has been altered by some specific circumstance but not changed in its definition or code. The modifier can affect payment or be used for information only. Modifiers are listed in fee schedules.

"National correct coding initiative (NCCI)" - A national standard for the accurate and consistent description of medical goods and services using procedural codes. The standard is based on coding conventions defined in the *American Medical Associations' Current Procedural Terminology (CPT®)* manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. The Centers for Medicare and Medicaid Services (CMS) maintain NCCI policy. Information can be found at http://www.cms.hhs.gov/NationalCorrectCodInitEd/.

"National drug code (NDC)" ((~~means~~)) - The eleven-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The eleven-digit NDC is composed of a five-four-two grouping. The first five digits comprise the labeler code assigned to the manufacturer by the ((~~Federal Drug Administration (~~))FDA((~~)~~)). The second grouping of four digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of two digits describes the package size.

((~~**"Negotiated conversion factor (NCF)"** means, for dates of admission before July 1, 2007, a negotiated hospital-specific dollar amount which is used in lieu of the cost-based conversion factor as the multiplier for the applicable DRG weight to determine the DRG payment for a selective contracting program hospital. See also **"hospital conversion factor"** and **"cost-based conversion factor."** The department's hospital selective contracting program no longer exists for dates of admission on and after July 1, 2007.~~))

"National payment rate (NPR)" - A rate for a given procedure code, published by CMS, that does not include a state- or location-specific adjustment.

"National Provider Identifier (NPI)" - A standard, unique identifier for health care providers assigned by CMS. The agency's ProviderOne system pays for inpatient and outpatient services using only one NPI per provider. The agency may make an exception for inpatient claims billed with medicare-certified, distinct unit NPIs.

"Nationwide rate" - See **"national payment rate (NPR)."**

"NCCI edit" - A software step used to determine if a claim is billing for a service that is not in accordance with federal and state statutes, federal and state regulations, agency fee schedules, billing instructions, and other publications. The agency has the final decision whether the NCCI edits allow automated payment for services that were not billed in accordance with governing law, NCCI standards, or agency policy.

"Newborn" or **"neonate"** or **"neonatal"** ((~~means~~)) - A person younger than twenty-nine days old. ((~~However, a person who has been admitted to an acute care hospital setting as a newborn and is transferred to another acute care hospital setting is still considered a newborn for payment purposes.~~))

"Nonallowed service or charge" ((~~means~~)) - A service or charge ((~~that is not recognized for payment~~)) billed by the provider as noncovered or denied by the ((~~department, and~~)) agency. This service or charge cannot be billed to the client except under the conditions identified in WAC ((~~388-502-0160~~)) 182-502-0160.

((~~**"Noncontract hospital"** means, for dates of admission before July 1, 2007 a licensed hospital located in a selective contracting area (SCA) but which does not have a contract to participate in the hospital selective contracting program. The department's hospital selective contracting program no longer exists for dates of admission on and after July 1, 2007.~~))

"Noncovered charges" ((~~means~~)) - Billed charges ((~~submitted~~)) a provider submits to the ((~~department by a provider~~)) agency on a claim ((~~that are indicated by the provider~~)) and indicates them on the claim as noncovered.

"Noncovered service or charge" ((~~means~~)) - A service or charge ((~~that is not considered or paid by the department~~)) the agency does not consider or pay for as a "hospital covered service((~~," and cannot~~))." This service or charge may not be billed to the client, except under the conditions identified in WAC ((~~388-502-0160~~)) 182-502-0160.

((~~**"Nonemergency hospital admission"** means any inpatient hospitalization of a patient who does not have an emergent medical condition, as defined in WAC 388-500-0005.~~

~~**"Nonparticipating hospital"** means a noncontract hospital. See **"noncontract hospital."**~~))

"Nursing service personnel" - A group of health care professionals that includes, but is not limited to: Registered nurse (RN), licensed practical nurse (LPN), certified nursing assistant/nursing assistant certified (CNA/NAC).

"Observation services" ((~~means health care services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by hospital staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient~~)) **-** A well-defined set of clinically appropriate services furnished while determining whether a client will require formal inpatient admission or be discharged from the hospital. Services include ongoing short-term treatment, monitoring, assessment, and reassessment. Rarely do reasonable and necessary observation services exceed forty-eight hours. The agency or its designee may determine through the retrospective utilization review process that an inpatient hospital service should have been billed as an observation service.

"Operating costs" ((~~means~~)) **-** All expenses incurred ((~~in~~)) providing accommodation and ancillary services, excluding capital and medical education costs.

((**~~"OPPS" -~~** See **~~"outpatient prospective payment system."~~**

~~"OPPS adjustment"~~ ~~means the legislative mandated reduction in the outpatient adjustment factor made to account for the delay of OPPS implementation.~~

~~"OPPS outpatient adjustment factor"~~ ~~means the outpatient adjustment factor reduced by the OPPS and adjustment factor as a result of legislative mandate.~~))

"Orthotic device" or **"orthotic"** ((~~means~~)) **-** A corrective or supportive device that:

(1) Prevents or corrects physical deformity or malfunction; or

(2) Supports a weak or deformed portion of the body.

"Out-of-state hospital" ((~~means~~)) **-** Any hospital located outside the state of Washington and ((~~outside the designated~~)) the bordering cities ((~~in Oregon and Idaho (see WAC 388-501-0175)~~)) designated in WAC 182-501-0175. For ((~~medical assistance~~)) Washington apple health clients requiring psychiatric services, an "out-of-state hospital" ((~~means~~)) is any hospital located outside the state of Washington.

((**~~"Outlier set-aside factor"~~** ~~means the amount by which a hospital's cost-based conversion factor is reduced for payments of high cost outlier cases. The department's outlier set-aside factor is not applicable for dates of admission on and after August 1, 2007.~~

~~"Outlier set-aside pool"~~ ~~means the total amount of payments for high cost outliers which are funded annually based on payments for high cost outliers during the year. The department's outlier set-aside pool is not applicable for dates of admission on and after August 1, 2007.~~))

"Outliers" ((~~means~~)) **-** Cases with extraordinarily high ((~~or low~~)) costs when compared to other cases in the same DRG.

"Outpatient" ((~~means a patient~~)) **-** A client who is receiving health care services ((~~in~~)), other than ((~~an~~)) inpatient services, in a hospital setting.

"Outpatient care" ((~~means health care provided other than inpatient services in a hospital setting.~~)) **-** See **"outpatient hospital services."**

"Outpatient code editor (OCE)" - A software program the agency uses for classifying and editing in ambulatory payment classification (APC)-based OPPS.

"Outpatient hospital" ((~~means~~)) **-** A hospital authorized by ((~~the department of health~~)) DOH to provide outpatient services.

"Outpatient hospital services" ((~~means~~)) **-** Those health care services that are within a hospital's licensure and provided to a client who is designated as an outpatient.

"Outpatient observation" - See **"observation services."**

"Outpatient prospective payment system (OPPS)" ((~~means~~)) **-** The payment system used by the ((~~department~~)) agency to calculate reimbursement to hospitals for the facility component of outpatient services. ((~~This system uses ambulatory payment classifications (APCs) as the primary basis of payment.~~

~~"Outpatient short stay" -~~ See **~~"observation services"~~** and **~~"outpatient hospital services."~~**))

"Outpatient prospective payment system (OPPS) conversion factor" - See **"outpatient prospective payment system (OPPS) rate."**

"Outpatient prospective payment system (OPPS) rate" - A hospital-specific multiplier assigned by the agency that is one of the components of the APC payment calculation.

"Outpatient surgery" ((~~means~~)) **-** A surgical procedure that is not expected to require an inpatient hospital admission.

((**~~"Pain treatment facility"~~** ~~means a department-approved inpatient facility for pain management, in which a multidisciplinary approach is used to teach clients various techniques to live with chronic pain.~~

~~"Participating hospital"~~ ~~means a licensed hospital that accepts department clients.~~

~~"PAS length of stay (LOS)"~~ ~~means, for dates of admission before August 1, 2007, the average length of an inpatient hospital stay for patients based on diagnosis and age, as determined by the commission of professional and hospital activities and published in a book entitled *Length of Stay by Diagnosis, Western Region*.~~ See also **~~"professional activity study (PAS)."~~**

~~"Patient consent"~~ ~~means the informed consent of the patient and/or the patient's legal guardian, as evidenced by the patient's or guardian's signature on a consent form, for the procedure(s) to be performed upon or for the treatment to be provided to the patient.~~

~~"Peer group" -~~ See **~~"hospital peer group."~~**

~~"Peer group cap"~~ ~~means, for dates of admission before August 1, 2007, the reimbursement limit set for hospital peer groups B and C, established at the seventieth percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs.~~))

"Pass-throughs" - Certain drugs, devices, and biologicals, as identified by CMS, for which providers are entitled to additional separate payment until the drugs, devices, or biologicals are assigned their own APC.

"Per diem ((~~**rate" means**~~))**" -** A method which uses a daily rate ((~~used~~)) to calculate payment for services provided as a "hospital covered service."

((~~**"Personal comfort items"** means items and services which primarily serve the comfort or convenience of a client and do not contribute meaningfully to the treatment of an illness or injury.~~))

"PM&R" - See **"Acute PM&R."**

((~~**"Plan of treatment"** or **"plan of care"** means the written plan of care for a patient which includes, but is not limited to, the physician's order for treatment and visits by the disciplines involved, the certification period, medications, and rationale indicating need for services.~~

~~**"PPS"** see "prospective payment system."~~))

"Point of care testing (POCT)" - A test designed to be used at or near the site where the patient is located, that does not require permanent dedicated space, and that is performed outside the physical facilities of the clinical laboratory.

"Primary care case management (PCCM)" ((~~means~~)) **-** The coordination of health care services under the ((~~department's~~)) agency's Indian health center or tribal clinic managed care program. See WAC ((~~388-538-068~~)) 182-538-068.

"Principal diagnosis" ((~~means~~))**-** The condition ((~~established after study to be~~)) chiefly responsible for the admission of the patient to the hospital ((~~for care~~)).

((~~**"Principal procedure"** means a procedure performed for definitive treatment rather than diagnostic or exploratory purposes, or because it was necessary due to a complication.~~))

"Prior authorization" ((~~means a process by which clients or providers must request and receive department or a department designee's approval for certain health care services, equipment, or supplies, based on medical necessity, before the services are provided to clients, as a precondition for payment to the provider. Expedited prior authorization and limitation extension are forms of prior authorization~~))**-** See WAC 182-500-0085.

"Private room rate" ((~~means~~))**-** The rate customarily charged by a hospital for a one-bed room.

((~~**"Professional activity study (PAS)"** means the compilation of inpatient hospital data by diagnosis and age, conducted by the commission of professional and hospital activities, which resulted in the determination of an average length of stay for patients. The data are published in a book entitled *Length of Stay by Diagnosis, Western Region*.~~

~~**"Professional component"** means the part of a procedure or service that relies on the physician's professional skill or training, or the part of a payment that recognizes the physician's cognitive skill.~~

~~**"Prognosis"** means the probable outcome of a patient's illness, including the likelihood of improvement or deterioration in the severity of the illness, the likelihood for recurrence, and the patient's probable life span as a result of the illness.~~))

"Prospective payment system (PPS)" ((~~means a system that sets payment rates for a predetermined period for defined services, before the services are provided. The payment rates are based on economic forecasts and the projected cost of services for the predetermined period~~))**-** A payment system in which what is needed to calculate payments (methods, types of variables, and other factors) is set in advance and is knowable by all parties before care is provided. In a retrospective payment system, what is needed (actual costs or charges) is not available until after care is provided.

"Prosthetic device" or **"prosthetic"** ((~~means~~))**-** A replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner, within the scope of his or her practice as defined by state law, to:

(1) Artificially replace a missing portion of the body;

(2) Prevent or correct physical deformity or malfunction; or

(3) Support a weak or deformed portion of the body.

"Psychiatric hospital" ((~~means~~))**-** A medicare-certified distinct psychiatric unit, a medicare-certified psychiatric hospital, or a state-designated pediatric distinct psychiatric unit in a medicare-certified acute care hospital. Eastern state hospital and western state hospital are excluded from this definition.

((~~**"Psychiatric indigent inpatient (PII) program"** means a state-administered program established by the department specifically for mental health clients identified in need of voluntary emergency inpatient psychiatric care by a mental health division designee. See WAC 388-865-0217.~~

~~**"Psychiatric indigent person"** means a person certified by the department as eligible for the psychiatric indigent inpatient (PII) program.~~))

"Public hospital district" ((~~means~~))**-** A hospital district established under chapter 70.44 RCW.

"Ratable" ((~~means~~))**-** A factor used to calculate ((~~a reduction factor used to reduce medicaid level rates to determine~~)) inpatient payments for state-administered programs ((~~claim payment to hospitals~~)).

"Ratio of costs-to-charges (RCC)" ((~~means~~))**-** A method used to pay hospitals for some services exempt from the DRG payment method. It also refers to the ((~~factor or rate~~)) percentage applied to a hospital's allowed covered charges for medically necessary services to determine estimated costs, as determined by the ((~~department~~)) agency, and payment to the hospital for some DRG-exempt services.

((~~**"RCC" -** See **"ratio of costs-to-charges."**~~))

"Rebasing" ((~~means~~))**-** The process ((~~of recalculating the conversion factors, per diems, per case rates, or RCC rates using historical data~~)) used by the agency to update hospital payment policies, related variables (rates, factors, thresholds, multipliers, and caps), and system processes (edits, adjudication, grouping, etc.).

"Recalibration" ((~~means~~))**-** The process of recalculating DRG relative weights using historical data.

"Regional support network (RSN)" ((~~means a county authority or a group of county authorities recognized and certified by the department, that contracts with the department per chapters 38.52, 71.05, 71.24, 71.34, and 74.09 RCW and chapters 275-54, 275-55, and 275-57 WAC, to manage the provision of mental health services to medical assistance clients~~))**-** See WAC 182-500-0095.

((~~**"Rehabilitation accreditation commission, The" -** See **"CARF."**~~))

"Rehabilitation units" ((~~means~~))**-** Specifically identified rehabilitation hospitals and designated rehabilitation

units of hospitals that meet ((~~department and/or~~)) agency and medicare criteria for distinct rehabilitation units.

"Relative weights" - See **"DRG relative weights."**

((~~**"Remote hospitals"** means, for claims with dates of admission before July 1, 2007, hospitals that meet the following criteria during the hospital selective contracting (HSC) waiver application period:~~

~~(1) Are located within Washington state;~~

~~(2) Are more than ten miles from the nearest hospital in the HSC competitive area; and~~

~~(3) Have fewer than seventy-five beds; and~~

~~(4) Have fewer than five hundred medicaid and SCHIP admissions within the previous waiver period.~~))

"Reserve days" ((~~means~~)) - The days beyond the ninetieth day of hospitalization of a medicare patient for a benefit period or ((~~spell~~)) incidence of illness. See also **"lifetime hospitalization reserve."**

((~~**"Retrospective payment system"** means a system that sets payment rates for defined services according to historic costs. The payment rates reflect economic conditions experienced in the past.~~))

"Revenue code" ((~~means a nationally-assigned~~)) - A nationally assigned coding system for billing inpatient and outpatient hospital services, home health services, and hospice services.

"Room and board" ((~~means the services a hospital facility provides a patient~~)) - Routine supplies and services provided to a client during the ((~~patient's~~)) client's hospital stay. ((~~These services include~~)) This includes, but ((~~are~~)) is not limited to, a ((~~routine~~)) regular or special care hospital room and related furnishings, ((~~routine~~)) room supplies, dietary and bedside nursing services, and the use of certain hospital equipment and facilities.

"Rural health clinic" ((~~means a clinic that is located in areas designed by the bureau of census as rural and by the Secretary of the Department of Health and Human Services (DHHS), as medically underserved~~)) - See WAC 182-549-1100.

"Rural hospital" ((~~means~~)) - An acute care health care facility capable of providing or assuring availability of inpatient and outpatient hospital health services in a rural area.

((~~**"Secondary diagnosis"** means a diagnosis other than the principal diagnosis for which an inpatient is admitted to a hospital.~~

~~**"Selective contracting area (SCA)"** means, for dates of admission before July 1, 2007, an area in which hospitals participate in negotiated bidding for hospital contracts. The boundaries of an SCA are based on historical patterns of hospital use by medicaid and SCHIP clients. This definition is not applicable for dates of admission on and after July 1, 2007.~~))

"Semi-private room rate" ((~~means~~)) - A rate customarily charged for a hospital room with two to four beds; this charge is generally lower than a private room rate and higher than a ward room. See also **"multiple occupancy rate."**

((~~**"Seven-day readmission"** means the situation in which a client who was admitted as an inpatient and discharged from the hospital has returned to inpatient status to the same or a different hospital within seven days.~~

~~**"Special care unit"** means a department of health (DOH) or medicare-certified hospital unit where intensive care, coronary care, psychiatric intensive care, burn treatment or other specialized care is provided.~~))

"Significant procedure" - A procedure, therapy, or service provided to a client that constitutes one of the primary reasons for the visit to the health care professional, and represents a substantial portion of the resources associated with the visit.

"Specialty hospitals" ((~~means~~)) - Children's hospitals, psychiatric hospitals, cancer research centers or other hospitals which specialize in treating a particular group of patients or diseases.

"Spenddown" ((~~means the process by which a person uses incurred medical expenses to offset income and/or resources to meet the financial standards established by the department.~~)) - See chapter ((~~388-519~~)) 182-519 WAC.

((~~**"Stat laboratory charges"** means the charges by a laboratory for performing a test or tests immediately. "Stat." is the abbreviation for the Latin word "statim" meaning immediately.~~

~~**"State children's health insurance program (SCHIP)"** means the federal Title XXI program under which medical care is provided to uninsured children younger than age nineteen.~~))

"State plan" ((~~means~~)) - The plan filed by the ((~~department~~)) agency with ((~~the Centers for Medicare and Medicaid Services (CMS)~~)) CMS, Department of Health and Human Services (DHHS), outlining how the state will administer medicaid and ((~~SCHIP~~)) CHIP services, including the hospital program.

"Status indicator (SI)" - A code assigned to each medical procedure or service by the agency that contributes to the selection of a payment method.

"Subacute care" ((~~means~~)) - Care provided to a ((~~patient~~)) client which is less intensive than that given at an acute care hospital. Skilled nursing, nursing care facilities and other facilities provide subacute care services.

((~~**"Surgery"** means the medical diagnosis and treatment of injury, deformity or disease by manual and instrumental operations. For reimbursement purposes, surgical procedures are those designated in CPT as procedure codes 10000 to 69999.~~))

"Survey" - An inspection or review conducted by a federal, state, or private agency to evaluate and monitor a facility's compliance with program requirements.

"Swing bed" - An inpatient hospital bed certified by CMS for either acute inpatient hospital or skilled nursing services.

"Swing-bed day" ((~~means~~)) - A day in which a client is receiving skilled nursing services in a hospital-designated swing bed at the hospital's census hour. ((~~The hospital swing bed must be certified by the Centers for Medicare and Medicaid Services (CMS) for both acute care and skilled nursing services.~~

~~**"Technical component"** means the part of a procedure or service that relates to the equipment set-up and technician's time, or the part of a procedure and service payment that recognizes the equipment cost and technician time.~~

~~**"Tertiary care hospital"** means a specialty care hospital providing highly specialized services to clients with more complex medical needs than acute care services.~~))

"Total patient days" ((~~means~~)) - All patient days in a hospital for a given reporting period, excluding days for skilled nursing, nursing care, and observation days.

"Transfer" ((~~means~~)) - To move a client from one acute care ((~~facility or distinct unit to another~~)) setting to a higher level acute care setting for emergency care or to a post-acute, lower level care setting for ongoing care.

"Transferring hospital" ((~~means~~)) - The hospital or distinct unit that transfers a client to another acute care or subacute facility or distinct unit, or to a nonhospital setting.

((~~**"Trauma care facility"** means a facility certified by the department of health as a level I, II, III, IV, or V facility. See chapter 246-976 WAC.~~

~~**"Trauma care service"** - See department of health's WAC 246-976-935.~~))

"UB-04" ((~~is~~)) - The uniform billing document required for use nationally((~~, beginning on May 23, 2007,~~)) by hospitals, nursing facilities, hospital-based skilled nursing facilities, home health agencies, and hospice agencies in billing ((~~third party payers~~)) for services provided to patients. This document includes the current national uniform billing data element specifications developed by the National Uniform Billing Committee and approved ((~~and/or~~)) and modified by the Washington state payer group or the ((~~department~~)) agency.

((~~**"UB-92"** is the uniform billing document discontinued for billing claims submitted on and after May 23, 2007.~~

~~**"Unbundled services"** means interventions that are not integral to the major procedure and that are paid separately.~~

~~**"Uncompensated care"** - See **"charity care."**~~

~~**"Uniform cost reporting requirements"** means a standard accounting and reporting format as defined by medicare.~~

~~**"Uninsured patient"** means an individual who is not covered by insurance for provided inpatient and/or outpatient hospital services.~~

~~**"Usual and customary charge (UCC)"** means the charge customarily made to the general public for a health care procedure or service, or the rate charged other contractors for the service if the general public is not served.~~))

"Vendor rate increase" ((~~means an inflation~~)) - An adjustment determined by the legislature, that may be used to periodically increase rates for payment to vendors, including health care providers, that do business with the state.

"Washington apple health program" - Any health care program administered through the medicaid agency.

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

WAC 182-550-2900 Payment limits—Inpatient hospital services. (1) To be eligible for payment for covered inpatient hospital services, a hospital must:

(a) Have a core-provider agreement with the ((~~department~~)) agency; and

(b) Be an in-state hospital, a bordering city hospital, a critical border hospital, or a distinct unit of such a hospital, ((~~that meets~~)) and meet the definition in ((~~RCW 70.41.020 and is certified under Title XVIII of the federal Social Security Act~~)) WAC 182-550-1050; or

(c) Be an out-of-state hospital that meets the conditions in WAC ((~~388-550-6700~~)) 182-550-6700.

(2) The ((~~department~~)) agency does not pay for any of the following:

(a) ((~~A hospital or distinct unit for~~)) Inpatient care ((~~and/or~~)) or services, or both, provided in a hospital or distinct unit to a client when a managed care organization (MCO) plan is contracted to cover those services.

(b) ((~~A hospital or distinct unit for care and/or~~)) Care or services, or both, provided in a hospital or distinct unit provided to a client enrolled in the hospice program, unless the care or services are completely unrelated to the terminal illness that qualifies the client for the hospice benefit.

(c) ((~~A hospital or distinct unit for ancillary services in addition to the:~~

~~(i) Diagnosis related group (DRG) payment, or per case rate payment on claims with dates of admission before August 1, 2007; or~~

~~(ii) DRG payment, per diem payment, or per case rate payment on claims with dates of admission on and after August 1, 2007.~~)) Ancillary services provided in a hospital or distinct unit unless explicitly spelled out in this chapter.

(d) ((~~For~~)) Additional days of hospitalization on a non-DRG claim when:

(i) Those days exceed the number of days established by the ((~~department~~)) agency or mental health ((~~division (MHD)~~)) designee (see WAC ((~~388-550-2600~~)) 182-550-2600), as the approved length of stay (LOS); and

(ii) The hospital or distinct unit has not ((~~requested and/or~~)) received approval for an extended ((~~length of stay (~~))LOS((~~)~~)) from the ((~~department or MHD~~)) agency or mental health designee as specified in WAC ((~~388-550-4300~~)) 182-550-4300(6). The ((~~department~~)) agency may perform a prospective, concurrent, or retrospective utilization review as described in WAC ((~~388-550-1700~~)) 182-550-1700, to evaluate an extended LOS. A ((~~MHD~~)) mental health designee may also perform those utilization reviews to evaluate an extended LOS.

(e) ((~~For dates of admission before August 1, 2007, for elective or nonemergency inpatient services provided in a nonparticipating hospital. A nonparticipating hospital is defined in WAC 388-550-1050. See also WAC 388-550-4600.~~

~~(f) For~~)) Inpatient hospital services when the ((~~department~~)) agency determines that the client's medical record fails to support the medical necessity and inpatient level of care for the inpatient admission. The ((~~department~~)) agency may perform a retrospective utilization review as described in WAC ((~~388-550-1700~~)) 182-550-1700, to evaluate if the services are medically necessary and are provided at the appropriate level of care.

(((~~(g) For~~)) (f) Two separate inpatient hospitalizations if a client is readmitted to the same or ((~~different~~)) an affiliated hospital or distinct unit within ((~~seven~~)) fourteen calendar days of discharge((~~, unless the readmission is due to conditions unrelated to the previous admission. The department:~~

~~(i) May perform a retrospective utilization review as described in WAC 388-550-1700 to determine the appropriate payment for the readmission.~~

~~(ii) Determines if the combined hospital stay for the admission qualifies to be paid as an outlier. See WAC 388-550-3700 for DRG high-cost outliers and per diem high outliers for dates of admission on and after August 1, 2007.~~

~~(h) For~~)) and the agency determines one inpatient hospitalization does not qualify for a separate payment. See WAC 182-550-3000.

(g) A client's day(s) of absence from the hospital or distinct unit.

(((~~(i) For~~)) (h) An inappropriate or nonemergency transfer of a client ((~~from one acute care hospital or distinct unit to another. The department may perform a prospective, concurrent, or retrospective utilization review as described in WAC 388-550-1700 to determine if the admission to the second hospital or distinct unit qualifies for payment. See also WAC 388-550-3600~~)). See WAC 182-550-3600 for hospital transfers.

(i) Charges related to a provider preventable condition (PPC), hospital acquired condition (HAC), serious reportable event (SRE), or a condition not present on admission (POA). See WAC 182-502-0022.

(3) ((~~An interim billed inpatient hospital claim submitted for a client's continuous inpatient hospitalization of at least sixty calendar days, is considered for payment by the department only when the following occurs (this does not apply to interim billed hospital claims for which the department is not the primary payer (see (b) of this subsection), or to inpatient psychiatric admissions:~~)) This section defines when the agency considers payment for an interim billed inpatient hospital claim.

(a) When the agency is the primary payer, each interim billed ((~~hospital~~)) nonpsychiatric claim must:

(i) Be submitted in sixty calendar day intervals, unless the client is discharged prior to the next sixty calendar day interval.

(ii) Document the entire date span between the client's date of admission and the current date of services billed, and include the following for that date span:

(A) All inpatient hospital services provided; and

(B) All applicable diagnosis codes and procedure codes.

(iii) Be submitted as an adjustment to the previous interim billed hospital claim.

(b) When the ((~~department~~)) agency is not the primary payer((~~, the department~~)):

(i) The agency pays an interim billed ((~~hospital~~)) nonpsychiatric claim when the criteria in (a) of this subsection are met; and((~~:~~

~~(i) After sixty~~))

(ii) Either of the following:

(A) Sixty calendar days have passed from the date the ((~~department becomes~~)) agency became the primary payer; or

(((~~(ii) The date a~~)) (B) A client is eligible for both medicare and medicaid and has exhausted the medicare lifetime reserve days for inpatient hospital care.

(c) For psychiatric claims, (a)(i) and (b)(i) of this subsection do not apply.

(4) The agency considers for payment a hospital claim submitted for a client's continuous inpatient hospital admission of sixty calendar days or less ((~~is considered for payment by the department~~)) upon the client's ((~~discharge~~)) formal release from the hospital or distinct unit. ((~~The department considers a client discharged from the hospital or distinct unit if one of the following occurs. The client:~~

~~(a) Obtains a formal release issued by the hospital or distinct unit;~~

~~(b) Dies in the hospital or distinct unit;~~

~~(c) Transfers from the hospital or distinct unit as an acute care transfer; or~~

~~(d) Transfers from the hospital or distinct unit to a designated psychiatric unit or facility, or a designated acute rehabilitation unit or facility.~~))

(5) To be eligible for payment, a hospital or distinct unit must bill the agency using an inpatient hospital claim:

(a) In accordance with the current national uniform billing data element specifications:

(i) Developed by the National Uniform Billing Committee (NUBC);

(ii) Approved ((~~and/or~~)) or modified, or both, by the Washington state payer group or the ((~~department~~)) agency; and

(iii) In effect on the date of the client's admission.

(b) In accordance with the current published international classification of diseases clinical modification coding guidelines;

(c) Subject to the rules in this section and other applicable rules;

(d) In accordance with the ((~~department's current~~)) agency's published ((~~billing instructions~~)) provider guides and other documents; and

(e) With the date span that covers the client's entire hospitalization. See subsection (3) of this section for when the ((~~department~~)) agency considers and pays an initial interim billed hospital claim ((~~and/or~~)) and any subsequent interim billed hospital claims; ((~~and~~))

(f) That requires an adjustment due to, but not limited to, charges that were not billed on the original paid claim ((((~~i.e.~~)) e.g., late charges), through submission of an adjusted hospital claim. Each adjustment to a paid hospital claim must provide complete documentation for the entire date span between the client's admission date and discharge date, and include the following for that date span:

(i) All inpatient hospital services provided; and

(ii) All applicable diagnosis codes and procedure codes; and

(g) With the appropriate National Uniform Billing Committee (NUBC) revenue code(s) specific to the service or treatment provided to the client.

(6) ((~~The department allows the semiprivate room rate for a client's room charges, even if a hospital bills the private room rate.~~)) When a hospital charges multiple rates for an accommodation room and board revenue code, the agency pays the hospital's lowest room and board rate for that revenue code. The agency may request the hospital's charge master. Room charges must not exceed the hospital's usual and customary charges to the general public, as required by C.F.R. §447.271.

(7) ((~~For inpatient hospital claims, the department~~)) The agency allows hospitals an all-inclusive administrative ((~~date~~)) day rate((~~, beginning on the client's admission date,~~)) for those days of a hospital stay in which a client ((~~does not meet~~)) no longer meets criteria for the acute inpatient level of care((~~, but is not discharged because~~)). The agency allows this day rate only when an appropriate placement outside the hospital is not available.

(8) The ((~~department~~)) agency pays for observation services according to WAC ((~~388-550-3000 (2)(b), 388-550-6000 (4)(c) and 388-550-7200 (2)(c)~~)) 182-550-6000, 182-550-7200, and other applicable rules.

(9) The ((~~department~~)) agency determines its actual payment for an inpatient hospital admission by making any required adjustments from the calculations of the allowed covered charges. Adjustments include((~~, but are not limited to, any client~~)):

(a) Client responsibility((~~, any~~)) (e.g., spenddown);

(b) Any third-party liability amount, including medicare part A and part B((~~,~~)); and

(c) Any other adjustments as determined by the ((~~department~~)) agency.

(10) The ((~~department reduces payment rates to~~)) agency pays hospitals ((~~and distinct units~~)) less for services provided to clients eligible under state-administered programs ((~~according to the hospital equivalency factor and/or ratable, or other department policy~~)), as provided in WAC ((~~388-550-4800~~)) 182-550-4800.

(11) All hospital providers must present final charges to the ((~~department within three hundred sixty-five days of the "statement covers period from date" shown on the claim. The state of Washington is not liable for payment based on billed charges received beyond three hundred sixty-five days from the "statement covers period from date" shown on the claim~~)) agency according to WAC 182-502-0150.

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

WAC 182-550-3000 Payment method((~~—DRG~~)). (1) The ((~~department~~)) medicaid agency uses the diagnosis-related group (DRG) payment method to pay for covered inpatient hospital services, except as specified in WAC ((~~388-550-4300 and 388-550-4400~~)) 182-550-4300 and 182-550-4400.

(2) The ((~~department uses the all-patient grouper (AP-DRG) to~~)) agency assigns a DRG code to each claim for an inpatient hospital stay((~~. The department periodically evaluates which version of the AP-DRG to use~~)) using 3M™ software (AP-DRG or APR-DRG) or other software currently in use by the agency. That DRG code determines the method used to pay claims for prospective payment system (PPS) hospitals. For the purpose of this section, PPS hospitals include all in-state and border area hospitals, except both of the following:

(a) Critical access hospitals (CAH), which the agency pays per WAC 182-550-2598; and

(b) Military hospitals, which the agency pays using the following payment methods depending on the revenue code billed by the hospital:

(i) Ratio of costs-to-charges (RCC); and

(ii) Military subsistence per diem.

(3) For each DRG code, the agency establishes an average length of stay (ALOS). The agency may use the DRG ALOS as part of its authorization process and payment methods as specified in this chapter.

(((~~(3) A DRG~~)) (4) An inpatient claim payment includes all hospital covered ((~~hospital~~)) services provided to a client during days the client is eligible. This includes, but is not limited to:

(a) ((~~An~~)) The inpatient hospital stay((~~.~~));

(b) Outpatient hospital services, including preadmission, emergency ((~~room~~)) department, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim (((~~see WAC 388-550-6000 (3)(c)).~~));

(c) Any ((~~specific service(s), treatment(s), or procedure(s) (such as renal dialysis services) that the admitting hospital is unable to provide and:~~

(~~i) The~~)) hospital covered service for which the admitting hospital sends the client to another facility or provider ((~~for the service(s), treatment(s), or procedure(s)~~)) during the client's inpatient hospital stay((~~; and~~

(~~ii) The client returns as an inpatient to the admitting hospital.~~

(~~d) All transportation costs for an inpatient client when the client requires transportation to another facility or provider for a specific service(s), treatment(s), or procedure(s) that the admitting hospital is unable to provide and:~~

(~~i) The admitting hospital sends the client to another facility or provider for the service(s), treatment(s), or procedure(s); and~~

(~~ii) The client returns as an inpatient to the admitting hospital.~~

(~~4) The department's allowed amount for the DRG payment is determined by multiplying the assigned DRG's relative weight, as determined in WAC 388-550-3100, by the hospital's specific DRG conversion factor. See WAC 388-550-3450. The total allowed amount also includes any high outlier amount calculated for claims.~~

(~~5) When directed by the legislature to achieve targeted expenditure levels, as deseribed in WAC 388-550-2800(2), the department may apply an inpatient adjustment factor to each hospital's specific DRG conversion factor rate used in calculating the DRG payment.~~)), and the client returns as an inpatient to the admitting hospital.

(5) The agency's claim payment for an inpatient stay is determined by the payment method. The agency pays hospitals for inpatient hospital covered services provided to clients using the following methods:

Payment Method	General Description of Payment Formula	WAC Reference
DRG (Diagnostic Related Group)	DRG specific relative weight times hospital specific DRG rate times maximum service adjustor	182-550-3000

Payment Method	General Description of Payment Formula	WAC Reference
Per Diem	Hospital-specific daily rate for the service (psych, rehab, detox, or CUP) times covered allowable days	182-550-2600 and 182-550-3381
Single Case Rate	Hospital specific bariatric case rate per stay	182-550-3470
Fixed Per Diem for Long Term Acute Care (LTAC)	Fixed LTAC rate per day times allowed days plus ratio of cost to charges times allowable covered ancillaries not included in the daily rate	182-550-2595 and 182-550-2596
Ratio of Costs-to-Charges (RCC)	RCC times billed covered allowable charges	182-550-4500
Cost Settlement with Ratio of Costs-to-Charges	RCC times billed covered allowable charges (subject to hold harmless and other settlement provisions of the Certified Public Expenditure program)	182-550-4650 and 182-550-4670
Cost Settlement with Weighted Costs-to-Charges (WCC)	WCC times billed covered allowable charges subject to Critical Access Hospital settlement provisions	182-550-2598
Military	Depending on the revenue code billed by the hospital: • RCC times billed covered allowable charges; and • Military subsistence per diem.	182-550-4300
Administrative Day	Standard administrative day rate times days authorized by the agency combined with RCC times ancillary charges that are allowable and covered for administrative days	182-550-3381

(6) ((~~The department's DRG payment to a hospital may be adjusted~~)) For claims paid using the DRG method, the payment may not exceed the billed amount.

(7) The agency may adjust the initial allowable calculated for a claim when one or more of the following occur:

(a) ((~~For dates of admission before August 1, 2007, a claim qualifies as a DRG high-cost or low-cost outlier, and for dates of admission on and after August 1, 2007,~~)) A claim qualifies as a ((~~DRG~~)) high outlier (see WAC ((~~388-550-3700~~)) 182-550-3700);

(b) A claim is paid by the DRG method and a client transfers((~~:~~

~~(i) Before July 1, 2009, from one acute care hospital or distinct unit to another acute care hospital or distinct unit; or~~

~~(ii) On and after July 1, 2009 from one acute care hospital or distinct unit to:~~

~~(A) Another acute care hospital or distinct unit;~~

~~(B) A skilled nursing facility (SNF);~~

~~(C) An intermediate care facility;~~

~~(D) Home care under the department's home health program;~~

~~(E) A long term acute care facility (LTAC);~~

~~(F) Hospice (facility-based or in the client's home);~~

~~(G) A hospital-based medicare-approved swing bed, or another distinct unit such as a rehabilitation or psychiatric unit (see WAC 388-550-3600); or~~

~~(H) A nursing facility certified under medicaid but not medicare.~~)) from one acute care hospital or distinct unit per WAC 182-550-3600;

(c) A client is not eligible for a ((~~medical assistance~~)) Washington apple health program on one or more days of the hospital stay;

(d) A client has third-party liability coverage at the time of admission to the hospital or distinct unit;

(e) A client is eligible for Part B medicare, the hospital submitted a timely claim to medicare for payment, and medicare has made a payment for the Part B hospital charges; or

(f) A client is discharged from an inpatient hospital stay and, within ((~~seven~~)) fourteen calendar days, is readmitted as an inpatient to the same hospital or an affiliated hospital. The ((~~department~~)) agency or its designee performs a retrospective utilization review (see WAC ((~~388-550-1700~~)) 182-550-1700) on the initial admission and the readmission(s) to determine which inpatient hospital stay(s) qualify for ((~~DRG~~)) payment. ((~~Upon the department's retrospective review, an outlier payment may be made if the department determines the claim for combined hospital stays qualifies as a high cost outlier or high outlier. See WAC 388-550-3700 for DRG high-cost outliers and high outliers.~~

~~(7) For dates of admission on and after July 1, 2009, the department pays inpatient claims assigned by the all patient DRG grouper (AP-DRG) as cesarean section without complications and comorbidities, at the same rate as the vaginal birth with complicating diagnoses.~~

~~(8)~~)) (g) A readmission is due to a complication arising from a previous admission (e.g., provider preventable condition). The agency or its designee performs a retrospective utilization review to determine if both admissions are appropriate and qualify for individual payments;

(h) The agency identifies an enhanced payment due to a provider preventable condition, hospital-acquired condition, serious reportable event, or a condition not present on admission.

(8) In response to direction from the legislature, the agency may change any one or more payment methods outlined in chapter 182-550 WAC for the purpose of achieving the legislature's targeted expenditure levels. The legislative direction may take the form of express language in the Biennial Appropriations Act or may be reflected in the level of funding appropriated to the agency in the Biennial Appropriations Act. In response to this legislative direction, the agency may calculate an adjustment factor (known as an "inpatient adjustment factor") to apply to inpatient hospital rates.

(a) The inpatient adjustment factor is a specific multiplier calculated by the agency and applied to existing inpatient hospital rates to meet targeted expenditure levels as directed by the legislature.

(b) The agency will apply the inpatient adjustment factor when the agency determines that its expenditures on inpatient hospital rates will exceed the legislature's targeted expenditure levels.

(c) The agency will apply any such inpatient adjustment factor to each affected rate.

(9) The ((~~department~~)) agency does not pay for a client's day(s) of absence from the hospital.

(((~~(9)~~))) (10) The ((~~department~~)) agency pays an interim billed hospital claim ((~~or~~)) for covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC ((~~388-550-2900~~)) 182-550-2900.

(((~~(10)~~))) (11) The ((~~department~~)) agency applies to the ((~~payment~~)) allowable for each claim all applicable adjustments for client responsibility, any third-party liability, medicare payments, and any other adjustments as determined by the ((~~department~~)) agency.

(((~~(11)~~))) (12) The ((~~department~~)) agency pays hospitals in designated bordering cities for allowed covered services as described in WAC ((~~388-550-3900~~)) 182-550-3900.

(((~~(12)~~))) (13) The ((~~department~~)) agency pays out-of-state hospitals for allowed covered services as described in WAC ((~~388-550-4000~~)) 182-550-4000.

(14) The agency's annual aggregate payments for inpatient hospital services, including payments to state-operated hospitals, will not exceed the estimated amounts that the agency would have paid using medicare payment principles.

(15) When hospital ownership changes, the agency's payment to the hospital will not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(16) Hospitals participating in the Washington apple health program must annually submit to the agency:

(a) A copy of the hospital's CMS medicare cost report (Form 2552 version currently in use by the agency) that is the official "as filed" cost report submitted to the medicare fiscal intermediary; and

(b) A disproportionate share hospital (DSH) application if the hospital wants to be considered for DSH payments. See WAC 182-550-4900 for the requirements for a hospital to qualify for a DSH payment.

(17) Reports referred to in subsection (16) of this section must be completed according to:

(a) Medicare's cost reporting requirements;

(b) The provisions of this chapter; and

(c) Instructions issued by the agency.

(18) The agency requires hospitals to follow generally accepted accounting principles.

(19) Participating hospitals must permit the agency to conduct periodic audits of their financial records, statistical records, and any other records as determined by the agency.

(20) The agency limits payment for private room accommodations to the semiprivate room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by 42 C.F.R. Sec. 447.271.

(21) For a client's hospital stay that involves regional support network (RSN)-approved voluntary inpatient or involuntary inpatient hospitalizations, the hospital must bill the agency for payment. When the hospital contracts directly with the RSN, the hospital must bill the RSN for payment.

(22) For psychiatric hospitals and psychiatric hospital units, when a claim groups to a DRG code that pays by the DRG method, the agency may manually price the claim at the hospital's psychiatric per diem rate.

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

WAC 182-550-3381 Payment ((~~methodology~~)) method for acute PM&R services and administrative day services. ((~~The department's~~)) This section describes the agency's payment ((~~methodology~~)) method for acute physical medicine and rehabilitation (PM&R) services provided by acute PM&R hospitals ((~~is described in this section~~)).

(1) ((~~For dates of admission before August 1, 2007, the department pays an acute PM&R rehabilitation hospital according to the individual hospital's current ratio of costs-to-charges as described in WAC 388-550-4500. For dates of admission on and after August 1, 2007, the department~~)) The agency pays an acute PM&R hospital for acute PM&R services based on a rehabilitation per diem rate. See ((~~WAC 388-550-3010 and 388-550-3460~~)) chapter 182-550 WAC and WAC 182-550-3000.

(2) Acute PM&R room and board includes, but is not limited to:

(a) Facility use;

(b) ((~~Medical~~)) Social services (e.g., discharge planning);

(c) Bed and standard room furnishings; and

(d) Dietary and nursing services.

(3) When the ((~~department~~)) agency authorizes administrative day(s) for a client as described in WAC ((~~388-550-2561(8)~~)) 182-550-2561(8), the ((~~department~~)) agency pays the facility:

(a) The administrative day rate; and

(b) For pharmaceuticals prescribed ((~~in~~)) for the client's use during the administrative portion of the client's stay.

(4) The ((~~department~~)) agency pays for transportation services provided to a client receiving acute PM&R services in an acute PM&R hospital according to chapter ((~~388-546~~)) 182-546 WAC.

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

WAC 182-550-3800 Rebasing ((~~and recalibration~~)). (((~~(1) The department rebases most of the rates used in~~)) The agency redesigns (rebases) the medicaid inpatient payment system ((~~once every three years. Changes to the inpatient hospital rate calculations and rate-setting methods involved in this rebasing process are implemented pursuant to the rebasing of the rate system.~~

~~(a) To determine costs for that rebasing process, the department uses:~~

~~(i) Each instate hospital's medicare cost report for the hospital fiscal year that ends during the calendar year that the rebasing base year designated by the department begins; and~~

~~(ii) Inpatient medicaid and SCHIP claims data for the twelve-month period designated by the department as the rebasing base year.~~

~~(b) The rebasing process updates rates for the diagnosis related group (DRG), per diem, and per case rate payment methods.~~

~~(c) Other inpatient payment system rates (e.g., the ratio of costs-to-charges (RCC) rates, departmental weighted~~

~~costs-to-charges (DWCC) rates, administrative day rate, and swing bed rate) are rebased on an annual basis.~~

~~(d) The department increases inpatient hospital rates only when mandated by the state legislature. These increases are implemented according to the base methodology in effect, unless otherwise directed by the legislature.~~

~~(2) The department periodically recalibrates diagnosis-related group (DRG) relative weights, as described in WAC 388-550-3100, but no less frequently than each time the rate rebasing process described in subsection (1) takes place. The department makes recalibrated relative weights effective on the rebasing implementation date, which can change with each rebasing process.~~

~~(3) When recalibrating DRG relative weights without rebasing, the department may apply a budget neutrality factor (BNF) to hospitals' conversion factors to ensure that total DRG payments to hospitals do not exceed total DRG payments that would have been made to hospitals if the relative weights had not been recalibrated. For the purposes of this section, BNF equals the percentage change from total aggregate payments calculated under a new payment system to total aggregate payments calculated under the prior payment system.~~)) as needed. The base inpatient conversion factor and per diem rates are only updated during a detailed rebasing process, or as directed by the state legislature. Inpatient payment system factors such as the ratio of costs-to-charges (RCC), weighted costs-to-charges (WCC), and administrative day rate are rebased on an annual basis. As part of the rebasing, the agency does all of the following:

(1) Gathers data. The agency uses the following data resources considered to be the most complete and available at the time:

(a) One year of fee-for-service (FFS) paid claim data from the agency's medicaid management information system (MMIS). The agency excludes:

(i) Claims related to state programs and paid at the Title XIX reduced rates from the claim data; and

(ii) Critical access hospital claims paid per WAC 182-550-2598; and

(b) The hospital's most current medicare cost report data from the health care cost report information system (HCRIS) maintained by the Centers for Medicare and Medicaid Services (CMS). If the hospital's medicare cost report from HCRIS is not available, the agency uses the medicare cost report provided by the hospital.

(2) Estimates costs. The agency uses one of two methods to estimate costs. The agency may perform an aggregate cost determination by multiplying the ratio of costs-to-charges (RCC) by the total billed charges, or the agency may use the following detailed costing method:

(a) The agency identifies routine and ancillary cost for operating capital, and direct medical education cost components using different worksheets from the hospital's medicare cost report;

(b) The agency estimates costs for each claim in the dataset as follows:

(i) Accommodation services. The agency multiplies the average hospital cost per day reported in the medicare cost report data for each type of accommodation service (e.g., adult and pediatric, intensive care unit, psychiatric, nursery) by the number of days reported at the claim line level by type of service; and

(ii) Ancillary services. The agency multiplies the RCC reported for each ancillary type of services (e.g., operating room, recovery room, radiology, laboratory, pharmacy, or clinic) by the allowed charges reported at the claim line level by type of service; and

(c) The agency uses the following standard cost components for accommodation and ancillary services for estimating costs of claims:

(i) Routine cost components:

(A) Routine care;

(B) Intensive care;

(C) Intensive care-psychiatric;

(D) Coronary care;

(E) Nursery;

(F) Neonatal ICU;

(G) Alcohol/substance abuse;

(H) Psychiatric;

(I) Oncology; and

(J) Rehabilitation.

(ii) Ancillary cost components:

(A) Operating room;

(B) Recovery room;

(C) Delivery/labor room;

(D) Anesthesiology;

(E) Radio, diagnostic;

(F) Radio, therapeutic;

(G) Radioisotope;

(H) Laboratory;

(I) Blood administration;

(J) Intravenous therapy;

(K) Respiratory therapy;

(L) Physical therapy;

(M) Occupational therapy;

(N) Speech pathology;

(O) Electrocardiography;

(P) Electroencephalography;

(Q) Medical supplies;

(R) Drugs;

(S) Renal dialysis/home dialysis;

(T) Ancillary oncology;

(U) Cardiology;

(V) Ambulatory surgery;

(W) CT scan/MRI;

(X) Clinic;

(Y) Emergency;

(Z) Ultrasound;

(AA) NICU transportation;

(BB) GI laboratory;

(CC) Miscellaneous; and

(DD) Observation beds.

(3) Specifies resource use with relative weights. The agency uses national relative weights designed by 3M™ Corporation as part of its all-patient refined-diagnostic related group (APR-DRG) payment system.

(4) Calculates base payment factors. The agency calculates the average, or base, DRG conversion factor and per diem rates. The base is calculated as the maximum amount that can be used, along with all other payment factors and

adjustments described in this chapter, to maintain aggregate payments across the system. The agency ensures that base DRG conversion factors and per diem rates are sufficient to support economy, efficiency, and access to services for medicaid recipients. The agency will publish base rate factors on its web site.

(5) Determines global adjustments.

(a) Claims paid under the DRG, rehab per diem, and detox per diem payment methods were reduced to support an estimated three million five hundred thousand dollar increase in psychiatric payments to acute hospitals.

(b) Claims for acute hospitals paid under the psychiatric per diem method were increased by a factor to inflate estimated system payments by three million five hundred thousand dollars.

(6) Determines provider specific adjustments. The following adjustments are applied to the base factor or rate established in subsection (4) of this section:

(a) Wage index adjustments reflect labor costs in the cost-based statistical area (CBSA) where a hospital is located.

(i) The agency determines the labor portion by multiplying the base factor or rate by the labor factor established by medicare; then

(ii) The amount in (a)(i) of this subsection is multiplied by the most recent wage index information published by CMS at the time the rates are set; then

(iii) The agency adds the nonlabor portion of the base rate to the amount in (a)(ii) of this subsection to produce a hospital-specific wage adjusted factor.

(b) Indirect medical education factors are applied to the hospital-specific base factor or rate. The agency uses the indirect medical education factor established by medicare on the most currently available medicare cost report that exists at the time the rates are set; and

(c) Direct medical education amounts are applied to the hospital-specific base factor or rate. The agency determines a percentage of direct medical education costs to overall costs using the most currently available medicare cost report that exists at the time the rates are set.

(7) The final, hospital-specific rate is calculated using the base rate established in subsection (4) of this section along with any applicable adjustments in subsections (5) and (6) of this section.

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

WAC 182-550-3900 Payment method—Bordering city hospitals and critical border hospitals. The ((~~department~~)) agency uses the payment methods described in this section to pay bordering city hospitals and critical border hospitals for inpatient and outpatient claims. Bordering city hospitals and critical border hospitals are defined in WAC ((~~388-550-1050~~)) 182-550-1050.

(1) ((~~Bordering city hospitals —~~)) For inpatient hospital claims ((~~payment methods.~~

~~(a) For dates of admission before August 1, 2007, under the diagnosis related group (DRG) payment method:~~

~~(i) The department calculates the cost-based conversion factor (CBCF) of a bordering city hospital as defined in WAC 388-550-1050, in accordance with WAC 388-550-3450.~~

~~(ii) For a bordering city hospital with no medicare cost report (Form 2552-96) submitted for the rebasing year, the department assigns the department peer group average conversion factor. This is the average of all final conversion factors of hospitals in that group.~~

~~(b) For dates of admission before August 1, 2007, under the ratio of costs-to-charges (RCC) payment method:~~

~~(i) The department calculates the RCC in accordance with WAC 388-550-4500.~~

~~(ii) For a bordering city hospital with no medicare cost report (Form 2552-96) submitted for the rebasing year, the department bases the RCC on the Washington instate average RCC.~~

~~(c) For dates of admission on and after August 1, 2007:~~

~~(i)~~)) from bordering city hospitals, the ((~~department~~)) agency calculates the payment for allowed covered charges related to medically necessary services, by using the lowest of the in-state inpatient hospital rates ((~~without graduate medical education (GME) (excluding DWCC rates that are paid to instate critical access hospitals)~~)) for the:

(a) Diagnosis-related group (DRG) conversion factor((~~, the~~));

(b) Per diem((~~,~~)) payment method;

(c) Per case((~~,~~)) payment method; and

(d) Ratio of costs-to-charges (RCC) payment method((~~; and~~

~~(ii) The department pays the lesser of the:~~

~~(A) Billed charges; or~~

~~(B) Calculated payment amount~~)).

(2) ((~~Bordering city hospitals —~~)) For outpatient hospital claims ((~~payment methods for allowed covered charges related to medically necessary services.~~

~~(a) For bordering city hospitals paid according to the outpatient prospective payment system (OPPS), refer to WAC 388-550-7000 through 388-550-7600. The department uses the following types of payment methods used in OPPS:~~

~~(i) Ambulatory payment classification (APC) method (the primary payment method for OPPS) (WAC 388-55-7200):~~

~~(A) Before August 1, 2007, the department determines the OPPS conversion factor using the methods described in WAC 388-550-7500.~~

~~(B) On and after August 1, 2007, the department pays using the lowest instate OPPS conversion factor.~~

~~(ii) OPPS maximum allowable fee schedule (WAC 388-550-7200).~~

~~(iii) Hospital outpatient RCC rate (WAC 388-550-4500).~~

~~(A) Before August 1, 2007, the department pays the instate average hospital outpatient RCC rate times the allowed covered charges for medically necessary services.~~

~~(B) On and after August 1, 2007, the department pays the lowest instate hospital outpatient RCC rate times the allowed covered charges for medically necessary services.~~

~~(b) For bordering city hospitals exempt from OPPS, the department uses the following payment methods:~~

~~(i) Outpatient maximum allowable fee schedule (WAC 388-550-6000); and~~

~~(ii) Hospital outpatient RCC rate (WAC 388-550-4500).~~

~~(c) When the RCC payment method described in WAC 388-550-4500 is used to pay for outpatient services provided:~~

~~(i) Before August 1, 2007, the department pays the instate average hospital outpatient RCC rate times the allowed covered charges for medically necessary services.~~

~~(ii) On and after August 1, 2007, the department pays the lowest instate hospital outpatient RCC rate times the allowed covered charges for medically necessary services.~~

~~(d) When the maximum allowable fee schedule method is used to pay for outpatient services provided, the department pays the lesser of the:~~

~~(i) Billed charges; or~~

~~(ii) Calculated payment amount~~)) from bordering city hospitals, the agency calculates the payment for allowed covered charges related to medically necessary services, using the lowest of the in-state outpatient hospital rates for the outpatient prospective payment system (OPPS). Refer to WAC 182-550-7000 through 182-550-7600.

(3) Designated critical border hospitals.

(a) ((~~Beginning August 1, 2007, the department designated~~)) The agency designates certain qualifying hospitals located out-of-state as critical border hospitals. A designated critical border hospital must:

(i) Be a bordering city hospital as described in WAC ((~~388-550-1050~~)) 182-550-1050; and

(ii) Have submitted at least ten percent of the total nonemergency inpatient hospital claims ((~~that have been~~)) paid to bordering city hospitals for the prior state fiscal year (SFY) for clients eligible for Washington ((~~state medicaid and state-administered programs~~)) apple health. Nonemergency inpatient hospital claims are defined as those that do not include emergency ((~~room~~)) department charges (revenue code 045X series).

(b) The ((~~department~~)) agency analyzes bordering city hospitals' base period claims data during the rebasing process, and annually thereafter, to determine if a bordering city hospital qualifies or continues to qualify as a critical border hospital.

(4) Critical border hospitals((~~—~~)) - Inpatient hospital claim payment methods. The ((~~department~~)) agency pays inpatient critical border hospital claims ((~~with dates of services on and after August 1, 2007,~~)) as follows:

(a) The inpatient payment rates used to calculate payments to critical border hospitals are prospective payment rates. The rates are not used to pay for claims with dates of admission before the hospital qualified as a critical border hospital.

(b) The ((~~department~~)) agency pays inpatient critical border hospital claims using the same payment methods and rates ((~~as~~)) used for in-state hospital claims, including DRG, RCC, per diem, outliers, and per case rate, subject to the following:

(i) Inpatient payment rates used to pay critical border university hospitals for inpatient hospital claims cannot exceed the highest corresponding inpatient payment rate for an in-state university hospital;

(ii) Inpatient payment rates used to pay critical border Level 1 trauma centers for inpatient hospital claims cannot exceed the highest corresponding inpatient payment rate for an in-state Level 1 trauma center; and

(iii) Inpatient payment rates used to pay critical border hospitals ((~~not listed in (A) and (B) of this subsection for inpatient hospital claims~~)) that are not university hospitals or Level 1 trauma centers cannot exceed the highest corresponding in-state inpatient payment rate for in-state hospitals ((~~that are~~)) not designated as((~~:~~

~~(A) Critical access hospitals (CAHs);~~

~~(B) University hospitals; or~~

~~(C) Level 1 trauma centers~~)) university hospitals or Level 1 trauma centers.

(5) Critical border hospitals((~~—~~)) - Outpatient hospital claim payment methods. The ((~~department~~)) agency pays outpatient critical border hospital claims ((~~with dates of services on and after August 1, 2007,~~)) using the same payment methods ((~~as~~)) used for in-state outpatient hospital claims((~~, including the APC method using the hospital's OPPS conversion factor, maximum allowable fee schedule method, and the hospital outpatient RCC rate method (refer to WAC 388-550-7000 through 388-550-7600 and WAC 388-550-4500)~~)) (see WAC 182-550-7000 through 182-550-7600 and 182-550-4500), subject to the following:

(a) Outpatient rates used to pay critical border university hospitals for outpatient claims cannot exceed the highest corresponding rate for an in-state university hospital((~~.~~));

(b) Outpatient rates used to pay critical border Level 1 trauma centers for outpatient claims cannot exceed the highest corresponding rate for an in-state Level 1 trauma center((~~.~~)); and

(c) Outpatient rates used to pay ((~~the~~)) critical border hospitals ((~~not listed in (i) and (ii) of this subsection for outpatient claims~~)) that are not university hospitals or Level 1 trauma centers cannot exceed the highest corresponding rate for in-state hospitals ((~~that are~~)) not designated as((~~:~~

~~(i) Critical access hospitals (CAH);~~

~~(ii) University hospitals; or~~

~~(iii) Level 1 trauma centers~~)) university hospitals or Level 1 trauma centers.

(6) Critical border hospitals are eligible to receive payment for graduate medical education (GME). All other bordering city hospitals are not eligible to receive payment for GME.

(7) The ((~~department~~)) agency makes:

(a) Claim payment adjustments, including but not limited to, third-party liability, medicare, and client responsibility; and

(b) Other necessary adjustments, as directed by the legislature (e.g., rate rebasing and other changes).

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

WAC 182-550-4000 Payment method—Out-of-state hospitals. This section describes the payment methods the ((~~department~~)) agency uses to pay hospitals located out-of-state for providing services to eligible Washington ((~~state medical assistance~~)) apple health clients. This section does not apply to hospitals located in any of the designated bordering cities listed in WAC ((~~388-501-0175~~)) 182-501-0175.

Payment methods that apply to bordering city hospitals, including critical border hospitals, are described in WAC ((~~388-550-3900.~~

~~(1) Emergency hospital services before August 1, 2007.~~

~~(a) For inpatient hospital claims for emergency services provided in out-of-state hospitals with dates of admission before August 1, 2007, the department limits the payment to the lesser of the:~~

~~(i) Billed charges; or~~

~~(ii) Weighted average of ratio of costs-to-charges (RCC) ratios for in-state hospitals multiplied by the allowed covered charges for medically necessary services.~~

~~(b) For outpatient hospital claims for emergency services provided in out-of-state hospitals with the first date of service before August 1, 2007, the department limits the payment to the lesser of the:~~

~~(i) Billed charges; or~~

~~(ii) Weighted average of hospital outpatient RCC rates for instate hospitals multiplied by the allowed covered charges for medically necessary services.~~

~~(2)~~)) 182-550-3900. See also WAC 182-501-0180, health care services provided outside the state of Washington - General provisions, and WAC 182-502-0120, payment for health care services provided outside the state of Washington.

(1) Emergency hospital services ((~~on and after August 1, 2007~~)).

(a) For inpatient hospital claims for emergency services provided in out-of-state hospitals ((~~with dates of admission on and after August 1, 2007~~)), the ((~~department~~)) agency:

(i) Pays using the same methods used to pay in-state hospitals((~~:~~

~~(A) Diagnosis related group (DRG) (WAC 388-550-3000);~~

~~(B) Per diem (WAC 388-550-3010);~~

~~(C) DRG and per diem outliers (WAC 388-550-3700); and~~

~~(D) Ratio of costs-to-charges (RCC) (WAC 388-550-4500).~~)) as specified in this chapter; and

(ii) ((~~Pays~~)) Calculates the payment using the lowest in-state inpatient hospital rate corresponding to the payment method ((~~used in (a)(i) of this subsection.~~

~~(iii) Limits payment to out-of-state hospitals to the lesser of the:~~

~~(A) Billed charges; or~~

~~(B) Calculated payment amount~~)).

(b) For outpatient hospital claims for emergency services provided in out-of-state hospitals ((~~with dates of service on or after August 1, 2007~~)), the ((~~department~~)) agency pays an out-of-state hospital using ((~~one or both of~~)) the following methods:

(i) The agency's outpatient prospective payment system (OPPS) described in WAC 182-550-7000;

(ii) The maximum allowable fee schedule method described in WAC ((~~388-550-6000, and limits payment when~~)) 182-550-6000. When the maximum allowable fee schedule method is used, the agency limits payment to the lesser of the:

(A) Billed charges; or

(B) Calculated payment amount((~~:~~

~~(ii)~~)); and

(iii) The hospital outpatient RCC payment method described in WAC ((~~388-550-4500~~)) 182-550-4500. When using the RCC payment method, the ((~~department~~)) agency pays the lowest in-state hospital outpatient RCC ((~~rate~~)), excluding ((~~departmental~~)) weighted costs-to-charges (((~~DWCC~~))) (WCC) rates that are paid to in-state critical access hospitals.

(((~~(c) Out-of-state hospitals are not eligible to receive payment for graduate medical education (GME).~~

~~(3) The department makes:~~

~~(a) Claim payment adjustments, including but not limited to client responsibility, third party liability, and medicare; and~~

~~(b) Other necessary adjustments as directed by the legislature (e.g., rate rebasing and other changes).~~

~~(4)~~)) (2) Nonemergency hospital services.

(a) The agency pays for:

(i) Contracted and prior authorized nonemergency hospital services according to the contract terms whether or not the hospital has signed a core provider agreement; and

(ii) Nonemergency hospital services authorized by the agency after the fact (subsequent to the date of admission, if the client is still at the out-of-state hospital, or after the services have been provided) according to subsections (1) and (3) of this section.

(b) The ((~~department~~)) agency does not pay for:

(i) Nonemergency hospital services provided to a ((~~medical assistance~~)) Washington apple health client in a hospital located out-of-state unless the hospital is contracted ((~~and/or~~)) and prior authorized by the ((~~department~~)) agency or the ((~~department's~~)) agency's designee((~~,~~)) for the specific service provided((~~:~~

~~(a) Contracted services are paid according to the contract terms whether or not the hospital has signed a core provider agreement.~~

~~(b) Authorized services are paid according to subsections (1), (2), and (3) of this section.~~

~~(c) Bariatric surgery performed in a designated department-approved hospital is paid a per case rate and must be prior authorized by the department (see WAC 388-550-3020).~~)) to a specific client; and

(ii) Unauthorized nonemergency hospital services are not paid by the agency. See WAC 182-501-0182.

(3) The agency makes claim payment adjustments including, but not limited to, client responsibility, third-party liability, and medicare. All applicable adjustments are factored into the final hospital payment amount.

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

WAC 182-550-4100 Payment method—New hospitals. (1) For rate-setting purposes, the ((~~department~~)) agency considers as new:

(a) A hospital which began services after the most recent ((~~rebased cost-based conversion factors (CBCFs) conversion factors, RCC rates, per diem rates, per case rates, etc.~~)) rebasing; or

(b) A hospital that has not been in operation for a complete fiscal year.

(2) The ((~~department~~)) agency determines a new hospital's((~~:~~

~~(a) CBCF as the average of the CBCF of all hospitals within the same department peer group for dates of admission before August 1, 2007.~~

~~(b)~~)) Conversion factor, per diem rate, or per case rate, to be the statewide average rate for the conversion factor, category of per diem rate, or per case rate((~~, for dates of admission on and after August 1, 2007,~~)) adjusted by the geographically appropriate hospital specific medicare wage index.

(3) The ((~~department~~)) agency determines a new hospital's ratio of costs-to-charges (RCC) by calculating and using the average RCC ((~~rate~~)) for all current Washington in-state hospitals.

(4) ((~~The department considers that a change in hospital ownership does not constitute~~)) When a hospital changes ownership, the agency does not consider it a new hospital.

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

WAC 182-550-4300 Hospitals and units exempt from the DRG payment method. (1) Except when otherwise specified, inpatient services provided by hospitals and units that are exempt from the diagnosis-related group (DRG) payment method are paid under the ratio of costs-to-charges (RCC) payment method described in WAC ((~~388-550-4500~~)) 182-550-4500, the per diem payment method described in WAC ((~~388-550-3010~~)) 182-550-3000, the per case rate payment method described in WAC ((~~388-550-3020~~)) 182-550-3000, or other payment methods identified in this chapter (e.g., long term acute care (LTAC), certified public expenditure (CPE), critical access hospital (CAH), etc.). ((~~The department limits inpatient hospital stays based on the department's determinations from medical necessity and quality assurance reviews.~~

~~(2) For dates of admission before August 1, 2007, subject to the restrictions and limitations listed in this section, the department exempts the following hospitals and units from the DRG payment method for inpatient services provided to medicaid-eligible clients:~~

~~(a) Peer group A hospitals, as described in WAC 388-550-3300(2). Exception: Inpatient services provided to clients eligible under the following programs are paid through the DRG payment method (see WAC 388-550-4400):~~

~~(i) General assistance programs; and~~

~~(ii) Other state administered programs.~~

~~(b) Peer group E hospitals, as described in WAC 388-550-3300(2). See WAC 388-550-4650 for how the department calculates payment to Peer group E hospitals.~~

~~(c) Peer group F hospitals (critical access hospitals).~~

~~(d) Rehabilitation units when the services are provided in department-approved acute physical medicine and rehabilitation (acute PM&R) hospitals and designated distinct rehabilitation units in acute care hospitals.~~

~~The department uses the same criteria as the medicare program to identify exempt rehabilitation hospitals and designated distinct rehabilitation units. Inpatient rehabilitation services provided to clients eligible under the following programs are covered and paid through the DRG payment method (see WAC 388-550-4400 for exceptions):~~

~~(i) General assistance programs; and~~

~~(ii) Other state-only administered programs.~~

~~(e) Out-of-state hospitals excluding hospitals located in designated bordering cities as described in WAC 388-501-0175. Inpatient services provided in out-of-state hospitals to clients eligible under the following programs are not covered or paid by the department:~~

~~(i) General assistance programs; and~~

~~(ii) Other state administered programs.~~

~~(f) Military hospitals when no other specific arrangements have been made with the department. Military hospitals may individually elect or arrange for one of the following payment methods in lieu of the RCC payment method:~~

~~(i) A negotiated per diem rate; or~~

~~(ii) DRG.~~

~~(g) Nonstate-owned specifically identified psychiatric hospitals and designated hospitals with medicare certified distinct psychiatric units. The department uses the same criteria as the medicare program to identify exempt psychiatric hospitals and distinct psychiatric units of hospitals.~~

~~(i) Inpatient psychiatric services provided to clients eligible under the following programs are paid through the DRG payment method:~~

~~(A) General assistance programs; and~~

~~(B) Other state administered programs.~~

~~(ii) Mental health division (MHD) designees that arrange to reimburse nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals directly, may use the department's payment methods or contract with the hospitals to reimburse using different methods. Claims not paid directly through a MHD are paid through the department's payment system.~~

~~(3) The department limits inpatient hospital stays for dates of admission before August 1, 2007 that are exempt from the DRG payment method and identified in subsection (2) of this section to the number of days established at the seventy-fifth percentile in the current edition of the publication, "*Length of Stay by Diagnosis and Operation, Western Region*," unless the stay is:~~

~~(a) Approved for a specific number of days by the department, or for psychiatric inpatient stays, by the regional support network (RSN);~~

~~(b) For chemical dependency treatment which is subject to WAC 388-550-1100; or~~

~~(c) For detoxification of acute alcohol or other drug intoxication.~~

~~(4) If subsection (3)(c) of this section applies to an eligible client, the department will:~~

~~(a) Pay for three-day detoxification services for an acute alcoholic condition; or~~

~~(b) Pay for five-day detoxification services for acute drug addiction when the services are directly related to detoxification; and~~

~~(c) Extend the three- and five-day limitations for up to six additional days if either of the following is invoked on a client under care in a hospital:~~

~~(i) Petition for commitment to chemical dependency treatment; or~~

~~(ii) Temporary order for chemical dependency treatment.~~

~~(5) For dates of admission on and after August 1, 2007, the department~~)) Inpatient services provided by hospitals and units are exempt from the DRG payment method only if they qualify for payment methods specifically mentioned in other sections of this chapter or in this section.

(2) The agency exempts the following hospitals, units, and services from the DRG payment method for inpatient services provided to ((~~medicaid-eligible~~)) clients eligible for Washington apple health:

(a) ((~~Peer group E hospitals as described in WAC 388-550-3300(2), i.e.,~~)) Hospitals participating in the ((~~department's~~)) agency's certified public expenditure (CPE) payment program((~~.~~)) (see WAC ((~~388-550-4650.~~)) 182-550-4650);

(b) ((~~Peer group F hospitals, i.e., critical~~)) Hospitals participating in the agency's critical access hospital((~~s.~~)) program (see WAC ((~~388-550-2598.~~)) 182-550-2598);

(c) Rehabilitation services. All rehabilitation services are paid through the per diem payment method except as indicated in (((~~(b), (e), and (f)~~))) (a), (b), and (d) of this subsection((~~. See WAC 388-550-3010. Inpatient psychiatric services, Involuntary Treatment Act services, and detoxification services provided in out-of-state hospitals are not covered or paid by the department or a MHD designee. The department does not cover or pay for other hospital services provided to clients eligible for those services in the following programs, when the services are provided in out-of-state hospitals that are not in designated bordering cities:~~

~~(i) General assistance programs; and~~

~~(ii) Other state-administered programs.~~

~~(f)~~)) (See WAC 182-550-3000);

(d) Military hospitals when no other specific arrangements have been made with the ((~~department~~)) agency. The ((~~department~~)) agency, or the military hospital, may elect or arrange for one of the following payment methods in lieu of the RCC payment method:

(i) Per diem payment method; or

(ii) DRG payment method((~~.~~

~~(g)~~)); and

(e) Psychiatric services. All psychiatric services are paid through the per diem payment method except as indicated in (((~~(b), (e), and (f)~~))) (a), (b), and (d) of this subsection (see WAC 182-550-3000). ((~~See WAC 388-550-3010. A MHD~~)) A mental health designee that arranges to directly pay a hospital and/or a designated distinct psychiatric unit of a hospital ((~~directly,~~)) may use the ((~~department's~~)) agency's payment methods or contract with the hospital((~~s~~)) to pay using different methods. Claims not paid directly through a ((~~MHD~~)) mental health designee are paid through the ((~~department's~~)) agency's payment system.

(((~~(6) For dates of admission on and after August 1, 2007, the department~~)) (3) Inpatient psychiatric services, Involuntary Treatment Act services, and detoxification services provided in out-of-state hospitals are not covered or paid by the agency or the agency's mental health designee. The agency does not cover or pay for other hospital services provided to clients eligible for those services in the following programs, when the services are provided in out-of-state hospitals that are not in designated bordering cities:

(a) Medical care services; and

(b) Other state-administered programs.

(4) The agency has established an average length of stay (ALOS) for each DRG classification((~~. The DRG ALOS is based on the claims data used during the rebasing period. For DRGs with an exceptionally low volume of claims, the department uses a proxy DRG ALOS~~)) and publishes it on the agency's web site. The agency uses the DRG ALOS ((~~is used~~)) as a benchmark to authorize and pay inpatient hospital stays exempt from the DRG payment method. When an inpatient hospital stay exceeds the ((~~department's~~)) agency's DRG ALOS benchmark or prior authorized LOS:

(a) For a psychiatric inpatient stay, the hospital must obtain approval for additional days beyond the prior authorized days from the ((~~MHD~~)) division of behavioral health and recovery (DBHR) or the ((~~MHD~~)) mental health designee who prior authorized the admission. See WAC ((~~388-550-2600~~)) 182-550-2600;

(b) For an acute physical medicine and rehabilitation (PM&R) or a long term acute care (LTAC) stay, the hospital must obtain approval for additional days beyond the prior authorized days from the ((~~department~~)) agency unit that prior authorized the admission. See WAC ((~~388-550-2561 and 388-550-2590~~)) 182-550-2561 and 182-550-2590;

(c) For an inpatient hospital stay for detoxification for a chemical ((~~dependent~~)) using pregnant (CUP) client, see WAC ((~~388-550-1100~~)) 182-550-1100;

(d) For other medical inpatient stays for detoxification, see WAC ((~~388-550-1100~~)) 182-550-1100 and subsection (((~~(7)~~))) (5) of this section;

(e) For an inpatient stay in a certified public expenditure (CPE) hospital, see WAC ((~~388-550-4690~~)) 182-550-4690; and

(f) For an inpatient hospital stay not identified in (a) through (e) of this subsection, the ((~~department~~)) agency may perform retrospective utilization review to determine if the LOS was medically necessary and at the appropriate level of care.

(((~~(7)~~))) (5) If subsection (((~~(6)~~))) (4)(d) of this section applies to an eligible client, the ((~~department~~)) agency will:

(a) Pay for three-day detoxification services for an acute alcoholic condition; or

(b) Pay for five-day detoxification services for acute drug addiction when the services are directly related to detoxification; and

(c) If WAC 182-550-1100 (5)(b) applies, extend the three- and five-day limitations ((~~for up to six additional days if either of the following is invoked on a client under care in a hospital:~~

~~(i) Petition for commitment to chemical dependency treatment; or~~

~~(ii) Temporary order for chemical dependency treatment~~)) when the following are true:

(i) The days are billed as covered;

(ii) A medical record is submitted with the claim;

(iii) The medical record clearly documents that the days are medically necessary; and

(iv) The level of care is appropriate according to WAC 182-550-2900.

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

WAC 182-550-4400 Services—Exempt from DRG payment. (((~~(1) Except when otherwise specified, inpatient services exempt from the diagnosis-related group (DRG) payment method are paid under the ratio of costs-to-charges (RCC) payment method described in WAC 388-550-4500, the per diem payment method described in WAC 388-550-3010, the per case rate payment method described in WAC 388-550-3020, or other payment methods identified in this chapter (e.g., long-term acute care (LTAC), certified public expenditure (CPE), critical access hospital (CAH), etc.). The department limits inpatient hospital stays based on the department's determinations from medical necessity and quality assurance reviews.~~

~~(2) Subject to the restrictions and limitations in this section, for dates of admission before August 1, 2007, the department exempts the following services for medicaid clients from the DRG payment method:~~

~~(a) Neonatal services for DRGs 602-619, 621-628, 630, 635, and 637-641.~~

~~(b) Acquired immunodeficiency syndrome (AIDS)-related inpatient services for those cases with a reported diagnosis of AIDS-related complex and other human immunodeficiency virus infections. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state administered program.~~

~~(c) Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agreement with the department to perform these services. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state administered program.~~

~~(d) Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to chemically dependent pregnant women (CUP program) by a certified hospital. These are medicaid program services and are not funded by the department for the general assistance programs or any other state administered program.~~

~~(e) Acute physical medicine and rehabilitation services provided in department-approved rehabilitation hospitals and hospital distinct units, and services for physical medicine and rehabilitation patients. See WAC 388-550-4300 (2)(d). Rehabilitation services provided to clients under the general assistance programs and any other state-only administered program are also reimbursed through the RCC payment method.~~

~~(f) Psychiatric services provided in nonstate-owned psychiatric hospitals and designated distinct psychiatric units of hospitals. Inpatient psychiatric services provided to clients eligible under the following programs are reimbursed through the DRG payment method:~~

~~(i) General assistance programs; and~~

~~(ii) Other state administered programs.~~

~~(g) Chronic pain management treatment provided in department-approved pain treatment facilities.~~

~~(h) Administrative day services. The department pays administrative days based on the statewide average medicaid nursing facility per diem rate, which is adjusted annually each November 1. The department applies this rate to patient days identified as administrative days on the hospital's notice of rates. Hospitals must request an administrative day designation on a case-by-case basis.~~

~~(i) Inpatient services recorded on a claim that is grouped by the department to a DRG for which the department has not published an all patient DRG relative weight, except that claims grouped to DRGs 469 and 470 will be denied payment. This policy also applies to covered services paid through the general assistance programs and any other state administered program.~~

~~(j) Organ transplants that involve the heart, kidney, liver, lung, allogeneic bone marrow, pancreas, autologous bone marrow, or simultaneous kidney/pancreas. These services are also exempt from the DRG payment method when funded by the department through the general assistance programs and any other state administered program.~~

~~(k) Bariatric surgery performed in hospitals that meet the criteria in WAC 388-550-2301. The department pays hospitals for bariatric surgery on a per case rate basis. See WAC 388-550-3470.~~

~~(3) Inpatient services provided through a managed care plan contract are paid by the managed care plan.~~

~~(4)~~)) (1) Inpatient services are exempt from the diagnosis-related group (DRG) payment method only if they qualify for payment methods specifically mentioned in other sections of this chapter or in this section.

(2) Subject to the restrictions and limitations in this section, ((~~for dates of admission on and after August 1, 2007, the department~~)) the agency exempts the following services for medicaid and ((~~SCHIP~~)) CHIP clients from the DRG payment method. This policy also applies to covered services paid through ((~~the general assistance programs~~)) medical care services (MCS) and any other state-administered program, except when otherwise indicated in this section. The exempt services are:

(a) Alcohol or other drug detoxification services when provided in a hospital having a detoxification provider agreement with the ((~~department~~)) agency to perform these services.

(b) Hospital-based intensive inpatient detoxification, medical stabilization, and drug treatment services provided to ((~~chemically-using~~)) chemical-using pregnant (CUP) women ((~~program~~)) by a certified hospital. These are medicaid program services and are not covered or funded by the ((~~department~~)) agency through ((~~the general assistance programs~~)) MCS or any other state-administered program.

(c) Acute physical medicine and rehabilitation (acute PM&R) services.

(d) Psychiatric services. A mental health ((~~division (MHD)~~)) designee that arranges to pay a hospital directly for psychiatric services((~~,~~)) may use the ((~~department's~~)) agency's payment methods or contract with the hospital to pay using different methods. Claims not paid directly through a ((~~MHD~~)) mental health designee are paid through the ((~~department's~~)) agency's payment system.

(e) Chronic pain management treatment provided in a hospital approved by the ((~~department~~)) agency to provide that service.

(f) Administrative day services. ((~~The department~~)) For patient days during an inpatient stay where no acute care services were provided, a hospital may request an administrative day designation on a case-by-case basis. The agency pays administrative days based on the statewide average medicaid nursing facility per diem rate, which is adjusted annually. The ((~~department applies this rate to patient days identified as administrative days on the hospital's notice of rates. A hospital must request an administrative day designation on a case-by-case basis. The department~~)) agency may designate part of a client's stay to be paid an administrative day rate upon review of the claim ((~~and/or~~)) or the client's medical record, or both.

(g) Inpatient services recorded on a claim ((~~that is~~)) grouped by the ((~~department~~)) agency to a DRG for which the ((~~department~~)) agency has not published an all-patient DRG (AP-DRG) or all-patient refined DRG (APR-DRG) relative weight. The agency will deny payment for claims grouped to DRG 469 ((~~or~~)), DRG 470 ((~~will be denied payment~~)), APR DRG 955, or APR DRG 956.

(h) Organ transplants that involve heart, intestine, kidney, liver, lung, allogeneic bone marrow, autologous bone marrow, pancreas, or simultaneous kidney/pancreas. The ((~~department~~)) agency pays hospitals for these organ transplants using the ratio of costs-to-charges (RCC) payment method. The agency maintains a list of DRGs which qualify as transplants on the agency's web site.

(i) Bariatric surgery performed in hospitals that meet the criteria in WAC ((~~388-550-2301~~)) 182-550-2301. The ((~~department~~)) agency pays hospitals for bariatric surgery on a per case rate basis for clients in medicaid and state-administered programs when the services are prior authorized and take place at an approved hospital. The agency approves bariatric services at Sacred Heart Medical Center, the University of Washington Medical Center, and the Oregon Health Sciences University and may approve other hospitals based on agency discretion. See WAC ((~~388-550-3020 and 388-550-3470~~)) 182-550-3000 and 182-550-3470.

((~~(j) Services provided by a critical access hospital (CAH).~~

~~(k) Services provided by a hospital participating in the certified public expenditure (CPE) payment program. The CPE "hold harmless" provision allows a reconciliation that is described in WAC 388-550-4670.~~

~~(l) Services provided by a long term acute care (LTAC) hospital.~~))

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

WAC 182-550-4800 Hospital payment methods—State-administered programs. ((~~Subsections (1) through (11) of this section apply to hospital payment methods for state-administered programs for dates of admission before August 1, 2007. Subsections (12) through (19) of this section apply to hospital payment methods for state-administered programs for dates of admission on and after August 1, 2007.~~

~~(1) Except as provided in subsection (2) of this section, the department uses the ratio of costs-to-charges (RCC) and diagnosis-related group (DRG) payment methods described in this section to pay hospitals at reduced rates for covered services provided to a client who is not eligible under a medicaid program, the SCHIP program, or alien emergency medical (AEM) program and:~~

~~(a) Who qualifies for the general assistance unemployable (GAU) program; or~~

~~(b) Is involuntarily detained under the Involuntary Treatment Act (ITA).~~

~~(2) The department exempts the following services from the state-administered programs' payment methods and/or reduced rates:~~

~~(a) Detoxification services when the services are provided under a department-assigned provider number starting with "thirty-six." (The department pays these services using the Title XIX medicaid RCC payment method.)~~

~~(b) Program services provided by department-approved critical access hospitals (CAHs) to clients eligible under state-administered programs. (The department pays these services through cost settlement as described in WAC 388-550-2598.)~~

~~(c) Program services provided by Peer group E hospitals to clients eligible under the GAU program. (The department these services through the "full cost" public hospital certified public expenditure (CPE) payment program (see WAC 388-550-4650).)~~

~~(3) The department determines:~~

~~(a) A state-administered program RCC payment by reducing a hospital's Title XIX medicaid RCC rate using the hospital's ratable.~~

~~(b) A state-administered program DRG payment by reducing a hospital's Title XIX medicaid DRG cost based conversion factor (CBCF) using the hospital's ratable and equivalency factor (EF).~~

~~(4) The department determines:~~

~~(a) The RCC rate for the state-administered programs mathematically as follows:~~

~~State-administered programs' RCC rate = current Title XIX medicaid RCC rate x (one minus the current hospital ratable)~~

~~(b) The DRG conversion factor (CF) for the state-administered programs mathematically as follows:~~

~~State-administered programs' DRG CF = current Title XIX medicaid DRG CBCF x (one minus the current hospital ratable) x EF~~

~~(5) The department determines payments to hospitals for covered services provided to clients eligible under the state-administered programs mathematically as follows:~~

~~(a) Under the RCC payment method:~~

~~State-administered programs' RCC payment = state-administered programs' RCC Rate x allowed charges~~

~~(b) Under the DRG payment method:~~

~~State-administered programs' DRG payment = state-administered programs' DRG CF x all patient DRG relative weight (see subsection (6) of this section for how the department determines payment for state-administered program claims that qualify as DRG high-cost outliers).~~

(6) For state-administered program claims that qualify as DRG high-cost outliers, the department determines:

(a) In-state children's hospital payments for state-administered program claims that qualify as DRG high-cost outliers mathematically as follows:

Eighty-five percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the DRG allowed amount

(b) Psychiatric DRG high-cost outlier payments for DRGs 424 through 432 mathematically as follows:

One hundred percent of the allowed charges above the outlier threshold x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

(c) Payments for all other claims that qualify as DRG high-cost outliers as follows:

Sixty percent x the specific hospital's RCC rate x (one minus the current hospital ratable) plus the applicable DRG allowed amount

High-cost Outlier Calculations for Qualifying Claims
State-administered Programs
(for admission dates January 1, 2001 and after)

In-state Children's Hospitals Allowed charges	(-)	> of $33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Ratable	(x)	85%	(=)	Outlier Add-on Amount	(+)	*DRG Allowed Amount
Psychiatric DRGs 424-432 Allowed charges	(-)	> of $33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Ratable	(x)	100%	(=)	Outlier Add-on Amount	(+)	* DRG Allowed Amount
All other qualifying claims Allowed charges	(-)	> of $33000 or 3 x DRG	(=)	Charges > threshold	(x)	RCC	(x)	1 (-) Ratable	(x)	60%	(=)	Outlier Add-on Amount	(+)	* DRG Allowed Amount

*Basic DRG allowed amount calculation: DRG relative weight x conversion factor = DRG allowed amount

(7) See WAC 388-550-3700(5) for how claims qualify as low-cost outliers.

(8) The department determines payments for claims that qualify as DRG low-cost outliers mathematically as follows:

Allowed charges for the claim x the specific hospital's RCC rate x (one minus the current hospital ratable)

(9) To calculate a hospital's ratable that is applied to both the Title XIX medicaid RCC rate and the Title XIX medicaid DRG CBCF used to determine the respective state-administered program's reduced rates, the department:

(a) Adds the hospital's medicaid revenue (medicaid revenue as reported by department of health (DOH) includes all medicaid revenue and all other medical assistance revenue) and medicare revenue to the value of the hospital's charity care and bad debts, all of which is taken from the most recent complete calendar year data available from DOH at the time of the ratable calculation; then

(b) Deducts the hospital's low-income disproportionate share hospital (LIDSH) revenue from the amount derived in (a) of this subsection to arrive at the hospital's community care dollars; then

(c) Subtracts the hospital-based physicians revenue that is reported in the hospital's most recent HCFA-2552 medicare cost report received by the department at the time of the ratable calculation, from the total hospital revenue reported by DOH from the same source as discussed in (a) of this subsection, to arrive at the net hospital revenue; then

(d) Divides the amount derived in (b) of this subsection by the amount derived in (c) of this subsection to obtain the ratio of community care dollars to net hospital revenue (also called the preliminary ratable factor); then

(e) Subtracts the amount derived in (d) of this subsection from 1.0 to obtain the hospital's preliminary ratable; then

(f) Determines a neutrality factor by:

(i) Multiplying hospital-specific medicaid revenue that is reported by DOH from the same source as discussed in (a) of this subsection by the preliminary ratable factor; then

(ii) Multiplying that same hospital-specific medicaid revenue by the prior year's final ratable factor; then

(iii) Summing all hospital-medicaid revenue from the hospital-specific calculations that used the preliminary ratable factor discussed in (f)(i) of this subsection; then

(iv) Summing all hospital revenue from the hospital-specific calculations that used the prior year's final ratable factor discussed in (f)(ii) of this subsection; then

(v) Comparing the two totals; and

(vi) Setting the neutrality factor at 1.0 if the total using the preliminary ratable factor is less than the total using the prior year's final ratable factor; or

(vii) Establishing a neutrality factor that is less than 1.0 that will reduce the total using the preliminary ratable factor to the level of the total using the prior year's final ratable factor, if the total using the preliminary ratable factor is greater than the total using the prior year's ratable factor; then

(g) Multiplies, for each specific hospital, the preliminary ratable by the neutrality factor to establish hospital specific final ratables for the year; then

(h) Subtracts each hospital-specific final ratable from 1.0 to determine hospital specific final ratable factors for the year; then

(i) Calculates an instate-average ratable and an instate-average ratable factor used for new hospitals with no prior year history.

(10) The department updates each hospital's ratable annually on August 1.

(11) The department:

(a) Uses the equivalency factor (EF) to hold the hospital specific state-administered programs' DRG CF at the same level prior to rebasing, adjusted for inflation; and

(b) Calculates a hospital's EF as follows:

EF = State-administered programs' prior DRG CF divided by current Title XIX medicaid DRG CBCF x (one minus the prior ratable)

(12) For dates of admission on and after August 1, 2007, the department)) This section does not apply to out-of-state hospitals unless they are border hospitals (critical or noncritical).

(1) The agency:

(a) Pays for services provided to a client eligible for a state-administered program (SAP) based on ((state-administered program)) SAP rates((. The state-administered program));

(b) Establishes SAP rates ((are established)) independently from the process used in setting the medicaid payment rates((. The state-administered program rates may not be changed unless the legislature authorizes the changes. The department uses the));

(c) Calculates a ratable ((factor and)) each year to adjust each hospital's SAP rates for their percentage of community-based dollars to the total revenues for all hospitals;

(d) Calculates an equivalency factor (EF) to keep the ((state-administered program)) SAP payment rates at the same level ((they were at)) before and after the ((state)) medicaid rates ((are)) were rebased.

(((13) The table in this subsection shows a comparison of the payment policy for the department's inpatient payment system for dates of admission before August 1, 2007, and the inpatient payment system effective for dates of admission on and after August 1, 2007. Under this inpatient payment system effective August 1, 2007, the per diem rates are used to pay for many services previously paid using the RCC payment method.

The following table indicates differences in policy for the two inpatient payment systems:

	Inpatient payment system for dates of admission before August 1, 2007	Inpatient payment system for dates of admission on and after August 1, 2007
Stable DRGs	DRG Grouper v 14.1	DRG grouper v 23.0
Unstable/Medical DRGs	RCC	Per diem
Unstable Surgical DRGs Unstable Neonate DRGs	RCC RCC	Per diem Per diem
Psych	RCC	Per diem
Rehab	RCC	Per diem
Detox	RCC	Per diem
Transplant	RCC	RCC
Military hospitals	RCC	RCC
HIV Chronic pain management	RCC Per diem	Not separately defined Per diem
Bariatric surgery	Per case rate	Per case rate
CUP	Not separately defined	Per diem
Burns	Not separately defined	Per diem

See specific sections in the chapter 388-550 WAC to determine how the department pays hospitals participating in the critical access hospital (CAH) program, the long term acute care (LTAC) program, and the certified public expenditure (CPE) payment program.

(14) Due to changes in payment methodologies established for the inpatient payment system effective August 1, 2007, the department)) (2) The agency has established the following ((state administered program rates used for dates of admission on and after August 1, 2007)):

(a) ((State-administered program)) SAP diagnosis-related group (DRG) conversion factor (CF) for claims grouped under ((stable)) DRG classifications services((.));

(b) ((State-administered program)) SAP per diem rates for claims grouped under the following specialty service categories:

(i) Chemical-using pregnant (CUP) women;

(ii) Detoxification; ((and))

(iii) Physical medicine and rehabilitation((.)) (PM&R); and

(iv) Psychiatric;

(c) ((State-administered program per diem rates for the claims grouped to unstable DRG classifications under the following nonspecialty service categories:

(i) Surgical;

(ii) Medical;

(iii) Burns; and

(iv) Neonate and pediatric.

(d) State-administered program per diem rates for claims grouped under psychiatric services.

(e) State-administered program)) SAP per case rate for claims grouped under bariatric services((.

(f) State-administered program)); and

(d) SAP ratio of costs-to-charges (RCC) ((rates)) for claims grouped under transplant services.

(((15))) (3) This subsection describes the ((state-administered program (DRG) conversion factor)) SAP DRG CF and payment calculation processes used by the ((department)) agency to pay claims ((paid)) using the DRG payment method. The ((department)) agency pays for services

grouped to a ((~~stable~~)) DRG classification ((~~that are~~)) provided to clients eligible for a ((~~state-administered program~~)) SAP based on the use of a DRG ((~~conversion factor and~~)) CF, a DRG relative weight, and a maximum service adjustor. This process is similar to the payment method used to pay for medicaid and ((~~SCHIP~~)) CHIP services ((~~that are~~)) grouped to a ((~~stable~~)) DRG classification.

(a) The ((~~department's state-administered program DRG conversion factor~~)) agency's SAP DRG CF calculation process is as follows:

(i) ((~~For instate and critical border hospitals,~~)) The hospital's specific DRG ((~~conversion factor that is~~)) CF used to calculate payment for a ((~~state-administered program claim, is based on the medicaid conversion factor adjusted by the most available ratable factor and the applicable equivalency factor. Mathematically the calculation is:~~

~~State administered program DRG CF =~~

~~((Medicaid DRG CF x applicable Equivalency Factor) x most available ratable factor)~~)) SAP claim is the medicaid DRG CF multiplied by the applicable EF multiplied by the ratable;

(ii) For ((~~instate and critical border~~)) hospitals that do not have ((~~a current state-administered program DRG conversion factor~~)) a ratable or an EF, the ((~~state-administered program conversion factor~~)) SAP CF is the hospital's specific ((~~proposed~~)) medicaid ((~~conversion factor~~)) CF multiplied by the average ((~~applicable equivalent factor and average applicable ratable.~~)) EF and the average ratable; and

(iii) For ((~~bordering city hospitals that are not critical border hospitals, and for other out-of-state hospitals that are not critical border hospitals, the state-administered program DRG conversion factor~~)) noncritical border hospitals, the SAP DRG CF is the lowest in-state medicaid DRG ((~~conversion factor~~)) CF multiplied by the average ratable and ((~~equivalency factor~~)) the average EF.

(b) The ((~~department's state-administered program DRG equivalency factor calculation process is~~)) agency calculates the SAP DRG EF as follows:

(i) The ((~~equivalency factor is a factor used to hold the hospital's specific state-administered program DRG conversion factor or rates at the same level before and after the medicaid DRG rate is rebased. Mathematically the calculation is:~~

~~Equivalency factor = (State-administered program DRG CF/(medicaid DRG CF x ratable))~~

~~(ii) The department may make an adjustment to the equivalency factor to address the differences in the relative weight values of the two DRG grouper versions due to the recalibration of the weights.~~

~~(iii) Refer to the ratable and ratable factor definition and calculation for the ratable factor determination.~~)) hospital-specific current SAP DRG CF is divided by the rebased medicaid DRG CF and then divided by the ratable factor to compute the preliminary EF.

(ii) The current SAP DRG payment is determined by multiplying the hospital specific SAP DRG CF by the AP-DRG version 23 relative weight.

(iii) The current aggregate DRG payment is determined by summing the current SAP DRG payments for all hospitals.

(iv) The hospital projected SAP DRG payment is determined by multiplying the hospital specific current SAP DRG CF by the APR-DRG relative weights version 31.0 and the maximum service adjustor.

(v) The projected aggregate DRG payment is determined by summing the projected SAP program DRG payments for all hospitals.

(vi) The aggregate amounts derived in (b)(iii) and (v) of this subsection are compared to identify a neutrality factor that keeps the projected aggregate SAP DRG payment (based on DRG-APR relative weights version 31.0) at the same level as the current aggregate SAP DRG payment (based on AP-DRG relative weights version 23.0).

(vii) The neutrality factor is multiplied by the hospital specific preliminary EF to determine the hospital specific final EF that is used to determine the SAP DRG conversion factors for the rebased system implementation.

(c) The ((~~department's~~)) agency calculates the DRG payment ((~~calculation process for DRG classifications grouped to stable DRG relative weights is~~)) for services paid under the DRG payment method as follows:

(i) The ((~~department determines~~)) agency calculates the allowed amount for the inlier portion of the ((~~state-administered program~~)) SAP DRG payment ((~~calculation. Mathematically the calculation is:~~

~~State-administered program DRG inlier portion allowed amount of the payment = (State-administered program DRG CF x DRG relative weight)~~

~~(ii) The department determines the high outlier claim calculation for the state-administered program DRG payment. See WAC 388-550-3700 for more information about high outlier qualification and calculation processes. Mathematically the calculation is:~~

~~State-administered program DRG inlier and outlier portion allowed amount of the payment = (State-administered program DRG CF x DRG relative weight) + outlier adjustment~~

~~(iii) The outlier payment adjustment calculation for a state-administered program claim is different than the outlier payment calculation for a medicaid claim. The outlier adjustment for a state-administered program claim is adjusted by the ratable factor.~~

~~(iv) The outlier threshold amount for claims that are eligible for a high outlier payment and are grouped to nonneonatal DRGs and nonpediatric DRGs, equals one hundred seventy-five percent of the DRG inlier allowed amount calculation. This same outlier threshold is used for claims that are eligible for a high outlier payment in hospitals other than Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center.~~

~~(v) The outlier threshold amount for claims that are eligible for a high outlier payment and are grouped to neonatal DRGs, pediatric DRGs, equals one hundred fifty percent of the DRG inlier allowed amount calculation. This same outlier threshold is used for claims that are eligible for a high outlier payment when the claim is from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.~~

~~(vi) The outlier transfer provision is applied for the calculation of services paid under the state-administered program DRG payments.~~

~~(vii) Refer to the medicaid percent of outlier adjustment factor described in WAC 388-550-3700 and (d) of this subsection for how the percent of outlier adjustment factor is reduced by a ratable to determine the outlier portion allowed amount for the claim.~~

~~(d) The department determines the outlier portion allowed amount calculation for the state-administered program high outlier claim DRG payment as follows. Mathematically the calculation is:~~

~~State administered program outlier portion allowed amount of claim = ((Covered charges x RCC) - outlier threshold) x (Percent of outlier adjustment factor x ratable factor)~~

~~(i) A claim is an outlier claim when the claim cost (covered charges x RCC) is greater than both the fixed loss amount of fifty thousand dollars and one hundred seventy-five percent (one hundred fifty percent for neonatal, pediatric DRGs, Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center) of the DRG inlier allowed amount for payment.~~

~~(ii) The outlier threshold used in calculation of the outlier payment adjustment will always be one hundred seventy-five percent (one hundred fifty percent for neonatal, pediatric DRGs, Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center) of the DRG inlier allowed amount for payment.~~

~~(iii) Refer to the ratable and ratable factor definition and calculation for the ratable factor determination.~~

~~(16)~~)) by multiplying the SAP DRG CF by the DRG relative weight and the maximum service adjustor.

(ii) SAP claims are also subject to outlier pricing. See WAC 182-550-3700 for details on outlier pricing.

(4) This subsection describes ((~~the state-administered program~~)) how the agency calculates the SAP per diem rate and payment ((~~calculation for the following specialty service categories and unstable DRG nonspecialty service categories.~~

~~(a) The per diem rate is separately established for each of the following services:~~

~~(i) CUP;~~

~~(ii) Detoxification;~~

~~(iii) Physical medicine and rehabilitation;~~

~~(iv) Surgical;~~

~~(v) Medical;~~

~~(vi) Burns; and~~

~~(v) Neonate and pediatric.~~

~~(b) The per diem rate calculation process for CUP, detoxification, physical medicine and rehabilitation, surgical, medical, burns, and neonate and pediatric services is,~~)) for CUP, detoxification, PM&R, and psychiatric services.

(a) The agency calculates the SAP per diem rate for in-state and critical border hospitals((~~, the hospital's specific state administered program per diem rate is based on the Title XIX medicaid rates multiplied by the most available ratable factor and the equivalency factor. Mathematically the calculation is:~~

~~State administered program per diem rate =~~

~~((Hospital's specific medicaid per diem x ratable factor) x Equivalency factor)~~

~~(c) The per diem equivalency factor calculation process is as follows:~~

~~(i) The per diem equivalency factor is a factor used to hold the aggregate payment for all nonmedicaid claims grouped under per diem payment method at the same level before and after the per diem medicaid rate is rebased. The equivalency factor is the calculated based on the estimate nonmedicaid per diem, the medicaid per diem, and the hospital's specific ratable factor. Mathematically the calculation is:~~

~~Equivalency factor =~~

~~(Estimated state administered program per diem rate/ (medicaid per diem rate x ratable))~~

~~(ii) For bordering city hospitals that are not critical border hospitals, and for other out-of-state hospitals that are not critical border hospitals, the state administered program per diem rate is the lowest instate medicaid per diem rate multiplied by the average ratable and equivalency factor.~~

~~(iii) The state administered program per diem rate is an estimate based on the actual payment per day. The actual payment per day equals the aggregate payment amount (inflated from the base year to the implementation year) divided by the number of days associated with the aggregate costs.~~

~~(iv) For a hospital with more than twenty state administered program claims that grouped in the base year data to DRG classifications that are paid using the per diem payment method, a hospital's specific equivalency factor is established based on the hospital's data.~~

~~(v) For a hospital with less than twenty state administered program claims that grouped in the base year data to DRG classifications are paid using the per diem payment method, an average equivalency factor is established based on the hospital data base of all hospitals.~~

~~(d) The state administered program~~)) by multiplying the hospital's specific medicaid per diem by the ratable and the per diem EF.

(b) The agency calculates the SAP per diem rate for non-critical border hospitals by multiplying the lowest in-state medicaid per diem rate by the average ratable and the average per diem EF.

(c) For hospitals with more than twenty nonpsychiatric SAP per diem paid services during SFY 2011, the agency calculates a per diem EF for each hospital using the individual hospital's claims as follows:

(i) The agency calculates a SAP average payment per day by dividing the total current SAP per diem payments by the total number of days associated with the payments.

(ii) The agency calculates a medicaid average payment per day by dividing the aggregate payments based on the rebased medicaid rates by the total number of days associated with the aggregate payments (same claims used in (c)(i) of this subsection).

(iii) The agency divides the hospital estimated SAP average payment per day in (a) of this subsection by the hospital medicaid average payment per day in (b) of this subsection.

(iv) The agency divides the result of (c)(iii) of this subsection by the hospital specific ratable factor to determine the EF.

(d) For hospitals with twenty or less nonpsychiatric SAP per diem paid services during SFY 2011, the EF is an average for all hospitals. The agency uses the following process to determine the average EF:

(i) The agency calculates a SAP average payment per day by dividing the total current SAP per diem payments for all hospitals by the total number of days associated with the aggregate payments.

(ii) The agency calculates a medicaid average payment per day by dividing the aggregate payments based on the rebased medicaid rates by the total number of days associated with the aggregate payment (same claims used in (d)(i) of this subsection).

(iii) The agency divides the SAP average per day in (a) of this subsection by the medicaid average payment per day in (b) of this subsection.

(iv) The agency divides the result of (d)(iii) of this subsection by the hospital specific ratable factor to determine the EF. The EF is an average based on claims for all the hospitals in the group.

(e) A psychiatric EF is used to keep SAP psychiatric rates at the level required by the Washington state legislature. The agency's SAP psychiatric rates are eighty-five and four one hundredths of a percent (85.04%) of the agency's medicaid psychiatric rates. The factor is applied to all hospitals.

(f) The agency calculates the SAP per diem allowed amount ((~~of payment calculation process~~)) for CUP, detoxification, ((~~and physical medicine and rehabilitation~~)) PM&R, and psychiatric services ((~~is as follows. Mathematically the calculation is:~~

~~Per diem payment =~~

~~Hospital's state administered program~~)) by multiplying the hospital's SAP per diem rate ((~~x patient stay LOS recognized by the department for payment~~)) by the agency's allowed patient days.

(g) The agency does not apply the high outlier ((~~and~~)) or transfer policy ((~~is not applied~~)) to the payment calculations for CUP, detoxification, ((~~and physical medicine and rehabilitation~~)) PM&R, and psychiatric services.

(((~~(e) The state administered program per diem allowed amount of payment calculation process for surgical, medical, burns, and neonate services is as follows. Mathematically the calculation is:~~

~~Per diem payment =~~

~~Hospital's state administered program per diem rate x patient stay LOS recognized by the department for payment~~

~~(i) The outlier policy is applied to payment calculations for a claim grouped to an unstable DRG classification when the claim is for surgical, medical, burns, neonate and pediatric services (see WAC 388-550-3700). Refer to the state administered program outlier DRG adjustment payment calculation for the outlier calculation.~~

~~(ii) The transfer policy is not applied to payment calculations for a claim grouped to an unstable DRG classification when the claim is for surgical, medical, burns, neonate and pediatric services.~~

~~(17) The state administered program per diem rate and payment calculation for psychiatric services is as follows:~~

~~(a) The department uses a payment method similar to the method used to pay for medicaid psychiatric services, for state administered program psychiatric services provided to clients eligible for those services. Psychiatric services provided to state administered program clients are paid using a psychiatric per diem rate. The per diem rate calculation process for state administered program psychiatric services is as follows:~~

~~(i) For instate hospitals, the hospital's specific state administered program psychiatric per diem rate used to calculate the allowed amount for payment is based on the Title XIX medicaid rate adjusted by a ratable factor specified by the legislature to reduce the medicaid psychiatric per diem to a state program per diem. Mathematically the calculation is:~~

~~State administered program psychiatric per diem rate =~~

~~Medicaid psychiatric per diem x a ratable factor specified by the legislature to reduce the medicaid psychiatric per diem to a state program per diem.~~

~~(ii) For hospitals located outside the state of Washington, including bordering city hospitals, critical border hospitals, and other out-of-state hospitals, psychiatric services and Involuntary Treatment Act (ITA) services are not covered or paid by the department.~~

~~(b) The per diem payment calculation process for state-administered program psychiatric services is as follows. Mathematically the calculation is:~~

~~Psychiatric payment =~~

~~State administered program hospital's specific per diem rate x patient stay LOS recognized by the department's MHD designee for payment~~

~~(i) Outlier payment and transfer policies are not applied to state administered program psychiatric claims.~~

~~(ii) The ratable factor was provided to the department by the legislature.~~

~~(18)~~)) (5) This subsection describes the ((~~state administered program~~)) SAP per case rate and payment processes for bariatric surgery services.

(a) ((~~The department limits provision of bariatric surgery services to medical assistance clients to hospitals that are approved by the department to provide those services. Bariatric surgery services provided to a medical assistance client by an approved hospital must also be prior authorized by the department for the hospital to receive payment from the department for those services. Effective August 1, 2007, the department approved bariatric surgery services programs at the Sacred Heart Medical Center, the University of Washington Medical Center, and the Oregon Health Science University. The department may approve other programs based on department discretion.~~

~~(b) The department~~)) The agency calculates the ((~~state administered program~~)) SAP per case rate for bariatric surgery services by multiplying the hospital's ((~~specific~~)) medicaid per case rate for bariatric surgery services by the hospital's ((~~specific~~)) ratable ((~~factor and DRG-equivalency factor. Mathematically the calculation is:~~

~~State administered program per case rate =~~

~~Medicaid per case rate x hospital's specific ratable factor x DRG equivalency factor~~)).

(b) The per case payment rate for bariatric surgery services is an all-inclusive rate. ((~~No outlier provision is applied to the per case rate.~~

~~(19) This subsection describes the state administered program RCC rates and payment calculation processes for transplant services and other RCC paid services. Transplant services provided to a client eligible for those services through a state administered program are paid using the RCC~~

~~payment method. There are some other services that may be paid using the RCC payment method, e.g., services provided by military hospitals when no other payment method is agreed upon by the department and the hospital. The state administered program RCC rate is calculated by multiplying the medicaid RCC rate by the ratable factor. Mathematically the calculation is:~~

~~State administered program RCC rate = Medicaid RCC x ratable factor~~

~~(20) The department may pay for authorized psychiatric indigent inpatient claims submitted by an instate community hospital designated as an institution for mental diseases (IMD) using state funds when such funds are provided by the state legislature specifically for this purpose.~~

~~(21) The department's policy for payment on state-administered program claims that involve third party liability (TPL) and/or client responsibility payments is the same policy indicated in the table in WAC 388-550-2800, except that when the department determines the payment on the claim, it applies state-administered program rates, not medicaid or SCHIP rates, when comparing the lesser of billed charges or the allowed amount on the claim.~~))

(c) The agency does not apply the high outlier or transfer policy to the payment calculations for bariatric surgery services.

(6) The agency calculates the SAP RCC by multiplying the medicaid RCC by the hospital's ratable.

(7) The agency establishes annually the hospital-specific ratable factor used in the calculation of SAP payment rate based on the most current hospital revenue data available from the department of health (DOH). The agency uses the following process to determine the hospital ratable factor:

(a) The agency adds the hospital's medicaid revenue, medicare revenue, charity care, and bad debts as reported in DOH data.

(b) The agency determines the hospital's community care dollars by subtracting the hospital's low-income disproportionate share hospital (LIDSH) payments from the amount derived in (a) of this subsection.

(c) The agency calculates the hospital net revenue by subtracting the hospital-based physician revenue (based on information available from the hospital's medicare cost report or provided by the hospitals) from the DOH total hospital revenue report.

(d) The agency calculates the preliminary hospital-specific ratable by dividing the amount derived in (b) of this subsection by the amount derived in (c) of this subsection.

(e) The agency determines a neutrality factor by comparing the hospital-specific medicaid revenue (used in (a) of this subsection) multiplied by the preliminary ratable to the hospital-specific medicaid revenue (used in (a) of this subsection) multiplied by the prior year ratable. The neutrality factor is used to keep the projected SAP payments at the same current payment level.

(f) The agency determines the final hospital-specific ratable by multiplying the hospital-specific preliminary ratable by the neutrality factor.

(g) The agency applies to the allowable for each SAP claim all applicable adjustments for client responsibility, any third-party liability, medicare payments, and any other adjustments as determined by the agency.

(8) The agency does not pay an SAP claim paid by the DRG method at greater than the billed charges.

(9) SAP rates do not apply to the critical access hospital (CAH) program's weighted cost-to-charges, to the long-term acute care (LTAC) program's per diem rate, or to the certified public expenditure (CPE) program's RCC (except as the RCC applies to the CPE hold harmless described in WAC 182-550-4670).

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-550-2511	Acute PM&R definitions.
WAC 182-550-2570	LTAC program definitions.
WAC 182-550-2800	Payment methods and limits—Inpatient hospital services for medicaid and SCHIP clients.
WAC 182-550-3010	Payment method—Per diem payment.
WAC 182-550-3020	Payment method—Bariatric surgery—Per case payment.
WAC 182-550-3100	Calculating DRG relative weights.
WAC 182-550-3150	Base period costs and claims data.
WAC 182-550-3200	Medicaid cost proxies.
WAC 182-550-3250	Indirect medical education costs—Conversion factors, per diem rates, and per case rates.
WAC 182-550-3450	Payment method for calculating medicaid DRG conversion factor rates.
WAC 182-550-3460	Payment method—Per diem rate.
WAC 182-550-7050	OPPS—Definitions.

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

WAC 182-550-3400 Case-mix index. (1) The ((~~department:~~

~~(a) Adjusts hospital costs used to calculate the conversion factor and per diem rates during the rebasing process by the hospital's case-mix index; and~~

~~(b)~~)) medicaid agency calculates the case-mix index (CMI) for each individual hospital to measure the relative cost for treating medicaid and ((~~SCHIP~~)) CHIP cases in a given hospital. The CMI represents the relative acuity of the claims.

(2) ((~~The department calculates the CMI for each hospital using medicaid and SCHIP admissions data from the individual hospital and the hospital's base period cost report. See WAC 388-550-3150. The CMI is calculated for each hospital by summing all relative weights for all claims in the dataset, and dividing the sum of the relative weights by the number of claims. That amount represents the relative acuity of the claims. The hospital-specific CMI is calculated as follows:~~))

Using medicaid and children's health insurance program (CHIP) admissions data from the individual hospital and the hospital's base period cost report, the agency calculates the CMI by:

(a) ((~~The department multiplies~~)) Multiplying the number of medicaid and ((~~SCHIP~~)) CHIP admissions to the hospital for a specific diagnosis-related group (DRG) classification by the relative weight for that DRG classification. The ((~~department~~)) agency repeats this process for each DRG billed by the hospital((~~.~~));

(b) ((~~The department adds~~)) Adding together the products in (a) of this subsection for all of the medicaid and ((~~SCHIP~~)) CHIP admissions to the hospital in the base year((~~.~~)); and

(c) ((~~The department divides~~)) Dividing the sum obtained in (b) of this subsection by the corresponding number of medicaid and ((~~SCHIP~~)) CHIP hospital admissions.

(((~~(d) Example: If the average case mix index for a group of hospitals is 1.0, a CMI of 1.0 or greater for a hospital in that group means that the hospital has treated a mix of patients in the more costly DRG classifications. A CMI of less than 1.0 indicates a mix of patients in the less costly DRG classifications.~~)))

(3) The ((~~department~~)) agency recalculates each hospital's ((~~case-mix index periodically, but no less frequently than each time rebasing is done~~)) CMI during inpatient hospital rebasing, or as needed.

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

WAC 182-550-3600 Diagnosis-related group (DRG) payment—Hospital transfers. (1) The rules in this section apply when an eligible client transfers from an acute care hospital or distinct unit to any of the following:

(a) ((~~Before July 1, 2009, to another acute care hospital or distinct unit; and~~

~~(b) On or after July 1, 2009, to one of the following:~~

~~(i)~~)) Another acute care hospital or distinct unit;

(((~~(ii)~~))) (b) A skilled nursing facility (SNF);

(((~~(iii)~~))) (c) An intermediate care facility (ICF);

(((~~(iv)~~))) (d) Home care under the ((~~department's~~)) medicaid agency's home health program;

(((~~(v)~~))) (e) A long-term acute care facility (LTAC);

(((~~(vi)~~))) (f) Hospice (facility-based or in the client's home);

(((~~(vii)~~))) (g) A hospital-based, medicare-approved swing bed, or another distinct unit such as a rehabilitation or psychiatric unit (see WAC ((~~388-550-3000~~)) 182-550-3000); or

(((~~(viii)~~))) (h) A nursing facility certified under medicaid but not medicare.

(2) The ((~~department~~)) agency pays a transferring hospital ((~~that transfers an emergency case to another acute care hospital, including an acute physical medicine and rehabilitation (acute PM&R) facility or distinct unit, an acute psychiatric facility or distinct unit, and a long-term acute care facility,~~)) the lesser of:

(a) The appropriate diagnosis-related group (DRG) payment ((~~based on a stable DRG~~)); or

(b) ((~~A~~)) The prorated DRG payment ((~~when the client's stay at the transferring hospital is less than the average length of stay (LOS) for the AP-DRG classification as determined by the department.~~

~~(3) The department pays a transferring hospital as follows:~~

~~(a) For dates of admission before August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital. The department determines the per diem rate by dividing the hospital's DRG payment amount for the appropriate DRG by that DRG's average LOS.~~

~~(b) For dates of admission on and after August 1, 2007, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one day, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem by dividing the hospital's allowed payment amount for the appropriate DRG by that DRG's statewide average LOS (see WAC 388-550-4300) for the AP-DRG classification as determined by the department.~~

~~(4) The department uses:~~

~~(a) The hospital's midnight census to determine the number of days a client stayed in the transferring hospital prior to the transfer; and~~

~~(b) The department's LOS data to determine the number of medically necessary days for a client's hospital stay.~~

~~(5) When a post-acute care hospital transfer occurs to one of the locations listed in subsection (1)(b)(ii) through (viii) of this section, the department pays the transferring hospital the lesser of:~~

~~(a) The appropriate DRG payment; or~~

~~(b) For dates of admission on and after July 1, 2009, a per diem rate multiplied by the number of medically necessary days the client stays at the transferring hospital plus one day, not to exceed the total calculated DRG-based payment amount including any outlier payment amount. The department determines the per diem by dividing the hospital's allowed payment amount for the appropriate DRG by that DRG's statewide average length of stay (see WAC 388-550-4300) for the AP-DRG classification as determined by the department.~~

~~(6) The department applies the outlier payment methodology if a transfer case qualifies:~~

~~(a) For dates of admission before August 1, 2007, as a high-cost or low-cost outlier; and~~

~~(b) For dates of admission on or after August 1, 2007, as a high-cost outlier.~~

~~(7)~~)), which the agency calculates by:

(i) Using the average length of stay (ALOS) for the assigned DRG:

(A) The agency uses the 3M national average length of stay for paying inpatient claims.

(B) The agency publishes ALOS values on its web site;

(ii) Dividing the hospital's allowed payment amount for the assigned DRG by the ALOS in (b)(i) of this subsection;

(iii) Determining the client length of stay as all medically necessary days at the transferring hospital, plus one day; and

(iv) Multiplying the number in (b)(ii) of this subsection by the length of stay determined in (b)(iii) of this subsection.

(3) The agency applies the outlier payment method if a transfer case qualifies as a high outlier. To qualify for a high outlier, the costs (ratio of cost-to-charges multiplied by covered allowed charges) for the transfer must exceed the outlier threshold. The threshold is the DRG allowed amount (hospital-specific rate multiplied by DRG relative weight) plus forty thousand dollars.

(4) The ((department)) agency does not pay a transferring hospital for a nonemergency case when the transfer is to another acute care hospital.

(((8))) (5) The ((department)) agency pays the full DRG payment to the discharging hospital for a discharge to home or self-care. This is the ((department's)) agency's maximum payment to a discharging hospital.

(((9))) (6) The ((department does not pay a discharging hospital any additional amounts as a transferring hospital if it transfers a client to another hospital (intervening hospital) which subsequently sends the client back.

(10) The department)) agency pays ((the)) an intervening hospital(((s))) a per diem payment based on the method described in subsection (((3))) (2) of this section.

(((11))) (7) The transfer payment policy described in this section does not apply to claims grouped into ((AP-DRG)) DRG classifications ((that are paid)) the agency pays based on the per diem, case rate, or ratio of costs-to-charges (RCC) payment methods.

(((12))) (8) The ((department)) agency applies the following to the payment for each claim((,)):

(a) All applicable adjustments for client responsibility((,));

(b) Any third-party liability((,));

(c) Medicare((,)) payments; and

(d) Any other adjustments as determined by the ((department)) agency.

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

WAC 182-550-3700 DRG ((high-cost and low-cost)) high outliers((, and new system DRG and per diem high outliers)). ((This section applies to inpatient hospital claims paid under the diagnosis-related group (DRG) payment methodology, and for dates of admission on and after August 1, 2007. It also applies to inpatient hospital claims paid under the per diem payment methodology.

(1) For dates of admission before August 1, 2007, a medicaid or state-administered claim qualifies as a DRG high-cost outlier when:

(a) The client's admission date on the claim is before January 1, 2001, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of twenty-eight thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(b) The client's admission date on the claim is January 1, 2001, or after, the stay did not meet the definition of "administrative day," and the allowed charges exceed:

(i) A threshold of thirty-three thousand dollars; and

(ii) A threshold of three times the applicable DRG payment amount.

(2) For dates of admission before August 1, 2007, if the claim qualifies as a DRG high-cost outlier, the high-cost outlier threshold, for payment purposes, is the amount in subsection (1)(a)(i) or (ii), whichever is greater, for an admission date before January 1, 2001; or subsection (1)(b)(i) or (ii), whichever is greater, for an admission date on or after January 1.

(3) For dates of admission before August 1, 2007, the department determines payment for medicaid claims that qualify as DRG high-cost outliers as follows:

(a) All qualifying claims, except for claims in psychiatric DRGs 424-432 and claims from instate children's hospitals, are paid seventy-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(b) Instate children's hospitals are paid eighty-five percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

(c) Psychiatric DRG high-cost outliers for DRGs 424-432 are paid one hundred percent of the allowed charges above the outlier threshold determined in subsection (2) of this section, multiplied by the hospital's RCC rate, plus the applicable DRG payment.

Examples for DRG high-cost outlier claim qualification and payment calculation
(Admission dates are January 1, 2001, or after, and before August 1, 2007.)

Allowed Charges	Applicable DRG Payment	Three times App. DRG Payment	Allowed Charges > $33,000?	Allowed Charges > Three times App. DRG Payment?	DRG High-Cost Outlier Payment	Hospital's Individual RCC Rate
$17,000	$5, 000	$15,000	No	Yes	N/A	64%
*33,500	5,000	15,000	Yes	Yes	**$5,240	64%
10,740	35,377	106,131	No	No	N/A	64%

Medicaid Payment calculation example for allowed charges of:	Nonpsych DRGs/Noninstate children's hospital (RCC is 64%)
*$33,500	Allowed charges
- $33,000 $500	The greater amount of 3 x applicable DRG pymt ($15,000) or $33,000
x 48%	75% of allowed charges x hospital RCC rate (nonpsych DRGs/noninstate children's) (75% x 64% = 48%)
- $240	Outlier portion
+ $5,000	Applicable DRG payment
**$5,240	Outlier payment

(4) For dates of admission before August 1, 2007, DRG high-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(5) For dates of admission before August 1, 2007, a medicaid or state-administered claim qualifies as a DRG low-cost outlier if:

(a) The client's admission date on the claim is before January 1, 2001, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred dollars.

(b) The client's admission date on the claim is January 1, 2001, or after, and the allowed charges are:

(i) Less than ten percent of the applicable DRG payment; or

(ii) Less than four hundred fifty dollars.

(6) If the claim qualifies as a DRG low-cost outlier:

(a) For an admission date before January 1, 2001, the low-cost outlier amount is the amount in subsection (5)(a)(i) or (ii), whichever is greater; or

(b) For an admission date on January 1, 2001, or after, the low-cost outlier amount is the amount in subsection (5)(b)(i) or (ii), whichever is greater.

(7) For dates of admission before August 1, 2007, the department determines payment for a medicaid claim that qualifies as a DRG low-cost outlier by multiplying the allowed charges for each claim by the hospital's RCC rate.

(8) For dates of admission before August 1, 2007, DRG low-cost outliers for state-administered programs are paid according to WAC 388-550-4800.

(9) For dates of admission before August 1, 2007, the department makes day outlier payments to hospitals in accordance with section 1923 (a)(2)(C) of the Social Security Act, for clients who have exceptionally long stays that do not reach DRG high-cost outlier status. A hospital is eligible for the day outlier payment if it meets all of the following criteria:

(a) The hospital is a disproportionate share hospital (DSH) and the client served is under age six, or the hospital may not be a DSH hospital but the client served is a child under age one;

(b) The payment methodology for the admission is DRG;

(c) The allowed charges for the hospitalization are less than the DRG high-cost outlier threshold as defined in subsection (2) of this section; and

(d) The client's length of stay exceeds the day outlier threshold for the applicable DRG payment amount. The day outlier threshold is defined as the number of days in an average length of stay for a discharge (for an applicable DRG payment), plus twenty days.

(10) For dates of admission before August 1, 2007 the department bases the day outlier payment on the number of days that exceed the day outlier threshold, multiplied by the administrative day rate.

(11) For dates of admission before August 1, 2007, the department's total payment for a day outlier claim is the applicable DRG payment plus the day outlier or administrative days payment.

(12) For dates of admission before August 1, 2007, a client's outlier claim is either a day outlier or a high-cost outlier, but not both.

(13) For dates of admission on and after August 1, 2007, the department does not identify a claim as a low-cost outlier or day outlier. Instead, these claims are processed using the applicable payment method described in this chapter. The department may review claims with very low costs.

(14) For dates of admission on and after August 1, 2007, the department)) (1) The agency identifies a diagnosis-related group (DRG) high outlier claim based on the claim's estimated costs. The agency allows a high outlier payment for claims paid using the DRG payment method when high outlier ((~~qualifying~~)) criteria are met.

(a) To qualify as a DRG high outlier claim, the estimated costs for the claim must be greater than the outlier threshold effective for the date of admission. The outlier threshold amount is depicted in the following table:

Dates of Admission	Pediatric	Nonpediatric
February 1, 2011 - July 31, 2012	Base DRG * 1.50	Base DRG * 1.75
August 1, 2012 - June 30, 2013	Base DRG * 1.429	Base DRG * 1.667
July 1, 2013 - June 30, 2014	Base DRG * 1.563	Base DRG * 1.823
July 1, 2014, and after	Base DRG + $40,000	Base DRG + $40,000

(b) The agency calculates the estimated costs of the claim ((~~are calculated~~)) by multiplying the total submitted charges, minus the ((~~noncovered~~)) nonallowed charges on the claim, by the hospital's ratio of costs-to-charges (RCC) ((~~rate. The department identifies a DRG high outlier claim based on the claim's estimated costs. To qualify as a DRG high outlier claim, the department's estimated costs for the claim must be greater than both the fixed outlier cost threshold of fifty thousand dollars, and one hundred seventy-five percent of the applicable base DRG allowed amount for payment~~)).

((~~These~~)) (c) When a transferring hospital submits a transfer claim to the agency, the high outlier criteria ((~~are also~~)) used to determine ((~~if a transfer~~)) whether the claim qualifies for high outlier payment ((~~when a transfer claim is submitted to the department by a transferring hospital.~~

~~For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims grouped to neonatal and pediatric DRGs under the DRG payment method, the department identifies a high outlier claim based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost amount must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty percent of the applicable base DRG allowed amount for payment.~~

~~(15) For dates of admission on and after August 1, 2007, the department may allow an adjustment for a high outlier for per diem claims grouped to a DRG classification in one of the acute unstable DRG service categories, i.e., medical, surgical, burn, and neonatal. These service categories are described in subsection (16) of this section.~~

~~(a) The department identifies high outlier per diem claims for medical, surgical, burn, and neonatal DRG service categories based on the claim estimated costs. The claim estimated costs are the total submitted charges, minus the noncovered charges for the claim, multiplied by the hospital's ratio of costs to charges (RCC) related to the admission. Except as specified in (b) of this subsection, a claim that is grouped to a medical, surgical, or burn DRG service category qualifies as a high outlier when the claim's estimated cost is greater than both the fixed outlier threshold of fifty thousand dollars and one hundred seventy-five percent of the applicable per diem base allowed amount for payment.~~

~~(b) For Children's Hospital Regional Medical Center, Mary Bridge Children's Hospital and Health Center, and claims grouped to neonatal and pediatric DRGs under medical, surgical, burn, and neonatal services categories, the department identifies high outlier claims based on the claim's estimated costs. To qualify as a high outlier claim, the claim's estimated cost must be greater than both the fixed outlier threshold of fifty thousand dollars and one hundred fifty percent of the applicable per diem base allowed amount for payment.~~

~~(c) The department may perform retrospective utilization reviews on all per diem outlier claims that exceed the department determined DRG average length of stay (LOS). If the department determines the entire LOS or part of the LOS is not medically necessary, the claim will be denied or the payment will be adjusted.~~

~~(16) For dates of admission on and after August 1, 2007, the term "unstable" is used generically to describe an AP-DRG classification that has fewer than ten occurrences (low volume), or that is unstable based on the statistical stability test indicated in this subsection, and to describe such claims in the major service categories of per diem paid claims identified in this section. The formula for the statistical stability test calculates the required size of a sample population of values necessary to estimate a mean cost value with ninety percent confidence and within an acceptable error of plus or minus twenty percent given the population's estimated standard deviation.~~

~~Specifically, this formula is:~~

~~$N = (Z^2 * S^2)/R^2$, where~~

~~• The Z statistic for 90 percent confidence is 1.64~~

~~• S = the standard deviation for the AP-DRG classification, and~~

~~• R = acceptable error range, per sampling unit~~

~~If the actual number of claims within an AP-DRG classification is less than the calculated N size for that classification during relative weight recalibration, the department designates that DRG classification as unstable for purposes of calculating relative weights. And as previously stated, for relative weight recalibration, the department also designates any DRG classification having less than ten claims in total in the claims sample used to recalibrate the relative weights, as low volume and unstable.~~

~~The DRG classifications assigned to the per diem payment method, that are in one of the major service categories in subsection (16)(a) through (d) of this section, qualify for examination if a high outlier payment is appropriate. The department specifies those DRG classifications to be paid the per diem payment method because the DRG classification has low volume and/or unstable claims data for determination of an AP-DRG relative weight. A claim in a DRG classification that falls into one of the following major services categories that the department designates for per diem payment, may receive a per diem high outlier payment when the claim meets the high outlier criteria as described in subsection (15) of this section:~~

~~(a) Neonatal claims, based on assignment to medical diagnostic category (MDC) 15;~~

~~(b) Burn claims based on assignment to MDC 22;~~

~~(c) AP-DRG groups that include primarily medical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection; and~~

~~(d) AP-DRG groups that include primarily surgical procedures, excluding any neonatal or burn per diem classifications identified in (a) and (b) of this subsection.~~

~~(17) For dates of admission on and after August 1, 2007, the high outlier claim payment processes for the general assistance-unemployable (GA-U) program are the same as those for the medicaid or SCHIP DRG paid and per diem paid claims, except that the DRG rates and per diem rates are reduced, and the percent of outlier adjustment factor applied to the payment may be reduced. The high outlier claim payment process for medicaid or SCHIP DRG paid and per diem paid claims is as follows:~~

~~(a) The department determines the claim estimated cost amount that is used in the determination of the high outlier claim qualification and the high outlier threshold for the calculation of outlier adjustment amount. The claim estimated cost is equal to the total submitted charges, minus the noncovered charges reported on the claim, multiplied by the hospital's inpatient ratio of costs-to-charges (RCC) related to the admission.~~

~~(b) The high outlier threshold when calculating the high outlier adjustment portion of the total payment allowed amount on the claim is:~~

~~(i) For DRG paid claims grouped to nonneonatal or nonpediatric DRG classifications, and for DRG paid claims that are not from Children's Hospital Regional Medical Center or~~

Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base DRG payment allowed amount;

(ii) For DRG paid claims grouped to neonatal or pediatric DRG classifications, and for DRG paid claims that are from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base DRG payment allowed amount;

(iii) For nonspecialty service category per diem paid claims grouped to nonneonatal and nonpediatric DRG classifications, and for nonspecialty service category per diem paid claims that are not from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred seventy-five percent of the base per diem payment allowed amount; and

(iv) For nonspecialty service category per diem paid claims grouped to neonatal and pediatric DRG classifications, and for all nonspecialty service category per diem paid claims from Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center, the high outlier threshold is one hundred fifty percent of the base per diem payment allowed amount;

(c) The high outlier payment allowed amount is equal to the difference between the department's estimated cost of services associated with the claim, and the high outlier threshold for payment indicated in (b)(i) through (iv) of this subsection, respectively, the resulting amount being multiplied by a percent of outlier adjustment factor. The percent of outlier adjustment factor is:

(i) Ninety-five percent for outlier claims that fall into one of the neonatal or pediatric AP-DRG classifications. Hospitals paid with the payment method used for out-of-state hospitals are paid using the percent of outlier adjustment factor identified in (c)(iii) of this subsection. All high outlier claims at Children's Hospital Regional Medical Center and Mary Bridge Children's Hospital and Health Center receive a ninety-five percent of outlier adjustment factor, regardless of AP-DRG classification assignment;

(ii) Ninety percent for outlier claims that fall into burn-related AP-DRG classifications;

(iii) Eighty-five percent for all other AP-DRG classifications; and

(iv) Used as indicated in WAC 388-550-4800 to calculate payment for state-administered programs' claims that are eligible for a high outlier payment.

(d) The high outlier payment allowed amount is added to the calculated allowed amount for the base DRG or base per diem payment, respectively, to determine the total payment allowed amount for the claim.

DRG high outlier

Three examples for medicaid or SCHIP DRG high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data.

Total Submitted Charges Minus Noncovered Charges	Base DRG Payment Allowed Amount[1]	175% of Base DRG Payment Allowed Amount	Department Determined Estimated Costs Are Greater Than $50,000?[2]	Department Determined Estimated Costs Are Greater Than 175% of Base DRG Payment Allowed Amount?	Total DRG High Outlier Claim Payment Allowed Amount[3,4]	Hospital's Individual RCC Rate
$95,600	$28,837	$50,465	Yes	Yes	$38,761	65%
$64,500	$28,837	$50,465	No	Yes	$28,837	65%
$77,000	$28,837	$50,465	Yes	No	$28,837	65%

All examples represent a claim that is a nonpsychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

[1]DRG conversion factor times DRG relative weight = Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$95,600 x 65% = $62,140 = Department determined estimated costs

[3]If department determined estimated costs are greater than the outlier qualifying criteria (in this example $50,000), then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.

$62,140 - $50,465 = $11,675 x 85% = $9,924 = High outlier portion allowed amount

[4]Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment amount

$28,837 + $9,924 = $38,761

Example two: The claim does not meet high cost outlier criteria due to department determined estimated cost being less than $50,000. Example dollar amounts are approximated and not based on real claims data:

[1]DRG conversion factor times DRG relative weight = Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$64,500 x 65% = $41,925 = Department determined estimated costs

[3]If department-determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.

($41,925 - $50,465 = ($8,540)) x 85% = ($7,259), which is converted to $0. Also, $41,925 is not greater than $50,000, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.

[4]Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$28,837 + $0 = $28,837

Example three: The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data:

[1]DRG conversion factor times DRG relative weight = Base DRG allowed amount

$6,300 x 4.5773 = $28,837 = Base DRG allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$77,000 x 65% = $50,050 = Department determined estimated costs

[3]If department-determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = high outlier portion allowed amount, if greater than $0, otherwise $0.

($50,050 - $50,465 = ($415)) x 85% = ($353), which is converted to $0. Also, $50,050 is greater than $50,000, but not greater than $50,465, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.

[4]Base DRG payment allowed amount plus high outlier portion allowed amount = Total DRG high outlier claim payment allowed amount

$28,837 + $0 = $28,837

Per Diem High Outlier

Three examples for medicaid and SCHIP per diem high outlier claim qualification and payment calculation (admission dates are on or after August 1, 2007). Example dollar amounts are approximated and not based on real claims data.

Total Submitted Charges Less Total Noncovered Charges	Base Per Diem Payment Allowed Amount[1]	175% of Base Per Diem Payment Allowed Amount	Department Determined Estimated Costs Are Greater Than $50,000?[2]	Department Determined Estimated Costs Are Greater Than 175% of Base Per Diem Payment Allowed Amount?	Total Per Diem High Outlier Claim's Payment Allowed Amount[3,4]	Hospital's Individual RCC Rate
$100,000	$25,000	$43,750	Yes	Yes	$47,313	70%
$64,000	$25,000	$43,750	No	Yes	$25,000	70%
$75,000	$35,000	$61,250	Yes	No	$35,000	70%

All examples represent a claim that is a nonpsychiatric claim and a claim that isn't from Children's Hospital Regional Medical Center or Mary Bridge Children's Hospital and Health Center.

Example one: The claim meets high cost outlier criteria. Example dollar amounts are approximated and not based on real claims data:

[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$1,000 (rate) x 25 (days) = $25,000 = Base per diem allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$100,000 x 70% = $70,000 = Department determined estimated costs

[3]If department-determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.

($70,000 - $43,750 = $26,250) x 85% = $22,313 = High outlier portion allowed amount

[4]Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount

$25,000 + $22,313 = $47,313

Example two: The claim does not meet high cost outlier criteria due to department-determined estimated cost being less than $50,000. Example dollar amounts are approximated and not based on real claims data:

[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount

$1,000 x 25 = $25,000 = Base per diem allowed amount

[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs

$64,500 x 70% = $45,150 = Department determined estimated costs

[3]If department-determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base per diem payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection

~~(17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.~~

~~($45,150 - $43,750 = $1,400), but $45,150 is not greater than $50,000, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.~~

~~[4]Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount~~

~~$25,000 + $0 = $25,000~~

~~**Example three:** (The claim does not meet high outlier criteria due to high DRG allowed amount. Example dollar amounts are approximated and not based on real claims data):~~

~~[1]Per diem rate times client's department recognized length of stay for eligible days = Base per diem allowed amount~~

~~$1,000 x 35 = $35,000 = Base per diem allowed amount~~

~~[2]Total submitted charges minus total noncovered charges times RCC rate = Department determined estimated costs~~

~~$75,000 x 70% = $52,500 = Department determined estimated costs~~

~~[3]If department determined estimated costs are greater than the outlier qualifying criteria, then (department determined estimated costs minus 175% of base DRG payment allowed amount (high outlier payment threshold)) times claim's percent of outlier adjustment factor (see subsection (17)(c)(i), (ii) and (iii)) = High outlier portion allowed amount, if greater than $0, otherwise $0.~~

~~($52,500 - $61,250 = (8,750)) x 85% = ($7,438), which is converted to $0. Also, $52,500 is greater than $50,000, but not greater than $61,250, so the claim does not meet the high outlier qualifying criteria. Therefore, the high outlier portion allowed amount is $0.~~

~~[4]Base per diem payment allowed amount plus high outlier portion allowed amount = Total per diem high outlier claim payment allowed amount~~

~~$35,000 + $0 = $35,000~~

~~(18)~~)) is the DRG allowed amount for the claim before the transfer payment reduction.

(2) The agency calculates the high outlier payment by multiplying the hospital's estimated cost above threshold (CAT) by the outlier adjustment factor. The outlier adjustment factors, which vary by dates of admission and inpatient payment policy, are depicted in the table at the end of this subsection.

(a) For inpatient claims paid under the all-patient-diagnosis-related group (AP-DRG), the agency uses a separate outlier adjustment factor for:

(i) Pediatric services, including all claims submitted by children-specialty hospitals;

(ii) Burn services; and

(iii) Nonpediatric services.

(b) For inpatient claims paid under the all-patient refined-DRG (APR-DRG), the agency uses a separate outlier adjustment factor for a:

(i) Severity of illness (SOI) of one or two; or

(ii) SOI of three or four.

AP-DRG Dates of Admission	Pediatric	Burn	Nonpediatric
Before August 1, 2012	CAT * 0.95	CAT * 0.90	CAT * 0.85
August 1, 2012 - June 30, 2013	CAT * 0.998	CAT * 0.945	CAT * 0.893
July 1, 2013 - June 30, 2014	CAT * 0.912	CAT * 0.864	CAT * 0.816
APR-DRG Dates of Admission	**SOI 1 or 2**	**SOI 3 or 4**	
July 1, 2014, and after	CAT * 0.80	CAT * 0.95	

(3) For state-administered programs (SAP), the agency applies the hospital-specific ratable to the outlier adjustment factor.

(4) This subsection contains examples of outlier claim payment calculations.

DRG SOI	DRG Allowed Amount	Threshold[1]	Cost[2]	Outlier Percent	Ratable	Base DRG	Outlier[3]	Claim Payment[4]
1	$10,000	$50,000	$100,000	0.80	n/a	$10,000	$40,000	$50,000
3	$10,000	$50,000	$100,000	0.95	n/a	$10,000	$47,500	$57,500

[1] Threshold = $40,000 + base DRG

[2] Cost = Billed charges - noncovered charges - denied charges

[3] Outlier = (cost - threshold) * outlier percent

[4] Claim payment = base DRG + outlier

(5) When directed by the legislature to achieve targeted expenditure levels, as described in WAC ((~~388-550-2800(2)~~)) 182-550-3000(8), the ((~~department~~)) agency may apply an inpatient adjustment factor to any of the high outlier thresholds and to any of the ((~~percentages of~~)) outlier adjustment factors described in this section.

(((~~19~~))) (6) The ((~~department~~)) agency applies the following to the payment for each claim((~~, all~~)):

(a) All applicable adjustments for client responsibility((~~, any~~));

(b) Any third-party liability((~~, medicare,~~));

(c) Medicare payments; and ((~~any~~))

(d) Any other adjustments as determined by the ((~~department~~)) agency.

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

WAC 182-550-4500 Payment method—Ratio of costs-to-charges (RCC). (1) The medicaid agency pays hospitals using the ratio of costs-to-charges (RCC) ((~~is defined in WAC 388-550-1050. The department uses:~~

~~(a) The RCC payment method to pay hospitals for hospital services that are exempt from the diagnosis related group (DRG), per diem, ambulatory~~)) payment method for services exempt from the following payment methods:

(a) Ambulatory payment classification (APC)((~~, maximum allowable fee schedule, and per case payment methods.~~

~~(b) The term "ratio of costs-to-charges" to refer to the factor (rate) applied to a hospital's allowed covered charges to determine estimated costs for medically necessary services~~));

(b) Diagnosis-related group (DRG);

(c) Enhanced ambulatory patient group (EAPG);

(d) Per case;

(e) Per diem; and

(f) Maximum allowable fee schedule.

(2) The ((~~department~~)) agency:

(a) Determines the payment ((~~due a hospital under the RCC payment method~~)) for:

(i) Inpatient claims by multiplying the hospital's inpatient RCC ((~~rate~~)) by the allowed covered charges for medically necessary services((~~.~~)); and

(ii) Outpatient claims by multiplying the hospital's outpatient RCC ((~~rate~~)) by the allowed covered charges for medically necessary services.

(b) Deducts from the amount derived in (a) of this subsection ((~~any~~)):

(i) All applicable adjustments for client responsibility ((~~amount~~));

(ii) Any third-party liability ((~~(TPL) amount~~));

(iii) Medicare payments; and

((~~(iii) Other applicable payment program adjustment~~)) (iv) Any other adjustments as determined by the agency.

(c) Limits the RCC payment to the hospital's ((~~allowable~~)) usual and customary charges for services allowed by the agency.

(3) ((~~For inpatient hospital dates of admission before August 1, 2007, the department uses the RCC payment method to pay for inpatient hospital services that are:~~

~~(a) Provided in a hospital located in the state of Washington (see WAC 388-550-4000 for out-of-state hospital payment methods and WAC 388-550-3900 for payment methods to designated bordering city and critical border hospitals);~~

~~(b) Provided in a diagnosis related group (DRG)-exempt hospital identified in WAC 388-550-4300; and~~

~~(c) Identified in WAC 388-550-4400 as DRG-exempt services (see WAC 388-550-4400 (2)(g), (h), and (k) for exceptions).~~

~~(4) For inpatient hospital dates of admission on and after August 1, 2007, the department~~)) The agency uses the RCC payment method to ((~~pay for~~)) calculate the following:

(a) Payment for the following services:

(i) Organ transplant services ((~~identified in~~)) (See WAC ((~~388-550-4400~~)) 182-550-4400 (4)(h));

((~~(b) High outlier qualifying claims (see WAC 388-550-3700 (14) and (15));~~

~~(c)~~)) (ii) Hospital services provided at a long-term acute care (LTAC) facility not covered under the LTAC per diem rate (see WAC ((~~388-550-2596~~)) 182-550-2596); and

((~~(d)~~)) (iii) Any other hospital service identified by the agency as being paid by the RCC payment method; and

(b) Costs for the following:

(i) High outlier qualifying claims (see WAC 182-550-3700); and

(ii) Hospital services provided in hospitals eligible for certified public expenditure (CPE) payments ((~~(see WAC 388-550-4650(5)); and~~

~~(e) Any other hospital service identified and published by the department as being paid by the RCC payment method.~~

~~(5)~~)) under WAC 182-550-4650(5).

(4) When directed by the legislature to achieve targeted expenditure levels, as described in WAC ((~~388-550-2800(2)~~)) 182-550-3000(8), the ((~~department~~)) agency may apply an inpatient adjustment factor to the inpatient RCC payments made for the services in subsection ((~~(4)~~)) (3) of this section((~~, except as provided in subsection (6) of this section~~)).

((~~(6) For hospitals paid under the certified public expenditure (CPE) payment method, the inpatient adjustment factor referred to in subsection (5) of this section does not apply, except to payments for repriced claims adjusted according to WAC 388-550-4670 (2)(a)(ii).~~

~~(7) The department~~)) (5) This section explains how the agency calculates each in-state and critical border hospital's RCC ((~~rate as follows~~)). For noncritical border city hospitals, see WAC 182-550-3900. The ((~~department~~)) agency:

(a) Divides ((~~each hospital's allowable costs by patient-related revenues associated with these allowable costs~~)) adjusted costs by adjusted patient charges. The ((~~department~~)) agency determines the allowable costs and associated ((~~revenues~~)) charges.

(b) Excludes((~~, prior to calculating the RCC rate, department~~)) agency nonallowed costs and nonallowed ((~~revenue~~)) charges, such as costs and ((~~revenues~~)) charges attributable to a change in ownership.

(c) Bases the RCC ((~~rate~~)) calculation on data from the hospital's ((~~"as filed"~~)) annual medicare cost report (Form ((~~2552-96~~)) 2552) and applicable patient revenue reconciliation data provided by the hospital. The ((~~"as filed"~~)) medicare cost report must cover a period of twelve consecutive months in its medicare cost report year.

(d) Updates a hospital's inpatient RCC ((~~rate~~)) annually after the hospital sends its ((~~"as filed"~~)) hospital fiscal year medicare cost report to the centers for medicare and medicaid services (CMS) and the ((~~department~~)) agency. ((~~In the case where~~)) If medicare grants a delay in submission of the CMS medicare cost report to the medicare fiscal intermediary ((~~is granted by medicare~~)), the ((~~department~~)) agency may determine an alternate method to adjust the RCC ((~~rate based on a department-determined method~~)).

(e) Limits a noncritical access hospital's RCC ((~~payment~~)) to one ((~~hundred percent of its allowed covered charges~~)) point zero (1.0).

(((~~(f) Determines an RCC rate, when~~)) (6) For a hospital ((~~is~~)) formed as a result of a merger (((~~refer to~~)) see WAC ((~~388-550-4200~~)) 182-550-4200), ((~~by combining~~)) the agency combines the previous hospital's medicare cost reports and ((~~following~~)) follows the process in (((~~(a)~~))) subsection (5) of this ((~~subsection~~)) section. The ((~~department~~)) agency does not use partial year cost reports for this purpose.

(((~~(g) Determines a new instate hospital's RCC rate by calculating and using the average RCC rate for all current noncritical access hospitals located in Washington state. The department~~)) (7) For newly constructed hospitals and hospitals not otherwise addressed in this chapter, the agency annually calculates a weighted average in-state RCC ((~~rate~~)) by ((~~identifying all instate hospitals with specific RCC rates and~~)) dividing the ((~~department-determined total patient-related revenues associated with those~~)) sum of agency-determined costs for all in-state hospitals with RCCs by the sum of agency-determined charges for all hospitals with RCCs.

(8) The ((~~department~~)) agency calculates each hospital's outpatient RCC ((~~rate~~)) annually. The agency calculates:

(a) ((~~The department calculates~~)) A hospital's outpatient RCC ((~~rate~~)) by multiplying the hospital's inpatient RCC ((~~rate~~)) by the outpatient adjustment factor (OAF)((~~.~~)); and

(b) The ((~~department determines the~~)) weighted average in-state hospital outpatient RCC ((~~rate~~)) by multiplying the in-state weighted average inpatient RCC ((~~rate~~)) by the ((~~outpatient adjustment factor~~)) OAF.

(9) The ((~~outpatient adjustment factor~~)) OAF:

(a) Is the ratio between the outpatient and inpatient RCC payments((~~, established in 1998 through negotiation with hospital providers~~));

(b) Is updated annually to adjust for cost and charge inflation; and

(c) Must not exceed ((~~1.0; and~~

~~(d) Is differentiated from the OPPS outpatient adjustment factor (defined in WAC 388-550-1050), and applies to hospitals exempt from OPPS~~)) one point zero (1.0).

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-550-3300	Hospital peer groups and cost caps.
WAC 182-550-3350	Outlier costs.
WAC 182-550-3500	Hospital annual inflation adjustment determinations.
WAC 182-550-4600	Hospital selective contracting program.

WSR 14-12-049
PERMANENT RULES
DEPARTMENT OF HEALTH

[Filed May 30, 2014, 7:07 a.m., effective July 1, 2014]

Effective Date of Rule: July 1, 2014.

Purpose: WAC 246-358-990 and 246-361-990, adopting reduced licensing fees for the temporary worker housing (TWH) program. The amended rules include a new fee structure and are comprised of a $50 administrative fee charged to all licensed TWH operators, plus a $4 per occupant fee for the maximum number of migrant farm workers living in the TWH during the operating season.

Citation of Existing Rules Affected by this Order: Amending WAC 246-358-990 and 246-361-990.

Statutory Authority for Adoption: RCW 43.70.340.

Other Authority: Chapter 70.114A RCW; section 219(32), chapter 7, Laws of 2012 2nd sp. sess.

Adopted under notice filed as WSR 14-07-068 on March 17, 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 2, Repealed 0.

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

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

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

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

Date Adopted: May 23, 2014.

John Wiesman, DrPH, MPH
Secretary

AMENDATORY SECTION (Amending WSR 11-13-124, filed 6/22/11, effective 7/23/11)

WAC 246-358-990 Fees. (1) **((~~License~~)) Licensing fee.** ((~~The license fee covers initial licenses and renewals, and includes on-site surveys. An operator must submit to the department an annual license fee for~~)) An operator shall submit to the department of health a licensing fee according to Table 1 of this section prior to the department of health issuing a temporary worker housing (TWH) operating license. Except as provided in subsection (2) of this section, the licensing fee consists of two portions:

(a) An administrative portion according to Table 1 of this section; and

(b) A facility portion, based on the maximum occupancy of the TWH, according to Table 1 of this section. For purposes of ((~~licensing~~)) this section, maximum occupancy is the ((~~total~~)) greatest number of occupants that ((~~the amount of space and fixtures of the temporary worker housing (TWH) can support~~)) reside in the TWH during the calendar year.

(2) ((**~~Technical assistance fee.~~** ~~An operator may be charged for each technical assistance visit conducted by the department when requested or approved by the operator or their designee. This fee will be charged according to WAC 246-359-990 Table 1, Part G.~~)) **Minimum licensing fee.** The minimum licensing fee is ninety dollars.

(3) **Late fees.** The department of health may charge a late fee ((~~may be charged~~)) according to Table 1 of this section in addition to the licensing fee when:

(a) ((~~The initial~~)) For a new license, the application and licensing fee((~~, as required by WAC 246-358-025(2),~~)) are not received by the department of health at least forty-five days prior to the new TWH opening operation date;

(b) ((~~The renewal~~)) For a previously licensed TWH, the application and licensing fee((~~, as required by WAC 246-358-025(2),~~)) are not received by the department of health by February twenty-eighth of the year the operator intends to operate the TWH ((~~renewal due date~~)).

(4) ((~~**TWH civil fine.** An operator may be assessed a civil fine for failure or refusal to obtain a license prior to occupancy of TWH. Civil fines for TWH are provided for in RCW 43.70.335.~~

~~(5)~~)) **Refunds.**

(a) The department of health will refund fees paid by the operator if:

(i) The operator submits a written request to the department of health for a refund; and

(ii) The operator provides documentation to the department of health that the ((~~housing~~)) TWH was not occupied during the license period.

(b) The department of health will refund two-thirds of the licensing fees paid, less a fifty dollar processing fee, if an application has been received but no preoccupancy ((~~survey~~)) inspection has been performed by the department of health.

(c) The department of health will refund one-third of the licensing fees paid, less a fifty dollar processing fee, if an application has been received and a preoccupancy ((~~survey~~)) inspection has been performed by the department of health.

(d) The department of health will not refund applicant licensing fees under the following conditions:

(i) The department of health has performed more than one on-site ((~~survey~~)) inspection for any purpose; or

(ii) One year has elapsed since a license application was received by the department of health, but no license was issued because the applicant failed to complete requirements for licensure.

(5) **Technical assistance fee.** The department of health may charge an operator for each technical assistance visit conducted by the department of health when requested or approved by the operator or their designee. This fee will be charged according to WAC 246-359-990, Table 1.

(6) **TWH civil fine.** The department of health may assess an operator a civil fine according to RCW 43.70.335.

Table 1

Fees, Regular Temporary Worker Housing

((~~**Fee Type**~~	~~**Fee**~~
~~License fee~~	~~$9 per occupant, at maximum occupancy ($90 minimum fee)~~
~~Late fee~~	~~$100~~))

Fee Type	**Administrative Portion**	**Facility Portion**
Licensing	$50	$4 per occupant, at maximum occupancy
	($90 minimum total fee)	
Late	$100 (Late fees are in addition to licensing fees)	

AMENDATORY SECTION (Amending WSR 11-13-124, filed 6/22/11, effective 7/23/11)

WAC 246-361-990 Fees for cherry harvest camps. (1) **((~~License~~)) Licensing fee.** ((~~The license fee covers initial licenses and renewals, and includes on-site surveys. An operator must submit to the department an annual license fee for~~)) An operator shall submit to the department of health a licensing fee according to Table 1 of this section prior to the department of health issuing a temporary worker housing (TWH) operating license. Except as provided in subsection (2) of this section, the licensing fee consists of two portions:

(a) An administrative portion according to Table 1 of this section; and

(b) A facility portion, based on the maximum occupancy of the TWH, according to Table 1 of this section. For purposes of ((~~licensing~~)) this section, maximum occupancy is the ((~~total~~)) greatest number of occupants that ((~~the amount of space and fixtures of the temporary worker housing (TWH) can support~~)) reside in the TWH during the calendar year.

(2) ((~~**Technical assistance fee.** An operator may be charged for each technical assistance visit conducted by the department when requested or approved by the operator or their designee. This fee will be charged according to WAC 246-359-990 Table 1, Part G.~~)) **Minimum licensing fee.** The minimum licensing fee is ninety dollars.

(3) **Late fees.** The department of health may charge a late fee ((~~may be charged~~)) according to Table 1 of this section in addition to the licensing fee when:

(a) For a new license, the initial application and licensing fee((~~, as required by WAC 246-361-025(2),~~)) are not received by the department of health at least forty-five days prior to the new TWH opening operation date;

(b) ((~~The renewal~~)) For a previously licensed TWH, the application and licensing fee((~~, as required by WAC 246-361-025(2),~~)) are not received by the department ((~~by the TWH renewal due date~~)) of health by February twenty-eighth of the year the operator intends to operate the TWH.

(4) ((~~**TWH civil fine.** An operator may be assessed a civil fine for failure or refusal to obtain a license prior to occupancy of TWH. Civil fines for TWH are provided for in RCW 43.70.335.~~

~~(5)~~)) **Refunds.**

(a) The department of health will refund fees paid by the operator if:

(i) The operator submits a written request to the department of health for a refund; and

(ii) The operator provides documentation to the department of health that the ((~~housing~~)) TWH was not occupied during the license period.

(b) The department of health will refund two-thirds of the licensing fees paid, less a fifty dollar processing fee, if an application has been received but no preoccupancy ((~~survey~~)) inspection has been performed by the department of health.

(c) The department of health will refund one-third of the licensing fees paid, less a fifty dollar processing fee, if an application has been received and a preoccupancy ((~~survey~~)) inspection has been performed by the department of health.

(d) The department of health will not refund applicant licensing fees under the following conditions:

(i) The department of health has performed more than one on-site ((~~survey~~)) inspection for any purpose; or

(ii) One year has elapsed since a license application was received by the department of health, but no license was issued because the applicant failed to complete requirements for licensure.

(5) **Technical assistance fee.** The department of health may charge an operator for each technical assistance visit conducted by the department of health when requested or approved by the operator or their designee. This fee will be charged according to WAC 246-359-990, Table 1.

(6) **TWH civil fine.** The department of health may assess an operator a civil fine according to RCW 43.70.335.

Table 1
Fees, Cherry Harvest Camps

((~~Fee Type~~	~~Fee~~
~~License fee~~	~~$9 per occupant, at maximum occupancy ($90 minimum fee)~~
~~Late fee~~	~~$100~~))

Fee Type	Administrative Portion	Facility Portion
Licensing	$50	$4 per occupant, at maximum occupancy
	($90 minimum total fee)	
Late	$100 (Late fees are in addition to licensing fees)	

WSR 14-12-050
PERMANENT RULES
DEPARTMENT OF EARLY LEARNING

[Filed May 30, 2014, 8:52 a.m., effective June 30, 2014]

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

Purpose: To define the terms "preschool age child" and "school-age child" consistent with concurrent updates to chapters 170-295 and 170-296A WAC revising the definition of "preschool age child."

Citation of Existing Rules Affected by this Order: Repealing WAC 170-290-0185; and amending WAC 170-290-0003, 170-290-0200, 170-290-0205, 170-290-0225, and 170-290-0230.

Statutory Authority for Adoption: RCW 43.215.060 and 43.215.070; chapter 43.215 RCW.

Adopted under notice filed as WSR 14-09-034 on April 10, 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 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 0, Amended 6, Repealed 0.

Date Adopted: May 30, 2014.

Elizabeth M. Hyde
Director

AMENDATORY SECTION (Amending WSR 12-11-025, filed 5/8/12, effective 6/8/12)

WAC 170-290-0003 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

"Able" means being physically and mentally capable of caring for a child in a responsible manner.

"Authorization" means the documentation that DSHS gives to providers specifying units of full-day, half-day or hourly child care a family may receive during their eligibility period, which may be adjusted based on the family's need for care or changes in eligibility.

"Available" means being free to provide care when not participating in an approved work activity under WAC 170-290-0040, 170-290-0045, 170-290-0050, or 170-290-0055 during the time child care is needed.

"Calendar year" means those dates between and including January 1st and December 31st.

"Collective bargaining agreement" or **"CBA"** means the most recent agreement that has been negotiated and entered into between the exclusive bargaining representative for all licensed and license-exempt family child care providers as defined in chapter 41.56 RCW.

"Consumer" means the person receiving:

(a) WCCC benefits as described in part II of this chapter; or

(b) SCC benefits as described in part III of this chapter.

"Copayment" means the amount of money the consumer is responsible to pay the child care provider toward the cost of child care each month.

"Days" means calendar days unless otherwise specified.

"DEL" means the department of early learning.

"DSHS" means the department of social and health services.

"Eligibility" means that a consumer has met all of the requirements of:

(a) Part II of this chapter to receive WCCC program subsidies; or

(b) Part III of this chapter to receive SCC program subsidies.

"Employment" or **"work"** means engaging in any legal, income generating activity that is taxable under the United States Tax Code or that would be taxable with or without a treaty between an Indian Nation and the United States. This includes unsubsidized employment, as verified by an employee's pay stubs or DSHS employer verification form, and subsidized employment, such as:

(a) Working in a federal or state paid work study program; or

(b) VISTA volunteers, AmeriCorps, JobCorps, and Washington Service Corps (WSC) if the income is taxed.

"In-home/relative provider" or **"license-exempt provider,"** referred to in the collective bargaining agreement as **"family, friends and neighbors provider"** or **"FFN provider,"** means a provider who meets the requirements in WAC 170-290-0130 through 170-290-0167.

"In loco parentis" means the adult caring for an eligible child in the absence of the biological, adoptive, or step-parents, and who is not a relative, court-ordered guardian, or custodian, and is responsible for exercising day-to-day care and control of the child.

"Night shift" means employment for a minimum of six hours between the hours of 8 p.m. and 8 a.m.

"Preschool age child" means a child age thirty months through six years of age who is not attending kindergarten or elementary school.

"SCC" means the seasonal child care program, which is a child care subsidy program described in part III of this chapter that assists eligible families who are seasonally employed in agriculturally related work outside of the consumer's home to pay for licensed or certified child care.

"School age child" means a child not less than five years of age through twelve years of age who is attending kindergarten or elementary school.

"Seasonally available labor" or **"seasonally available agricultural related work"** means work that is available only in a specific season during part of the calendar year. The work is directly related to the cultivation, production, harvesting or processing of fruit trees or crops.

"Self-employment" means engaging in any legal income generating activity that is taxable under the United States Tax Code or that would be taxable with or without a treaty between an Indian Nation and the United States, as verified by Washington state business license, or a tribal, county, or city business or occupation license, as applicable, and a uniform business identification (UBI) number for approved self-employment activities that occur outside of the home. Incorporated businesses are not considered self-employment enterprises.

"Waiting list" means a list of families who are currently working and waiting for child care subsidies when funding is not available to meet the requests from all eligible families.

"WCCC" means the working connections child care program, which is a child care subsidy program described in part II of this chapter that assists eligible families in obtaining child care subsidies for approvable activities that enable them to work, attend training, or enroll in educational programs outside the consumer's home.

AMENDATORY SECTION (Amending WSR 13-21-113, filed 10/22/13, effective 11/22/13)

WAC 170-290-0200 Daily child care rates—Licensed or certified child care centers and DEL contracted seasonal day camps. (1) **Base rate.** DSHS pays the lesser of the following to a licensed or certified child care center or DEL contracted seasonal day camp:

(a) The provider's private pay rate for that child; or

(b) The maximum child care subsidy daily rate for that child as listed in the following table:

		Infants (One month - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - ((~~5 yrs~~)) 6 yrs not attending kindergarten or school)	School-age (5 - 12 yrs attending kindergarten or school)
Region 1	Full-Day	$29.10	$24.47	$23.12	$21.77
	Half-Day	$14.57	$12.24	$11.57	$10.88
Spokane County	Full-Day	$29.76	$25.03	$23.65	$22.27
	Half-Day	$14.90	$12.53	$11.84	$11.13
Region 2	Full-Day	$29.39	$24.53	$22.75	$20.12
	Half-Day	$14.70	$12.27	$11.37	$10.08
Region 3	Full-Day	$38.89	$32.43	$28.01	$27.20
	Half-Day	$19.45	$16.21	$14.00	$13.61
Region 4	Full-Day	$45.27	$37.80	$31.71	$28.56
	Half-Day	$23.08	$18.91	$15.86	$14.28
Region 5	Full-Day	$33.19	$28.56	$25.14	$22.32
	Half-Day	$16.59	$14.28	$12.57	$11.17

		Infants (One month - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - ((~~5 yrs~~)) 6 yrs not attending kindergarten or school)	School-age (5 - 12 yrs attending kindergarten or school)
Region 6	Full-Day	$32.63	$28.01	$24.47	$23.93
	Half-Day	$16.33	$14.00	$12.24	$11.97

(i) Centers in Clark County are paid Region 3 rates.

(ii) Centers in Benton, Walla Walla, and Whitman counties are paid Region 6 rates.

(2) The child care center WAC 170-295-0010 allows providers to care for children from one month up to and including the day before their thirteenth birthday. The provider must obtain a child-specific and time-limited exception from their child care licensor to provide care for a child outside the age listed on the center's license. If the provider has an exception to care for a child who has reached his or her thirteenth birthday, the payment rate is the same as subsection (1) of this section, and the five through twelve year age range column is used for comparison.

(3) If the center provider cares for a child who is thirteen or older, the provider must have a child-specific and time-limited exception and the child must meet the special needs requirement according to WAC 170-290-0220.

AMENDATORY SECTION (Amending WSR 13-21-113, filed 10/22/13, effective 11/22/13)

WAC 170-290-0205 Daily child care rates—Licensed or certified family home child care providers. (1) **Base rate.** DSHS pays the lesser of the following to a licensed or certified family home child care provider:

(a) The provider's private pay rate for that child; or

(b) The maximum child care subsidy daily rate for that child as listed in the following table.

		Infants (Birth - 11 mos.)	Enhanced Toddlers (12 - 17 mos.)	Toddlers (18 - 29 mos.)	Preschool (30 mos. - ((~~5 yrs~~)) 6 yrs not attending kindergarten or school)	School-age (5 - 12 yrs attending kindergarten or school)
Region 1	Full-Day	$24.78	$24.78	$21.54	$21.54	$19.16
	Half-Day	$12.38	$12.38	$10.77	$10.77	$ 9.58
Spokane County	Full-Day	$25.34	$25.34	$22.03	$22.03	$19.59
	Half-Day	$12.67	$12.67	$11.02	$11.02	$ 9.79
Region 2	Full-Day	$26.16	$26.16	$22.75	$20.35	$20.35
	Half-Day	$13.08	$13.08	$11.37	$10.17	$10.17
Region 3	Full-Day	$34.71	$34.71	$29.92	$26.33	$23.93
	Half-Day	$17.36	$17.36	$14.96	$13.17	$11.97
Region 4	Full-Day	$40.84	$40.84	$35.51	$29.92	$28.72
	Half-Day	$20.43	$20.43	$17.77	$14.96	$14.36
Region 5	Full-Day	$27.53	$27.53	$23.93	$22.75	$20.35
	Half-Day	$13.77	$13.77	$11.97	$11.37	$10.17
Region 6	Full-Day	$27.53	$27.53	$23.93	$23.93	$22.75
	Half-Day	$13.77	$13.77	$11.97	$11.97	$11.37

(2) The family home child care WAC 170-296A-0010 and 170-296A-5550 allows providers to care for children from birth up to and including the day before their thirteenth birthday.

(3) If the family home provider cares for a child who is thirteen or older, the provider must have a child-specific and time-limited exception and the child must meet the special needs requirement according to WAC 170-290-0220.

(4) DSHS pays family home child care providers at the licensed home rate regardless of their relation to the children (with the exception listed in subsection (5) of this section). Refer to subsection (1) and the five through twelve year age range column for comparisons.

(5) DSHS cannot pay family home child care providers to provide care for children in their care if the provider is:

(a) The child's biological, adoptive or step-parent;

(b) The child's legal guardian or the guardian's spouse or live-in partner; or

(c) Another adult acting in loco parentis or that adult's spouse or live-in partner.

AMENDATORY SECTION (Amending WSR 14-03-060, filed 1/13/14, effective 2/13/14)

WAC 170-290-0225 Special needs rates—Licensed or certified child care centers and seasonal day camps. (1) In addition to the base rate for licensed or certified child care centers and seasonal day camps listed in WAC 170-290-0200, DSHS may authorize the following additional special

needs daily rates which are reasonable and verifiable as provided in WAC 170-290-0220:

(a) **Level 1.** The daily rate listed in the table below:

		Infants (One month - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - ((~~5 yrs~~)) 6 yrs not attending kindergarten or school)	School-age (5 - 12 yrs attending kindergarten or school)
Region 1	Full-Day	$7.30	$6.14	$5.80	$5.45
	Half-Day	$3.65	$3.07	$2.90	$2.73
Region 2	Full-Day	$7.36	$6.15	$5.70	$5.05
	Half-Day	$3.68	$3.08	$2.85	$2.52
Region 3	Full-Day	$9.75	$8.13	$7.02	$6.82
	Half-Day	$4.88	$4.06	$3.51	$3.41
Region 4	Full-Day	$11.35	$9.48	$7.95	$7.16
	Half-Day	$5.67	$4.74	$3.98	$3.58
Region 5	Full-Day	$8.32	$7.16	$6.30	$5.59
	Half-Day	$4.16	$3.58	$3.15	$2.80
Region 6	Full-Day	$8.18	$7.02	$6.14	$6.00
	Half-Day	$4.09	$3.51	$3.07	$3.00

(i) Centers in Clark County are paid Region 3 rates;

(ii) Centers in Benton, Walla Walla, and Whitman counties are paid Region 6 rates;

(b) **Level 2.** A rate greater than Level 1, not to exceed $15.89 per hour.

(2) If a provider is requesting one-on-one supervision or direct care for the child with special needs the person providing the one-on-one care must:

(a) Be at least eighteen years of age; and

(b) Meet the requirements for being an assistant under chapter 170-295 WAC and maintain daily records of one-on-one care provided, to include the name of the employee providing the care.

(3) If the provider has an exception to care for a child who:

(a) Is thirteen years or older; and

(b) Has special needs according to WAC 170-290-0220, DSHS authorizes the special needs payment rate as described in subsection (1) of this section using the five through twelve year age range for comparison.

AMENDATORY SECTION (Amending WSR 14-03-060, filed 1/13/14, effective 2/13/14)

WAC 170-290-0230 Special needs rates—Licensed or certified family home child care providers. (1) In addition to the base rate for licensed or certified family home child care providers listed in WAC 170-290-0205, DSHS may authorize the following additional special needs daily rates which are reasonable and verifiable as provided in WAC 170-290-0220:

(a) **Level 1.** The daily rate listed in the table below:

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - ((~~5 yrs~~)) 6 yrs not attending kindergarten or school)	School-age (5 - 12 yrs attending kindergarten or school)
Region 1	Full-Day	$6.00	$5.40	$5.40	$4.80
	Half-Day	$3.00	$2.70	$2.70	$2.40
Region 2	Full-Day	$6.00	$5.70	$5.10	$5.10
	Half-Day	$3.00	$2.85	$2.55	$2.55
Region 3	Full-Day	$8.70	$7.50	$6.60	$6.00
	Half-Day	$4.35	$3.75	$3.30	$3.00
Region 4	Full-Day	$9.00	$8.90	$7.50	$7.20
	Half-Day	$4.50	$4.45	$3.75	$3.60
Region 5	Full-Day	$6.60	$6.00	$5.70	$5.10
	Half-Day	$3.30	$3.00	$2.85	$2.55

		Infants (Birth - 11 mos.)	Toddlers (12 - 29 mos.)	Preschool (30 mos. - ((~~5 yrs~~)) 6 yrs not attending kindergarten or school)	School-age (5 - 12 yrs attending kindergarten or school)
Region 6	Full-Day	$6.60	$6.00	$6.00	$5.70
	Half-Day	$3.30	$3.00	$3.00	$2.85

(b) **Level 2.** A rate greater than Level 1, nto to exceed $15.89 per hour.

(2) If the provider has an exception to care for a child who:

(a) Is thirteen years or older; and

(b) Has special needs according to WAC 170-290-0220, DSHS authorizes the special needs payment rate as described in subsection (1) of this section using the five through twelve year age range for comparison.

(3) If a provider is requesting one-on-one supervision/direct care for the child with special needs, the person providing the one-on-one care must:

(a) Be at least eighteen years old; and

(b) Meet the requirements for being an assistant under chapter 170-296A WAC and maintain daily records of one-on-one care provided, to include the name of the employee providing the care.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 170-290-0185 WCCC subsidy rates—Five-year-old children.

WSR 14-12-051
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed May 30, 2014, 8:52 a.m., effective July 1, 2014]

Effective Date of Rule: July 1, 2014.

Purpose: The purpose of this rule proposal is to modify a formula in an existing rule that allowed a small number of retro participating employers to receive refunds or larger refunds inconsistent with the intent of the retrospective rating program, when their loss ratio (claim costs divided by standard premium) exceeds the maximum loss limit they had chosen.

This rule will amend WAC 296-17B-440 Net insurance charge. With this change, the department proposes removing the performance adjustment factor from the calculation of insurance charges for those retro participants whose insurance charges are based on standard premium paid.

Citation of Existing Rules Affected by this Order: Amending WAC 296-17B-440.

Statutory Authority for Adoption: RCW 51.18.010 (retrospective rating).

Other Authority: RCW 51.04.020(1) (general authority).

Adopted under notice filed as WSR 14-08-081 on April 1, 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 1, Repealed 0.

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

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

Date Adopted: May 30, 2014.

Joel Sacks
Director

AMENDATORY SECTION (Amending WSR 10-21-086, filed 10/19/10, effective 11/19/10)

WAC 296-17B-440 Net insurance charge. You will pay a net insurance charge for the protection provided by your single loss occurrence limit and your maximum loss ratio.

Your net insurance charge can be calculated as a percentage of either your standard premiums or your incurred loss and expense charge.

(1) If you choose to have your net insurance charge calculated using your standard premiums, your net insurance charge will be calculated using the following formula:

(Premium insurance charge factor - Premium insurance savings factor) x (Standard premiums)((~~x (Performance adjustment factor)~~))

Your premium insurance charge factor and premium insurance savings factor will depend on your maximum and minimum loss ratio choice, size group and hazard group, and can be found in WAC 296-17B-910 through 296-17B-990. If you choose a maximum and/or minimum loss ratio between the options found in one of the tables, the department will interpolate to obtain the charge and/or savings factors from the factors found in the tables.

(2) If you choose to have your net insurance charge calculated using your losses incurred, your net insurance charge will be calculated using the following formula:

(Loss insurance charge factor - Loss insurance savings factor) / [1.0 - (Loss insurance charge factor - Loss insurance savings factor)] x Incurred loss and expense charge

Your loss insurance charge factor and loss insurance savings factor will depend on your maximum and minimum loss ratio choice, size group and hazard group, and can be found in WAC 296-17B-910 through 296-17B-990. If you choose a maximum and/or minimum loss ratio between the options found in one of the tables, the department will interpolate to obtain the charge and/or savings factors from the factors found in the tables.

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

WSR 14-12-052
PERMANENT RULES
DEPARTMENT OF LABOR AND INDUSTRIES

[Filed May 30, 2014, 9:02 a.m., effective June 30, 2014]

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

Purpose: This agency classifies businesses according to their nature. The former rules stated that employers could have more than one basic risk classification if they qualified, but they must use different employees in each business. The adopted rule making allows employers to use the same employees in more than one basic risk classification as long as work records are kept and the rules allow. The rule making also removes the need to identify the governing class, and simplifies reporting by including all instructions for this situation in one rule.

Citation of Existing Rules Affected by this Order: Repealing WAC 296-17-310171; and amending WAC 296-17-31017.

Statutory Authority for Adoption: RCW 51.04.020 and 51.16.035.

Adopted under notice filed as WSR 14-03-111 on January 21, 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 1, Repealed 1.

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

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 30, 2014.

Joel Sacks
Director

AMENDATORY SECTION (Amending WSR 13-11-128, filed 5/21/13, effective 7/1/13)

WAC 296-17-31017 Multiple classifications. (1) **Can I have more than one basic classification assigned to my account?**

((~~Yes, we will assign other classifications to your business when the assignment of another basic classification is required or permitted by the description(s) of the employer's other classification(s).~~

~~Whenever you have more than one classification assigned to your account, you must keep detailed records of the actual time spent by each employee in each classification. An explanation of payroll records you must keep can be found under WAC 296-17-35201. Use of percentages, averages or estimates is not permitted. If you do not have original time card or time book entries to support your reporting, all worker hours in question will be assigned to the highest rated classification applicable to your business operations.~~

~~(2) **Are there other circumstances when I can have more than one basic classification assigned to my account?**~~

~~Yes, under certain circumstances we will assign more than one basic classification to your account. These circumstances include:~~

~~• The employer is operating a secondary business which includes operations that we do not consider a normal part of that employer's principal business in Washington, or~~

~~• The employer has multiple retail store locations.~~

~~In these instances we will assign additional basic classifications *only if all of the following conditions are met*:~~

~~• The employer maintains separate payroll records for each business,~~

~~• Different employees work in each business,~~

~~• Each business is separated by structural partitions if they share a common business location,~~

~~• Each business can exist independently of the other, and~~

~~• The classification language of the principal business does not prohibit the assignment of the secondary classification.~~

~~If all of the above *five* conditions are not met, then the operations of the secondary business will be reported in the highest rated classification that applies to the employer.~~

~~(3) **What do you mean by the term "principal business?"**~~

~~The principal business is represented by the basic classification assigned to an employer which produces the greatest amount of exposure. The principal business does not include standard exception or general exclusion classifications or operations.~~

~~(4) **If my business is assigned a basic classification and a standard exception classification and I have an employee who works in both classifications, can I divide their exposure (hours) between the two classifications on my quarterly report?**~~

~~No, you cannot divide an employee's exposure (*work hours*) between a basic classification and standard exception classification. An explanation of "standard exception classification" is discussed in *WAC 296-17-31018(2)*. If an employee performs work covered by a basic classification and a standard exception classification, all of their exposure~~

~~(*hours*) must be reported in the basic classification applicable to your business. You cannot report the exposure (*hours*) of any employee in a standard exception classification if they perform duties covered by a basic classification assigned to your business. Refer to WAC 296-17-31018 for a list and explanation of the "*exception classifications*."~~

~~(5) **I have more than one standard exception classification assigned to my business. One of my employees works in more than one of the standard exception classifications. Can I divide their exposure (hours) between two or more standard exception classifications on my quarterly report?**~~

~~No, you cannot divide an employee's work hours between two standard exception classifications. You must report all exposure (*work hours*) in the highest rated standard exception classification applicable to the work being performed.~~))

Yes, sometimes we will give you more than one basic classification because:

• The basic classification that describes your business specifies certain duties that must be reported separately.

• You have employees performing work described in the general exclusions, WAC 296-17-31018(4).

• You are a contractor with workers performing more than one phase of construction, as described in WAC 296-17-31013.

• You operate a farm that raises more than one type of crop or animal, as described in WAC 296-17-31014.

We also may assign more than one basic classification when a single classification does not describe all of your business operations because you have multiple enterprises.

A multiple enterprise is when you:

• Operate a secondary business with operations we do not normally consider related to your other business operations; or

• Have multiple retail stores.

When all four of the following conditions apply, we will add a basic classification(s) for a multiple enterprise:

• You maintain accurate payroll records that clearly distinguish the work performed for each business.

• Each business is physically separated and distinct.

• Each business can operate independently of any others. If one business closes, any others are able to continue on their own.

• The classifications are permitted to be assigned together by classification descriptions and general reporting rules.

If any of these conditions do not apply, we will assign your firm the classification(s) that identifies:

• Your principal business (this is the business that has the greatest number of hours); and

• Any secondary business operations that are higher rated than your principal business.

Note: Whenever you have more than one classification assigned to your account, you must keep accurate records of the hours (or alternative reporting units) worked by each employee in each classification. Using percentages, averages, or estimates is **not** permitted. If you do not have original time card or time book entries to support how you are reporting, all worker hours in question will be assigned to the highest rated classification to which the worker was exposed. An explanation of necessary payroll records can be found under WAC 296-17-35201.

(2) **My business is assigned a basic classification and a standard exception classification. I have an employee who works in both classifications. Can I divide this employee's hours (or alternative units) between the two classifications on my quarterly report?**

Normally you cannot report employees in a standard exception classification if they also perform duties covered by a basic classification. If any of their work is covered by a basic classification, then all of their hours (or alternative reporting units) must be reported in the basic classification.

The only time you are permitted to divide a worker's hours between a standard exception classification and a basic classification is when the basic classification is assigned to you because it is a general exclusion under WAC 296-17-31018(4).

(3) **Can I divide an employee's hours between two standard exception classifications on my quarterly report?**

No, you cannot divide employees' hours between two standard exception classifications. You must report all of their hours in the highest rated standard exception classification applicable to their work.

(4) **I have more than one basic classification assigned to my business and I have employees who work in more than one of these classifications. Can I divide their hours between these basic classifications on my quarterly report?**

Yes, you may divide an employee's hours between basic classifications when:

• The classification descriptions allow a division of hours; and

• You maintain records on each employee and the department can determine from those records the hours worked in each classification.

If the classification descriptions do not allow a division of hours, or if you do not maintain adequate records, you must report the workers' hours in the highest rated risk classification applicable to your business, unless your records show that a worker did not work in that classification.

For the following examples, suppose an employer has the classifications and rates shown below:

Risk Class	Description	Rates*
0507 05	Roofing work	$7.37/hour
0510 00	Wood frame building construction	$4.71/hour
0513 00	Interior finish carpentry	$2.01/hour

Example 1: If the employer does not keep records of which classifications an employee worked in, all of the employee's hours must be reported in classification 0507.

Example 2: If the employer's records show the employee worked only in classifications 0510 and 0513, but no time records were kept, all of the employee's hours must be reported in classification 0510.

Example 3: If the employer's records show the hours the employee worked in classification 0510 and the hours the employee worked in 0513, the employer may report the employee's hours in both classifications.

* The rates above do not reflect actual rates and are only intended for the purpose of this example.

(5) **I have employees with duties that support more than one basic classification, but it is not possible to distinguish their hours between classifications. How do I report these workers' hours?**

Sometimes employers are unable to divide a worker's hours between two or more classifications because the work simultaneously supports more than one basic classification. When this occurs, you must report the work in the highest rated classification that the work supports.

Example 1: You operate both a motel with classification 4905, and a restaurant with classification 3905. You have a laundry facility that cleans the linens for both the restaurant and for the motel and you choose not to distinguish schedules for washing the linens separately. If you do not maintain work or payroll records, you must report your employees in the higher premium rate classification.

If classification 3905 is higher than classification 4905, you need to report the laundry operations in classification 3905.

If classification 4905 is higher than classification 3905, you need to report the laundry operations in classification 4905.

Example 2: You have a floor covering store and also offers installation services to your customers. Your store operations are under classification 6309 and your employees performing the installation service are under classification 0502.

Since delivery is included in both your classifications, when your workers deliver floor covering to one of your own job sites, their drive time must be reported in whichever of your classifications is higher premium rated.

Example 3: You are a construction contractor and pay your workers for driving to and from the construction sites. Some of these workers work in more than one construction classification. You can keep records of when they work in each classification and report their hours at the job site accordingly, but all of their drive time on a given day must be reported in the highest rated construction classification they worked in the same day.

(6) **How can I find the rates for the classifications assigned to my account?**

Each of your classifications has a new rate assigned to it yearly. Your rates are on your annual rate notice and your quarterly report, or you may obtain your rates by contacting your account manager.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 296-17-310171 How to report hours for employees supporting multiple business operations.

WSR 14-12-057
PERMANENT RULES
DEPARTMENT OF HEALTH
(Dental Quality Assurance Commission)
[Filed May 30, 2014, 10:01 a.m., effective June 30, 2014]

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

Purpose: WAC 246-817-550 Acts that may be performed by licensed dental hygienists under general supervision, the rule implements HB 1330 (chapter 87, Laws of 2013), which amended RCW 18.29.050 and authorized a dentist to delegate to a dental hygienist application of topical anesthetic agents.

Citation of Existing Rules Affected by this Order: Amending WAC 246-817-550.

Statutory Authority for Adoption: RCW 18.32.0365 and 18.29.050.

Other Authority: RCW 18.32.002.

Adopted under notice filed as WSR 14-05-024 on February 10, 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 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: May 6, 2014.

LouAnn Mercier, D.D.S., Chair
Dental Quality Assurance Commission

AMENDATORY SECTION (Amending WSR 95-21-041, filed 10/10/95, effective 11/10/95)

WAC 246-817-550 Acts that may be performed by licensed dental hygienists under general supervision. A dentist may allow a dental hygienist licensed under the provisions of chapter 18.29 RCW to perform the following acts under the dentist's general supervision:

(1) Oral inspection and measuring of periodontal pockets, with no diagnosis.

(2) Patient education in oral hygiene.

(3) Take intra-oral and extra-oral radiographs.

(4) Apply topical preventive or prophylactic agents.

(5) Polish and smooth restorations.

(6) Oral prophylaxis and removal of deposits and stains from the surfaces of the teeth.

(7) Record health histories.

(8) Take and record blood pressure and vital signs.

(9) Perform sub-gingival and supra-gingival scaling.

(10) Perform root planing.

(11) Apply sealants.

(12) Apply topical anesthetic agents.

WSR 14-12-059
PERMANENT RULES
DEPARTMENT OF HEALTH
(Board of Optometry)

[Filed May 30, 2014, 10:13 a.m., effective June 30, 2014]

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

Purpose: WAC 246-851-610 Approval or removal of medications, the rule changes references from the board of pharmacy to the pharmacy quality assurance commission. HB 1609 (chapter 19, Laws of 2013), effective July 28, 2013, changed title and reference of the board of pharmacy to the pharmacy quality assurance commission. The rule does not change the effect of the rule or add additional requirements. The rule was proposed using the expedited rule-making process.

Citation of Existing Rules Affected by this Order: Amending WAC 246-851-610 Approval or removal of medications.

Statutory Authority for Adoption: RCW 18.54.070(2).

Adopted under notice filed as WSR 14-02-070 on December 27, 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 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: May 27, 2014.

Judy Chan, OD, Chair
Board of Optometry

AMENDATORY SECTION (Amending WSR 04-12-127, filed 6/2/04, effective 7/3/04)

WAC 246-851-610 Approval or removal of medications. The board((~~s~~)) of optometry and pharmacy quality assurance commission will use a joint process to determine changes to the oral drug list that includes a means to resolve disagreements**.**

(1) Categories of medications approved by the Food and Drug Administration may be added to WAC 246-851-580(1) by rule through consultation and approval of the board of optometry and ((~~board of~~)) pharmacy quality assurance commission.

(2) Medications approved by the Food and Drug Administration in categories that are within the scope of optometric physician practice that are not included in WAC 246-851-580(1) may be added through consultation and approval of the board of optometry and the ((~~board of~~)) pharmacy quality assurance commission. Approval will follow the joint process established by ((~~both boards~~)) the board and commission.

(3) WAC 246-851-580 and 246-851-590 may be updated to reflect additions or removal of medications.

WSR 14-12-065
PERMANENT RULES
CHARTER SCHOOL COMMISSION

[Filed June 2, 2014, 10:20 a.m., effective July 3, 2014]

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

Purpose: Chapter 108-40 WAC, the purpose of the proposed rules is to establish the charter school commission's charter school oversight and corrective action policy, renewal and nonrenewal policy, revocation policy, and termination protocol.

Chapter 108-50 WAC, the purpose of the proposed rules is to establish the charter school commission's public records officer, walk-in availability of public records, public records request processing protocol, agency exemption criteria, costs of printed and otherwise hardcopy versions of public records, and review of denial protocol for charter school commission compliance with Public Records Act, chapter 42.56 RCW.

Statutory Authority for Adoption: For chapter 108-40 WAC is RCW 27A.710.070 [28A.710.070], 27A.710.180 [28A.710.180], 27A.710.190 [28A.710.190], 27A.710.200 [28A.710.200]; and for chapter 108-50 WAC is chapter 42.56 RCW.

Adopted under notice filed as WSR 14-06-061 on February 28, 2014.

Changes Other than Editing from Proposed to Adopted Version: Redrafted WAC 108-40-030 (4)(c): If the commission imposes corrective action or sanctions, the school must submit a corrective action plan and/or adhere to sanctions imposed by the commission.

Redrafted WAC 108-40-040: (1) Upon a finding of one or more deficiency and imposition of corrective action, the school must comply with the corrective action process and successfully complete an approved corrective action plan.

(2) If there is immediate threat to student or employee health, safety or welfare, the commission may require immediate correction of the deficiency or correction within a timeframe indicated by the commission.

(3) All other violations will require a corrective action plan.

(4) In addition to requiring a school to comply with a corrective action plan designed to correct any deficiencies, the commission may impose sanctions up to and including revocation. Sanctions may include:

(a) Placement on a probationary status; and

(b) Revocation.

(5) The corrective action plan must identify the date by which the deficiency will be corrected.

(6) Implementation of a corrective action plan constitutes reasonable opportunity for the school to remedy the identified deficiencies.

(7) Within ten days from receipt of a deficiency finding, a school must provide the commission with a corrective action plan.

(8) If accepted, the commission will approve the corrective action plan. Once approved the school may seek one extension of the deadline for compliance for good cause shown. The commission is not required to approve the extension.

(9) If the extension is granted and the school does not satisfy the corrective action plan the failure will be considered grounds for revocation of the contract.

Revised WAC 108-40-070(7): ["]The school will have ~~one week~~ ten days to submit a written response to the renewal inspection report." According to an experienced school operator, one week makes it hard to get legal advice as needed.

Revised WAC 108-40-070(10): … failure to make such a request shall constitute a waiver of the school's right to respond.

Redrafted WAC 108-40-070(12): Upon approval of a school's renewal application, the school must execute a new contract within ninety days of the approval decision. The contract must include specific conditions that the commission determines are required for necessary improvements to the school; provided, however, if approval of the renewal application is conditional, the renewal conditions must be included in the contract.

Revised WAC 108-40-080 (2)(b): Financial information such as near term indicators, sustainability indicators, and audit and ~~accountability~~ accounting indicators ….

Revised WAC 108-40-080 (2)(c): Organizational information such as education program, charter school law compliance, safety and welfare compliance, board performance and stewardship, student involvement and retention, and mission specific accountability.

Revised WAC 108-40-090 (2)(e): Fallen in the bottom quartile of the schools on the state board's accountability index at the time of the renewal application;

Revised WAC 108-40-110: Subsection (5)(a), submit a written response explaining why it believes that its contract should ~~be renewed~~ not be revoked.

Subsection (5)(b) submit documents and give testimony ~~supporting the renewal~~ opposing the revocation of the contract.

Subsection (6) "The commission may also, through staff or counsel, present documents, witnesses or testimony to support the ~~ineligibility determination or nonrenewal~~ revocation recommendation at the public proceeding.

Subsection (10) Within ten days of issuing this resolution, the commission will submit a report of action to the school, ~~and~~ the state board of education, and the superintendent of public instruction.

Subsection (11) Nothing in these rules prevent the commission from engaging in contingency planning in initiating components of the termination protocol.

Revised WAC 108-40-140(1): Within ~~twenty-four~~ forty-eight hours of a decision to nonrenew, revoke, or terminate ….

Revised WAC 108-40-150: Subsection (3)(a) If the closure decision is being appealed, information of where parties are in the process and an estimated timeline for a final decision.

Subsection (3)(g)(i) A copy of a termination ~~agreement~~ protocol pursuant to RCW 29A.710.210(1) [28A.710.210 (1)].

Subsection (6) Within seventy-two hours of a decision to nonrenew, revoke, or terminate a charter school contract, the transition team will create a faculty contact list and notify faculty members of the closure decision. The faculty contact list may contain ….

Redrafted WAC 108-40-160(1): (1) The school's lead administrator will maintain corporate records and IRS 501 (C)(3) status. Corporate records include, but are not limited to records relating to the school:

(a) Loans, bonds, mortgages, and other financing;

(b) Contracts;

(c) Leases;

(d) Assets and asset distribution;

(e) Grants;

(f) Governance;

(g) Accounting and tax records;

(h) Personnel;

(i) Employee benefit programs and benefits;

(j) Insurance; and

(j) [(k)] Any other items listed in the closure plan.

Revised WAC 108-40-160(8): Within thirty days after the last day of classes, the charter school's lead administrator will transfer student records to students' new school or district of residence ….

Revised WAC 108-40-190 (1)(b): Ensure all necessary deliverables are accounted for ….

Redrafted WAC 108-40-190(2) In the event that the commission determines an incompletion and lacking of any protocols, deliverables, or audit findings, the charter school board, lead administrator, and financial lead should address these within forty-eight hours.

Revised WAC 108-50-030(3): … No member of the public may remove a document from the viewing area or disassemble or alter any document. ~~A requestor shall not take the commission records from the commission offices without the permission of the public records officer or designee~~ ….

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 27, 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 27, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 27, 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 22, 2014.

Colin Pippin-Timco
Executive Assistant

Chapter 108-40 WAC

CHARTER SCHOOL OVERSIGHT AND CORRECTIVE ACTION POLICY, RENEWAL AND NONRENEWAL POLICY, REVOCATION POLICY, AND TERMINATION PROTOCOL

NEW SECTION

WAC 108-40-010 Oversight and corrective action policy statement. The Washington state charter school commission is responsible under RCW 28A.710.180 for oversight and accountability of the performance and effectiveness of all charter schools it authorizes under RCW 28A.710.070. This oversight and accountability is ongoing and is not limited to the specific actions and procedures described in these rules. For the purposes of the commission's rules governing the oversight and accountability of charter schools it authorizes, the term "school" means a school that has been authorized by the commission under RCW 28A.710.070.

NEW SECTION

WAC 108-40-020 Oversight. (1) In carrying out its responsibilities for oversight and accountability of the performance and effectiveness of schools it authorizes, the commission may utilize information including, but not limited to:

(a) The annual reports submitted to the commission under RCW 28A.710.040;

(b) All reports and data submitted to the office of the superintendent of public instruction under chapter 28A.710 RCW;

(c) Data and information obtained through annual site visits;

(d) Data and information obtained under the charter contract;

(e) Financial data and audit materials; and

(f) Any other information, data or materials associated with the schools.

(2) The commission will require submission of, or access to, materials or data from the school deemed reasonably necessary for oversight and accountability of the schools.

NEW SECTION

WAC 108-40-030 Inquiries and site visits. (1) If the commission deems an inquiry or investigation necessary, it may request access to facilities, data, information, and staff. Charter schools are required to provide access to facilities, data, information, and staff in the manner and time frame requested by the commission.

(2) The commission will consider requests to adjust the manner and time frame for access if the school provides good cause. Failure to provide access as requested is considered a material and substantial violation of the charter school's legal and contractual obligations.

(3) Information about the investigation or inquiry will be provided at the discretion of the commission. One consideration is the possible impact of the disclosure on the inquiry or investigation.

(4) At the point of the inquiry or investigation when the commission has reason to believe that a charter school's performance or legal compliance is unsatisfactory, the commission will:

(a) Promptly notify the school of the perceived problem. Notice will be provided in writing. Depending on the nature of the apparent issue, prompt notice could range from between twenty-four hours to fourteen days;

(b) The school must respond in writing to the perceived problem within ten working days. The commission will consider the response and other evidence and information available and determine whether to take corrective action and/or impose sanctions as necessary; and

(c) If the commission imposes corrective action or sanctions, the school must submit a corrective action plan and/or adhere to sanctions imposed by the commission.

(5) The commission may conduct site visits to charter schools in its portfolio for the purpose of conducting oversight and holding schools accountable.

(6) If circumstances warrant it, the commission may alter the time frames within these rules.

NEW SECTION

WAC 108-40-040 Corrective action process. (1) Upon a finding of one or more deficiencies and imposition of corrective action, the school must comply with the corrective action process and successfully complete an approved corrective action plan.

(2) If there is immediate threat to student or employee health, safety or welfare, the commission may require immediate correction of the deficiency or correction within a time frame indicated by the commission.

(3) All other violations will require a corrective action plan.

(4) In addition to requiring a school to comply with a corrective action plan to correct any deficiencies, the commission may impose sanctions up to and including revocation. Sanctions may include:

(a) Placement on a probationary status; and

(b) Revocation.

(5) The corrective action plan must identify the date by which the deficiency will be corrected.

(6) Implementation of a corrective action plan constitutes reasonable opportunity for the school to remedy the identified deficiencies.

(7) Within ten days from receipt of a deficiency finding, a school must provide the commission with a corrective action plan.

(8) If accepted, the commission will approve the corrective action plan. Once approved, the school may seek one extension of the deadline for compliance for good cause shown. The commission is not required to approve the extension.

(9) If the extension is granted and the school does not satisfy the corrective action plan, the failure will be considered grounds for revocation of the contract.

NEW SECTION

WAC 108-40-050 Corrective action plans. (1) Corrective action plans must:

(a) Address how the corrective action will be accomplished;

(b) Address how the school will identify and address other deficiencies associated with the corrective action;

(c) Address what measure(s) will be put in place to prevent future occurrence of defect;

(d) Indicate how the school will monitor compliance to assure that solutions are sustained;

(e) Identify person(s) responsible for corrections and sustaining change;

(f) Give the date by which correction will be made; and

(g) Include steps that will be taken to accomplish correction with steps, dates, and supporting evidence that the plan will be carried out as scheduled.

(2) The school may be required to submit progress reports or updated plans in accordance with a schedule specified by the commission.

(3) Commission acceptance of the corrective action plan is at its discretion and does not rule out imposition of other remedies or sanctions.

NEW SECTION

WAC 108-40-060 Renewal policy statement. The renewal process begins at the end of the school year preceding a charter school's final year of operation under an existing charter school contract. This is a rigorous process designed to enable the commission to make an informed decision about whether or not a charter school should be allowed to continue to operate for an additional contract term.

NEW SECTION

WAC 108-40-070 Renewal process. (1) No later than May 1st, one school year before the expiration of the charter school contract, the charter school must notify the commission in writing of its decision to either:

(a) Apply for renewal of the contract; or

(b) Cease operation at the expiration of the contract term.

(2) If the school has decided to cease operation at the expiration of the contract term, a termination protocol shall be implemented.

(3) If the school is requesting renewal under the existing contract, it must submit a renewal application before the final school year begins. The renewal application must be submitted no later than June 1st and must be received by the commission by 5:00 p.m.; if June 1st falls on a weekend, the renewal application must be received by the commission no later than 5:00 p.m. on the Monday following June 1st.

(4) Within ninety days of receiving a renewal application, the commission will issue a written performance report addressing the information outlined in WAC 108-40-080. The performance report will be sent to the school seeking renewal and posted on the commission's web site.

(5) The school may submit a response to the performance report that corrects or clarifies information contained in the report. If the school is subject to the ineligibility presumptions enumerated in WAC 108-40-090, then the school must rebut those presumptions by demonstrating exceptional circumstances that justify renewal in the response to the performance report. If the school submits a response, it must be received by the commission within thirty days of issuance of the performance report.

(6) In conjunction with the performance report, the commission will issue renewal application guidance. The renewal application guidance will, at a minimum, provide the charter school with an opportunity to:

(a) Present additional evidence, beyond the data contained in the performance report, supporting its case for charter contract renewal;

(b) Describe improvements undertaken or planned for the school; and

(c) Detail the school's plans for the next charter contract term. The renewal application guidance will also contain the criteria that will guide the commission's renewal decisions.

(7) For those renewal applications deemed eligible for renewal consideration, individuals designated by the commission may conduct a school site visit (renewal inspection) during the renewal applicant school's final school year under the existing contract. The renewal inspection may serve as one of the mechanisms for the commission to evaluate and document the charter school's performance and representations to inform the commission's renewal decision. The renewal inspection will include a review of the school's performance and satisfaction of its obligations under the charter contract, with specific focus on any concerns identified in the performance report. Within fourteen days following the renewal inspection, a renewal inspection report will be issued. The school will have ten days to submit a written response to the renewal inspection report.

(8) Those renewal applications deemed ineligible for renewal consideration may appeal this determination in accordance with the procedures outlined in WAC 108-40-100.

(9) Interested parties, including members of the public, may submit written comments to the commission regarding the potential renewal of a school's charter contract. The deadline for submitting comments will be posted on the commission's web site.

(10) For applications deemed eligible for renewal consideration, commission staff will review renewal applications, the renewal inspection report, and other relevant infor-

mation, and make a recommendation, based on the renewal criteria, to approve, deny, or conditionally approve the renewal application. This recommendation will be provided to the school and commissioners. This recommendation shall serve as notice of the prospect of and reasons for nonrenewal. Within twenty days of issuance of this recommendation, the school may request an opportunity to respond to the recommendation in accordance with the procedures outlined in WAC 108-40-100; failure to make such a request shall constitute a waiver of the school's right to respond.

(11) The commission will pass a resolution approving, denying, or conditionally approving the renewal application. Renewal may be for a term of up to five years. This term may be shorter depending on the school's performance, demonstrated capacities and particular circumstances.

(12) Upon approval of a school's renewal application, the school must execute a new contract within ninety days of the approval decision. The contract must include specific conditions that the commission determines are required for necessary improvements to the school; provided, however, if approval of the renewal application is conditional, the renewal conditions must be included in the contract.

NEW SECTION

WAC 108-40-080 Performance report. (1) The performance report will summarize the school's performance record and provide notice of any weaknesses or concerns perceived by the commission that may jeopardize the school's renewal if not timely rectified.

(2) The commission's school performance report will include, but is not limited to, the following information:

(a) Academic information such as student achievement data, comparative performance, student progress, postsecondary readiness, state and federal accountability, and mission specific accountability;

(b) Financial information such as near term indicators, sustainability indicators, and audit and accounting indicators; and

(c) Organizational information such as education program, charter school law compliance, safety and welfare compliance, board performance and stewardship, student involvement and retention, and mission specific accountability.

(3) If there are reasons why the commission may not renew the charter, the performance report will provide the school with notice of those reasons and the prospect for nonrenewal.

NEW SECTION

WAC 108-40-090 Renewal decision and presumptions. (1) In making charter renewal decisions, the commission will:

(a) Ground its decisions in evidence of the school's performance over the term of the charter contract in accordance with the performance framework set forth in the charter contract;

(b) Ensure that data used in making renewal decisions are available to the school and the public; and

(c) Provide a public report summarizing the evidence that forms the basis for its decision. Specific criteria guiding the commission's renewal decisions will be set out in the commission's renewal application guidance.

(2) Schools are presumed to be ineligible for renewal if they have:

(a) Committed a material and substantial violation of any of the terms, conditions, standards, or procedures required under this chapter or the charter contract;

(b) Failed to meet or make sufficient progress toward the performance expectations set forth in the charter contract;

(c) Failed to meet generally accepted standards of fiscal management;

(d) Substantially violated any material provision of law from which the charter school is not exempt;

(e) Fallen in the bottom quartile of schools on the state board's accountability index at the time of the renewal application; and

(f) Are subject to an active corrective action plan for the failures or violations listed in (a) through (f) of this subsection.

(3) The presumption of ineligibility can be rebutted if the school demonstrates exceptional circumstances that the authorizer finds justifiable. The school must satisfy this burden in its application and response to the performance report.

(4) A decision to renew, conditionally renew, or nonrenew a school's contract will be memorialized in a resolution that sets forth the action taken, the reasons for the decision, and assurances of compliance with the commission's procedural requirements. A report of action, with the resolution attached, must be submitted to the renewal applicant and the state board of education within ten days of the decision.

NEW SECTION

WAC 108-40-100 Procedures associated with possible nonrenewal decision. (1) If a school is notified that it is considered ineligible for renewal, or that nonrenewal is recommended, within twenty days of that notice, the school may request an opportunity to respond and present evidence challenging the determination of ineligibility or recommendation for nonrenewal. This request must be sent to the commission's executive director or designee. Failure to make this request within twenty days acts as a waiver rendering the ineligibility determination or nonrenewal recommendation final.

(2) If a school requests an opportunity to respond, the commission will designate an individual, or individuals, to preside over a public proceeding at which the school may:

(a) Submit a written response explaining why it believes that its contract should be renewed;

(b) Submit documents and give testimony supporting the renewal of the contract;

(c) Call witnesses on its behalf; and

(d) Be represented by counsel.

(3) The commission may also, through staff or counsel, present documents, witnesses, and/or testimony to support the ineligibility determination or nonrenewal recommendation at the public proceeding.

(4) The presiding officer(s) shall regulate the course of the public proceeding and, in the discretion of the presiding officer(s), may impose reasonable limits on the conduct of the public proceeding including, but not limited to, limitations on the length of time that the school and commission has to present documents and evidence. The presiding officer(s) may issue deadlines and other requirements that the presiding officer(s) deem necessary for the orderly conduct of the proceeding. Unless they conflict with the Charter Schools Act and commission's rules, the provisions of chapter 34.05 RCW shall govern these proceedings.

(5) Within thirty days of the public proceeding, the presiding officer(s) shall make a written recommendation to the commission regarding whether the ineligibility or nonrenewal decision should stand or whether it should be altered in some manner. This recommendation will be transmitted to the commission, the school, and posted on the commission's web site.

(6) The commission will, after a reasonable period for deliberation, consider the recommendation of the presiding officer(s), as well as relevant evidence or documentation submitted during the application renewal process, and make a final determination. The commission's final determination shall be in the form of a resolution that, in the case of a nonrenewal, clearly states the reasons for the nonrenewal.

(7) Within ten days of issuing this resolution, the commission will submit a report of action to the school and the state board of education. The resolution will be attached to the report of action and will set forth the action taken, reasons for the decision, and assurances of compliance with the commission's renewal/nonrenewal procedures.

NEW SECTION

WAC 108-40-110 Revocation of charter school contract. (1) The commission may revoke a school's contract at any time that it determines that the school failed to comply with the Charter Schools Act or:

(a) Committed a material and substantial violation of any of the terms, conditions, standards, or procedures required under this chapter or the charter contract;

(b) Failed to meet or make sufficient progress toward the performance expectations set forth in the charter contract;

(c) Failed to meet generally accepted standards of fiscal management; or

(d) Substantially violated any material provision of law from which the charter school is not exempt.

(2) If the commission determines that a school's contract should be revoked, the commission will notify the school, in writing, of the determination and the associated reasons. The school may submit a written response that must be received by the commission within thirty days of issuance of the notice.

(3) The commission, or a person designated by the commission, will review the notice, response, and any supporting information and issue a draft resolution to revoke or not revoke the school's contract and any conditions that are recommended if the school's contract is not to be revoked. The draft resolution will be sent to the school.

(4) The school may request an opportunity to respond to a draft resolution recommending revocation. This request must be sent to the commission's executive director, or designee, within twenty days of issuance of the draft resolution. Failure to make this request within twenty days acts as a waiver rendering the draft resolution final.

(5) If a school requests an opportunity to respond, the commission will designate an individual or individuals to preside over a public proceeding at which the school may:

(a) Submit a written response explaining why it believes that its contract should not be revoked;

(b) Submit documents and give testimony opposing the revocation of the contract;

(c) Call witnesses on its behalf; and

(d) Be represented by counsel.

(6) The commission may also, through staff or counsel, present documents, witnesses and/or testimony to support the revocation at the public proceeding.

(7) The presiding officer(s) shall regulate the course of the public proceeding and, in the discretion of the presiding officer(s), may impose reasonable limits on the conduct of the public proceeding including, but not limited to, limitations on the length of time that the school and commission has to present documents and evidence. The presiding officer(s) may issue deadlines and other requirements that the presiding officer(s) deems necessary for the orderly conduct of the proceeding. Unless they conflict with the Charter Schools Act, and commission's rules, the provisions of chapter 34.05 RCW shall govern these proceedings.

(8) Within no more than thirty days of the public proceeding, the presiding officer(s) shall make a written recommendation to the commission regarding whether the revocation decision should stand or whether it should be altered in some manner. This recommendation will be transmitted to the commission, the school, and posted on the commission's web site.

(9) The commission will, after a reasonable period for deliberation, consider the recommendation of the presiding officer(s) as well as any other evidence or documentation submitted during the revocation process, and make a final determination. The commission's final determination shall be in the form of a resolution that clearly states the reasons for the revocation or decision not to revoke.

(10) Within ten days of issuing this resolution, the commission will submit a report of action to the school, the superintendent of public instruction, and the state board of education. The resolution will be attached to the report of action and will set forth the action taken, reasons for the decision, and assurances of compliance with the commission's renewal/nonrenewal procedures.

(11) Nothing within these rules prevents the commission from engaging in contingency planning in initiating the termination protocol.

NEW SECTION

WAC 108-40-120 Termination protocol statement. The following roles and procedures govern the closure of a school upon nonrenewal, revocation, or other termination of the charter school contract. All time frames are triggered by a

final decision to nonrenew, revoke, or terminate a charter school contract.

NEW SECTION

WAC 108-40-130 Termination protocol responsibilities of the charter school board. The charter school board shall be responsible for the obligations associated with this termination protocol. These obligations are personal and extend beyond the term of the contract.

NEW SECTION

WAC 108-40-140 Termination protocol responsibilities of the commission's staff. (1) Within forty-eight hours of a decision to nonrenew, revoke, or terminate a charter school contract, the commission's staff will establish a transition team.

(2) Within twenty-four hours of a decision to nonrenew, revoke, or terminate a charter school contract, the commission staff will notify the Washington state board of education and the office of superintendent of public instruction.

NEW SECTION

WAC 108-40-150 Termination protocol responsibilities of the transition team. (1) The transition team may include:

(a) Commission staff;

(b) Charter school board chair or designee;

(c) Lead administrator from the charter school;

(d) Lead finance person from the charter school;

(e) Lead person from the charter school faculty; and

(f) Lead person from the charter school parent organization.

(2) The transition team will develop a closure plan and assign roles.

(3) Within forty-eight hours of a decision to nonrenew, revoke, or terminate a charter school contract, the transition team will notify districts materially impacted by the closure decision with information including:

(a) If the closure decision is being appealed, information of where parties are in process and an estimated timeline for a final decision;

(b) A timeline for final decision;

(c) A copy of the closure letter sent to parents;

(d) A copy of letters sent to school faculty and staff;

(e) Information regarding the school closure process;

(f) Information regarding the plan being developed to ensure an orderly closure process; and

(g) Commission decision-making materials, including:

(i) A resolution to close school; and/or

(ii) A copy of a termination protocol pursuant to RCW 28A.710.210(1).

(4) Within seventy-two hours of a decision to nonrenew, revoke, or terminate a charter school contract, a parent contact list for enrolled students will be created and the transition team will notify parents of the closure decision. A parent contact list may include:

(a) Student name;

(b) Parent name;

(c) Address;

(d) Telephone number; and

(e) E-mail.

(5) A notification of the closure decision may include:

(a) Notification of the closure decision;

(b) Timeline for transition;

(c) Assurance that instruction will continue through the end of the school year or the date when instruction will cease;

(d) Assurance that parents and students will be assisted in the reassignment process;

(e) Frequently asked questions about the charter closure process; and

(f) Commission and school contact information for parents/guardians with questions.

(6) Within seventy-two hours of a decision to nonrenew, revoke, or terminate a charter school contract, the transition team will create a faculty contact list and notify faculty members of the closure decision. The faculty contact list may contain:

(a) Name;

(b) Position;

(c) Address;

(d) Telephone number; and

(e) E-mail.

(7) Within five business days of a decision to nonrenew, revoke, or terminate a charter school contract the transition team will develop a closure plan. The closure plan will include responsible persons and written reports concerning:

(a) Reassignment of students;

(b) Return or distribution of assets;

(c) Transfer of student records;

(d) Notification of entities doing business with the school;

(e) The status of the school's finances; and

(f) Submission of all required reports and data to the commission and/or OSPI.

NEW SECTION

WAC 108-40-160 Termination protocol responsibilities of the charter school lead administrator. (1) The school's lead administrator will maintain corporate records and IRS 501 (C)(3) status. Corporate records include, but are not limited to records relating to the school:

(a) Loans, bonds, mortgages, and other financing;

(b) Contracts;

(c) Leases;

(d) Assets and asset distribution;

(e) Grants;

(f) Governance;

(g) Accounting and tax records;

(h) Personnel;

(i) Employee benefit programs and benefits;

(j) Insurance; and

(k) Any other items listed in the closure plan.

(2) The charter school's lead administrator will maintain existing insurance coverage for assets under the closure plan, as well as for the facility, vehicles, and other assets until disposal, transfer of real estate, or termination of lease, and disposal, transfer, or sale of vehicles and other assets.

(3) Within ten days of a decision to nonrenew, revoke, or terminate a charter school contract, the charter school's lead administrator will notify commercial lenders and bond holders of the school's closure, and a likely date of when an event of default will occur, as well as the projected date for the last payment by the school towards its debt.

(4) Within ten days of a decision to nonrenew, revoke, or terminate a charter school contract, the charter school's lead administrator will notify the following groups as to the school's closure and project date of closure:

(a) Charitable partners; and

(b) Vendors.

(5) Within ten days of a decision to nonrenew, revoke, or terminate a charter school contract, the charter school's lead administrator will create and submit to commission staff a list of all creditors and debtors, and any amounts accrued and unpaid with respect to such creditor or debtor.

(6) Within fifteen days of the commission's resolution to not renew or terminate a charter school contract, the charter school's lead administrator will:

(a) Create a list of all contractors with contracts in effect, and notify the contractors of the school's closure and cessation of operations;

(b) Instruct contractors to remove any contractor property from the school prior to final day of school operation; and

(c) Retain records of past contracts as proof of full payment, and terminate contracts for goods and services as of the last date such goods or services will be provided.

(7) Within fifteen days of a decision to nonrenew, revoke, or terminate a charter school contract, the charter school's lead administrator will notify an education service provider of termination of education program by the school's board, providing:

(a) The last day of classes and absence of summer school;

(b) Notice of nonrenewal in accordance with management contract;

(c) Request for final invoice and accounting to include accounting of retained school funds and grant fund status; and

(d) Notice to the education service provider to remove any property lent to the school after the end of classes, and to request a receipt for such property.

(8) Within thirty days after the last day of classes, the charter school's lead administrator will transfer student records to students' new school or district of residence. Student records include:

(a) Grades and any evaluation data;

(b) All materials associated with individual education plans;

(c) Immunization records; and

(d) Parent or guardian information.

(9) Within five days of the transfer of student records, the charter school's lead administrator will provide the commission with written verification of transfer of student records. Written verification of records must include:

(a) Number of general education records transferred;

(b) Number of special education records transferred;

(c) Date of transfer;

(d) Signature and printed name of the charter school representative releasing the records; and

(e) Signature and printed name of the district or other entity recipient(s) of the records.

(10) Within thirty days after the last day of classes, the charter school's lead administrator will review, prepare and make available to commission staff an itemized financial statement that includes, but is not limited to:

(a) Fiscal year-end financial statements;

(b) Cash analysis;

(c) List of compiled bank statements for the year;

(d) List of investments;

(e) List of payables and determinations of when a check used to pay the liability will clear the bank;

(f) List of all unused checks;

(g) List of petty cash;

(h) List of bank accounts; and

(i) List of all payroll reports including taxes, retirement, or adjustments on employee contracts.

NEW SECTION

WAC 108-40-170 Termination protocol responsibilities of the charter school lead administrator and the charter school commission staff. (1) Within five business days of a decision to nonrenew, revoke, or terminate a charter school contract commission staff and lead administrator from charter school will review the school's budget. The purpose of the review is to:

(a) Ensure that funds are sufficient to operate the school through the end of the school year, if applicable;

(b) Emphasize the legal requirement to limit expenditures to only those in the approved budget, while delaying approved expenditures that might no longer be necessary until a revised budget is approved;

(c) Make revisions that take into account closure and associated expenses while prioritizing continuity of instruction; and

(d) Identify acceptable use of reserve funds.

(2) Within ten business days of a decision to nonrenew, revoke, or terminate a charter school contract, commission staff and lead administrator will hold a parent closure meeting. The purpose of the parent closure meeting is to:

(a) Provide overview of the commission's closure policy and closure decision;

(b) Provide calendar of important dates for parents;

(c) Provide specific remaining school vacation days and date for the end of classes;

(d) Present timeline for transitioning students;

(e) Present timeline for closing down of school operations; and

(f) Provide contact information.

(3) Within ten days of a decision to nonrenew, revoke, or terminate a charter school contract, commission staff and lead administrator will meet with charter school faculty and staff. The purpose of this meeting is to:

(a) Discuss reasons for closure;

(b) Emphasize importance of maintaining continuity of instruction through the end of the school year;

(c) Discuss plans for helping students find new schools;

(d) Identify date when last salary check will be issued, when benefits terminate, and last day of work; and

(e) Describe assistance, if any, which will be provided to faculty and staff to find new positions.

NEW SECTION

WAC 108-40-180 Termination protocol responsibilities of the charter school financial lead. (1) Within five business days of the last day of classes, the charter school's financial lead will file Federal Form 269 and 269a if the school has been receiving funds directly from the United States Department of Education.

(2) Within one hundred twenty days after the last day of classes, the charter school's financial lead will establish a date for audit to perform final close out audit. Lead must provide commission with findings of audit within forty-eight hours of receipt of findings.

NEW SECTION

WAC 108-40-190 Termination protocol final closure meeting. (1) Within five days of receiving the finalized audit report, commission staff will establish a date for a final report meeting between commission staff, charter school board, lead administrator, and financial lead. This meeting is established to:

(a) Ensure termination protocols have been followed;

(b) Ensure all necessary deliverables are accounted for;

(c) Review findings of final close out audit; and

(d) Ensure indemnification of the commission and its employees by the charter school board, lead administrator, and financial lead.

(2) In the event that the commission determines an incompletion and lacking of any protocols, deliverables, or audit findings, the charter school board, lead administrator, and financial lead should address these within forty-eight hours.

Chapter 108-50 WAC

PUBLIC RECORDS

NEW SECTION

WAC 108-50-010 Authority and purpose. These rules are established pursuant to chapter 42.56 RCW for the purposes of protecting public records and making them readily accessible to the public. In carrying out its responsibilities under the Public Records Act (act), the charter school commission (commission) will be guided by the provisions of the act describing its purposes and interpretation.

NEW SECTION

WAC 108-50-020 Agency description—Contact information—Public records officer. (1) The commission authorizes high quality public charter schools throughout the state and ensures the highest standards of accountability and oversight for those schools. The commission's central office is located at:

Washington State Charter School Commission
1068 Washington St. S.E.
Olympia, WA 98501

(2) Any person wishing to request access to public records of the commission, or seeking assistance in making such a request should contact the public records officer of the commission:

Public Records Officer
Washington State Charter School Commission
1068 Washington St. S.E.
Olympia, WA 98501
360-725-5511
Colin.pippin-timco@charterschool.wa.gov

Information is also available at the commission's web site.

(3) The public records officer will oversee compliance with the act but another commission staff member may process the request. Therefore, these rules will refer to the public records officer or "designee." The public records officer or designee and the commission will provide the "fullest assistance" to requestors; create and maintain for use by the public and officials an index to public records of the commission; ensure that public records are protected from damage or disorganization; and prevent fulfilling public records requests from causing excessive interference with essential functions of the commission.

NEW SECTION

WAC 108-50-030 Availability of public records. (1) **Hours for inspection of records.** Public records are available for inspection and copying during customary business hours of the commission, customary office hours are from 8:00 a.m. to noon and from 1:00 p.m. to 4:30 p.m., Monday through Friday, excluding legal holidays. The commission is a small state agency with limited staffing. Consistent with other demands, the commission will provide fullest assistance when a request for inspection is made; to avoid inconvenience, a time to inspect the records should be scheduled with the public records officer. Records must be inspected at the commission's office.

(2) **Records index.** An index of public records is available for use by members of the public, including:

(a) Commission monthly meetings;

(b) Annual solicitation documents;

(c) Charter school application documents;

(d) Evaluation team recommendation reports;

(e) Resolutions by the commission which are filed by resolution number, by year.

The index may be accessed online at the commission's web site.

(3) **Organization of records.** The commission will maintain its records in a reasonably organized manner. The commission will take reasonable actions to protect records from damage and disorganization. A requestor shall not take the commission records from the commission offices. A variety of records is available on the commission web site.

Requestors are encouraged to view the documents available on the web site prior to submitting a records request.

(4) **Making a request for public records.**

(a) Any person wishing to inspect or copy public records of the commission shall make the request in writing on the commission's request form, or by letter, fax, or e-mail addressed to the public records officer and including the following information:

• Name of requestor;

• Address of requestor;

• Other contact information, including telephone number and any e-mail address;

• Adequate identification of the public records for the public records officer or designee to locate the records; and

• The date and time of day of the request.

(b) No fee shall be charged for the inspection of public records. The commission may impose a reasonable charge for providing copies of public records; those charges shall not exceed the amount necessary to reimburse the commission for actual costs incident to such copying. When subject to reasonable charge, no public records will be released until and unless the requestor has tendered payment for such copying to the appropriate official. All charges must be paid by money order, check, or cash in advance.

(c) A form is available for use by requestors at the office of the public records officer and online at the commission's web site.

NEW SECTION

WAC 108-50-040 Processing of public records requests—General. (1) **Providing "fullest assistance."** The commission is charged by statute with adopting rules which provide for how it will "provide full access to public records," "protect records from damage or disorganization," "prevent excessive interference with other essential functions of the agency," provide "fullest assistance" to requestors, and provide the "most timely possible action" on public records requests. The public records officer or designee will process requests in the order allowing the most requests to be processed in the most efficient manner.

(2) **Acknowledging receipt of request.** Within five business days of receipt of the request, the public records officer will do one or more of the following:

(a) Make the records available for inspection or copying;

(b) If copies are requested and payment of a deposit for the copies, if any, is made or terms of payment are agreed upon, send the copies to the requestor;

(c) Provide a reasonable estimate of when records will be available; or

(d) If the request is unclear or does not sufficiently identify the requested records, request clarification from the requestor. Such clarification may be requested and provided by telephone. The public records officer or designee may revise the estimate of when records will be available; or

(e) Deny the request.

(3) **Consequences of failure to respond.** If the commission does not respond in writing within five business days of receipt of the request for disclosure, the requestor should consider contacting the public records officer to determine the reason for the failure to respond.

(4) **Protecting rights of others.** In the event that the requested records contain information that may affect rights of others and may be exempt from disclosure, the public records officer may, prior to providing the records, give notice to such others whose rights may be affected by the disclosure. Such notice should be given so as to make it possible for those other persons to contact the requestor and ask him or her to revise the request, or if necessary, seek an order from a court to prevent or limit the disclosure. The notice to the affected persons will include a copy of the request.

(5) **Records exempt from disclosure.** Some records are exempt from disclosure, in whole or in part. If the commission believes that a record is exempt from disclosure and should be withheld, the public records officer will state the specific exemption and provide a brief explanation of why the record or a portion of the record is being withheld. If only a portion of a record is exempt from disclosure, but the remainder is not exempt, the public records officer will redact the exempt portions, provide the nonexempt portions, and indicate to the requestor why portions of the record are being redacted.

(6) **Inspection of records.**

(a) Consistent with other demands, the commission shall promptly provide space to inspect public records. No member of the public may remove a document from the viewing area or disassemble or alter any document. The requestor shall indicate which documents he or she wishes the agency to copy.

(b) The requestor must claim or review the assembled records within thirty days of the commission's notification to him or her that the records are available for inspection or copying. The agency will notify the requestor in writing of this requirement and inform the requestor that he or she should contact the agency to make arrangements to claim or review the records. If the requestor or a representative of the requestor fails to claim or review the records within the thirty-day period or make other arrangements, the commission may close the request and refile the assembled records. Other public records requests can be processed ahead of a subsequent request by the same person for the same or almost identical records, which can be processed as a new request.

(7) **Providing copies of records.** After inspection is complete, the public records officer or designee shall make the requested copies or arrange for copying.

(8) **Providing records in installments.** When the request is for a large number of records, the public records officer or designee will provide access for inspection and copying in installments, if he or she reasonably determines that it would be practical to provide the records in that way. If, within thirty days, the requestor fails to inspect the entire set of records or one or more of the installments, the public records officer or designee may stop searching for the remaining records and close the request.

(9) **Completion of inspection.** When the inspection of the requested records is complete and all requested copies are provided, the public records officer or designee will indicate that the commission has completed a diligent search for the requested records and made any located nonexempt records available for inspection.

(10) **Closing withdrawn or abandoned request.** When the requestor either withdraws the request or fails to fulfill his or her obligations to inspect the records, or pay the deposit or final payment for the requested copies, the public records officer will close the request and indicate to the requestor that the commission has closed the request.

(11) **Later discovered documents.** If, after the commission has informed the requestor that it has provided all available records, the commission becomes aware of additional responsive documents existing at the time of the request, it will promptly inform the requestor of the additional documents and provide them on an expedited basis.

NEW SECTION

WAC 108-50-060 Exemptions. (1) The Public Records Act provides that a number of types of documents are exempt from public inspection and copying. In addition, documents are exempt from disclosure if any "other statute" exempts or prohibits disclosure. Requestors should be aware of the following exemptions, outside the Public Records Act, that restrict the availability of some documents held by the commission for inspection and copying:

(a) Examination test scores;

(b) Teacher, student, or public employee information that would constitute an invasion of privacy as defined in RCW 42.56.210;

(c) Preliminary drafts, notes, recommendations and intra-agency memorandums not publicly cited by the commission in connection with any commission action.

Pursuant to RCW 42.56.070, the commission reserves the right to delete identifying details when it makes available or publishes any public record when there is reason to believe that disclosure of such details would be an unreasonable invasion of personal privacy: Provided, however, in each case, the justification for the deletion shall be explained fully in writing.

(2) The commission is prohibited by statute from disclosing lists of individuals for commercial purposes.

NEW SECTION

WAC 108-50-070 Costs of providing copies of public records. (1) **Costs for paper copies.** There is no fee for inspecting public records. A requestor may obtain standard black and white photocopies for five cents per page and color copies for ten cents per page.

Before beginning to make the copies, the public records officer or designee may require a deposit of up to ten percent of the estimated costs of copying all the records selected by the requestor. The public records officer or designee may also require the payment of the remainder of the copying costs before providing all the records, or the payment of the costs of copying an installment, before providing that installment. The commission will not charge sales tax when it makes copies of public records.

(2) **Costs for electronic records.** The cost of electronic copies of records shall be two dollars for information on a CD-ROM. The cost of scanning existing commission paper or other nonelectronic records is five cents per page. There will be no charge for e-mailing electronic records to a requestor, unless another cost applies such as a scanning fee.

(3) **Costs of mailing.** The commission may also charge actual costs of mailing, including the cost of the shipping container.

(4) **Payment.** Payment may be made by cash, check, or money order to the commission.

NEW SECTION

WAC 108-50-080 Review of denials of public records. (1) **Petition for internal administrative review of denial of access.** Any person who objects to the initial denial or partial denial of a records request may petition in writing (including e-mail) to the public records officer for a review of that decision. The petition shall include a copy of or reasonably identify the written statement by the public records officer or designee denying the request.

(2) **Consideration of petition for review.** The public records officer shall promptly provide the petition and any other relevant information to the public records officer's supervisor or other agency official designated by the agency to conduct the review. That person will immediately consider the petition and either affirm or reverse the denial within two business days following the agency's receipt of the petition, or within such other time as the commission and the requestor mutually agree to.

(3) **Applicable to state agencies only - Review by the attorney general's office.** Pursuant to RCW 42.56.530, if the commission denies a requestor access to public records because it claims the record is exempt in whole or in part from disclosure, the requestor may request the attorney general's office to review the matter. The attorney general has adopted rules on such requests in WAC 44-06-160.

(4) **Judicial review.** Any person may obtain court review of denials of public records requests pursuant to RCW 42.56.550 at the conclusion of two business days after the initial denial regardless of any internal administrative appeal.

WSR 14-12-082
PERMANENT RULES
DEPARTMENT OF HEALTH

[Filed June 3, 2014, 11:12 a.m., effective July 4, 2014]

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

Purpose: WAC 246-282-990(5), Sanitary control of shellfish—Fees—Commercial geoduck paralytic shellfish poisoning (PSP) testing. The rule equitably assesses the costs of commercial geoduck PSP testing based on the number of tests done the previous year. The testing is essential to public health. It is the only way to know if dangerous levels of PSP exist in commercial geoduck and ensure toxic shellfish do not reach consumers.

Citation of Existing Rules Affected by this Order: Amending WAC 246-282-990.

Statutory Authority for Adoption: RCW 43.70.250.

Adopted under notice filed as WSR 14-06-102 on March 5, 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 1, Repealed 0.

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

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

Date Adopted: June 3, 2014.

John Wiesman, DrPH, MPH
Secretary

AMENDATORY SECTION (Amending WSR 13-11-038, filed 5/10/13, effective 6/10/13)

WAC 246-282-990 Fees. (1) The required annual shellfish operation license fees for shellstock shippers and shucker-packers due October 1, 2011, shall be reduced by twenty-five percent of the annual shellfish operation license fees in subsection (2) of this section. Beginning July 1, 2012, and for every subsequent year, the full annual shellfish operation license fees in subsection (2) of this section shall be assessed.

(2) Annual shellfish operation license fees are:

Type of Operation	Annual Fee
Harvester	$263
Shellstock Shipper	
0 - 49 Acres	$297
50 or greater Acres	$476
Scallop Shellstock Shipper	$297
Shucker-Packer	
Plants with floor space < 2000 sq. ft.	$542
Plants with floor space 2000 sq. ft. to 5000 sq. ft.	$656
Plants with floor space > 5000 sq. ft.	$1,210

(3) The fee for each export certificate is $20.00.

(4) Annual PSP testing fees for companies harvesting species other than geoduck intertidally (between the extremes of high and low tide) are as follows:

Fee Category

Type of Operation	Number of Harvest Sites	Fee
Harvester	≤ 2	$173
Harvester	3 or more	$259
Shellstock Shipper 0 - 49 acres	≤ 2	$195
Shellstock Shipper 0 - 49 acres	3 or more	$292
Shellstock Shipper 50 or greater acres	N/A	$468
Shucker-Packer (plants < 2000 ft²)	≤ 2	$354
Shucker-Packer (plants < 2000 ft²)	3 or more	$533
Shucker-Packer (plants 2000 - 5000 ft²)	≤ 2	$429
Shucker-Packer (plants 2000 - 5000 ft²)	3 or more	$644
Shucker-Packer (plants > 5000 ft²)	N/A	$1,189

(a) The number of harvest sites will be the total number of harvest sites on the licensed company's harvest site certificate:

(i) At the time of first licensure; or

(ii) January 1 of each year for companies licensed as harvesters; or

(iii) July 1 of each year for companies licensed as shellstock shippers and shucker packers.

(b) Two or more contiguous parcels with a total acreage of one acre or less is considered one harvest site.

(5) Annual PSP testing fees for companies harvesting geoduck are as follows:

Harvester	Fee
Department of natural resources (quota tracts harvested by DNR contract holders)	$((~~8,310~~)) 9,140
Discovery Bay Shellfish	$((~~166~~)) 2,226
Jamestown S'Klallam Tribe	$((~~3,158~~)) 2,226
Lower Elwha Klallam Tribe	$((~~2,991~~)) 3,515
Lummi Nation	$703
Nisqually Tribe	$((~~5,318~~)) 2,461
Port Gamble S'Klallam Tribe	$((~~4,653~~)) 3,749
Puyallup Tribe of Indians	$((~~10,470~~)) 9,257
((~~Skokomish Indian Tribe~~	~~$665~~))

Harvester	Fee
Squaxin Island Tribe	$((~~997~~)) 2,109
Suquamish Tribe	$((~~11,135~~)) 14,178
Swinomish Tribe	$((~~332~~)) 820
Taylor Shellfish	$((~~166~~)) 234
Tulalip Tribe	$((~~9,639~~)) 7,382

(6) PSP fees must be paid in full to department of health before a commercial shellfish license is issued or renewed.

(7) Refunds for PSP fees will be given only if the applicant withdraws a new or renewal license application prior to the effective date of the new or renewed license.

WSR 14-12-085
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)

[Filed June 3, 2014, 1:08 p.m., effective July 4, 2014]

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

Purpose: The department is amending WAC 388-450-0195 Does the department use my utility costs when calculating my Basic Food or WASHCAP benefits?

The amendments adopt new requirements for a household to receive the standard utility allowance based on receipt of a federal LIHEAP payment and to reinstate the standard utility, limited utility and telephone utility allowances when determining basic food as required by the Agricultural Act of 2014 (Farm Bill) as enacted.

Citation of Existing Rules Affected by this Order: Amending WAC 388-450-0195.

Statutory Authority for Adoption: RCW 74.04.005, 74.04.050, 74.04.055, 74.04.057, 74.04.500, 74.04.510, 74.08.090.

Other Authority: Agricultural Act of 2014 (Farm Bill).

Adopted under notice filed as WSR 14-07-110 on March 19, 2014.

Changes Other than Editing from Proposed to Adopted Version: Subsection (4) of the WAC was changed to extend the date from August 2014 to October 2014. The change is in response to recent guidance provided by FNS that allows us to delay implementation.

WAC	Proposed Rule	Adopted Rule
388-450-0195(4)	If your AU receives Basic Food on March 9, 2014, you receive the SUA through August 2014	If your AU receives Basic Food on March 9, 2014, you receive the SUA through October 2014
	regardless of your household's utility expenses unless you have a lapse in your Basic Food benefits.	regardless of your household's utility expenses unless you have a lapse in your Basic Food benefits.

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: June 3, 2014.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 14-04-050, filed 1/27/14, effective 2/27/14)

WAC 388-450-0195 Does the department use my utility costs when calculating my Basic Food or WASHCAP benefits? ((~~(1) We use a standard utility allowance (SUA) of four hundred nine dollars instead of your actual utility costs when we determine your assistance unit's:~~

~~(a) Monthly benefits under WAC 388-492-0070 if you receive WASHCAP; or~~

~~(b) Shelter cost income deduction under WAC 388-450-0190 for Basic Food.~~

~~(2) We considered the average cost of the following utilities to determine the value of the SUA:~~

~~(a) Heating and cooling fuel such as electricity, oil, or gas;~~

~~(b) Electricity;~~

~~(c) Water and sewer;~~

~~(d) Well or septic tank installation/maintenance;~~

~~(e) Garbage/trash collection; and~~

~~(f) Telephone service.~~

~~(3) The department uses the SUA if you have utility costs separate from your rent or mortgage payment or if you receive a low income home energy assistance program (LIHEAP) benefit during the year.~~)) (1) The department uses utility allowances instead of the actual utility costs your assistance unit (AU) pays when we determine your:

(a) Monthly benefits under WAC 388-492-0070 if you receive WASHCAP; or

(b) Shelter cost income deduction under WAC 388-450-0190 for Basic Food.

(2) For Basic Food, "utilities" include the following:

(a) Heating or cooling fuel;
(b) Electricity or gas;
(c) Water and sewer;
(d) Well or septic tank installation/maintenance;
(e) Garbage/trash collection; and
(f) Telephone service.

(3) We use the amounts below if you have utility costs separate from your rent or mortgage payment:

(a) If your AU has heating or cooling costs **or** receives more than twenty dollars in Low Income Home Energy Assistance Act (LIHEAA) benefits each year, you get a standard utility allowance (SUA) of four hundred nine dollars.

(b) If your AU does not qualify for the SUA and you have any two utility costs listed in subsection (2) of this section, you get a limited utility allowance (LUA) of three hundred thirty dollars.

(c) If your AU has only telephone costs and no other utility costs, you get a telephone utility allowance (TUA) of sixty-five dollars.

(4) If your AU receives Basic Food on March 9, 2014, you receive the SUA through October 2014 regardless of your household's utility expenses unless you have a lapse in your Basic Food benefits.

WSR 14-12-090
PERMANENT RULES
DEPARTMENT OF LICENSING
[Filed June 3, 2014, 2:20 p.m., effective July 4, 2014]

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

Purpose: Update WAC 308-88-020, regarding rental vehicle business registration, to account for the transfer of the business licensing service from the department of licensing to the department of revenue.

Citation of Existing Rules Affected by this Order: Amending WAC 308-88-020.

Statutory Authority for Adoption: RCW 46.01.110 and 46.87.023.

Adopted under notice filed as WSR 14-09-125 on April 23, 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 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 1, Repealed 0.

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

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

Date Adopted: June 3, 2014.

Damon Monroe
Rules Coordinator

AMENDATORY SECTION (Amending WSR 07-02-077, filed 1/2/07, effective 2/2/07)

WAC 308-88-020 Application and registration of rental vehicle businesses. (1) **What is required to become a rental vehicle business?**

(a) Applicants must apply for a rental vehicle business license by submitting a completed ((~~master~~)) business license application to the department of ((~~licensing's master license~~)) revenue's business licensing service. The business licensing service will process the application on behalf of the department of licensing.

(b) A separate ((~~master~~)) business license application must be filed for each place of business operated as a rental vehicle business. For the purposes of this section, "place of business" means a physical location at which arrangements to rent a rental vehicle may be made.

(c) Businesses operating in the form of a corporation, limited liability company, limited liability partnership, or similar form of legal entity must register their legal entity through the office of the secretary of state before applying for a rental vehicle business license.

(2) **What will I receive as proof that I qualified as a vehicle rental business?** A rental vehicle business registration number will be issued to your business and displayed on the ((~~master~~)) business license.

(3) **Can I transfer my business registration number to another company?** No. The rental vehicle business registration number issued through the ((~~master license~~)) business licensing service is not assignable or transferable, and is valid only for the rental vehicle business to which the registration number (R-number) was issued.

WSR 14-12-101
PERMANENT RULES
LIQUOR CONTROL BOARD
[Filed June 4, 2014, 11:26 a.m., effective July 5, 2014]

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

Purpose: The United States Post Office does not use postmarks on mail that has a bar code. The current rules need to address how the board will assess penalties on late payments when there is no postmark on the envelope.

Citation of Existing Rules Affected by this Order: Amending WAC 314-02-109, 314-19-020, 314-23-022, 314-23-042, and 314-28-080.

Statutory Authority for Adoption: RCW 66.08.030.

Adopted under notice filed as WSR 14-09-124 on April 23, 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 5, 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: June 4, 2014.

Sharon Foster
Chairman

AMENDATORY SECTION (Amending WSR 13-07-085, filed 3/20/13, effective 4/20/13)

WAC 314-02-109 What are the quarterly reporting and payment requirements for a spirits retailer license? (1) A **spirits retailer** must submit quarterly reports and payments to the board.

The required reports must be:

(a) On a form furnished by the board;

(b) Filed every quarter, including quarters with no activity or payment due;

(c) Submitted, with payment due, to the board on or before the twenty-fifth day following the tax quarter (e.g., Quarter 1 (Jan., Feb., Mar.) report is due April 25th). When the twenty-fifth 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; and

(d) Filed separately for each liquor license held.

(2) **What if a spirits retailer licensee fails to report or pay, or reports or pays late?** Failure of a spirits retailer licensee to submit its quarterly reports and payment to the board as required in subsection (1) of this section will be sufficient grounds for the board to suspend or revoke the liquor license.

A penalty of two percent per month will be assessed on any payments postmarked after the twenty-fifth day quarterly report is due. When the twenty-fifth 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 Washington state liquor control board, or designee, will be used to determine if penalties are to be assessed.

AMENDATORY SECTION (Amending WSR 12-24-091, filed 12/5/12, effective 1/5/13)

WAC 314-19-020 What if a licensee doesn't report or pay the taxes due, or reports or pays late? The board may take the following actions against a licensee or permit holder in order to collect any of the reports or taxes due that are outlined in this title.

(1) **Suspension or revocation of license**	(a) Failure to make a report and/or pay the taxes in the manner and dates outlined in this chapter will be sufficient ground for the board to suspend or revoke a liquor license, wine shipper permit, or certificate of approval (per RCW 66.08.150, 66.24.010, 66.24.120, 66.24.206, 66.20.370, 66.20.380, and 66.24.270).
	(b) The suspension will remain in effect until all missing reports and/or taxes have been filed with the board (see WAC 314-19-010(1) for the definition of "missing").
(2) **Penalties**	A penalty of two percent per month will be assessed on any tax payments postmarked after the twentieth day of the month following the reporting period of the transactions (per the reporting requirements outlined in WAC 314-19-015, RCW 66.24.290, and 66.24.210). 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 Washington state liquor control board, or designee, will be used to determine if penalties are to be assessed.
(3) **Surety bond requirements**	(a) **What is a surety bond?** A "surety bond" is a type of insurance policy that guarantees beer and/or wine tax payment to the state. The surety bond must be: (i) Executed by a surety company authorized to do business in the state of Washington; (ii) On a form and in an amount acceptable to the board; (iii) Payable to the Washington state liquor control board; and (iv) Conditioned that the licensee will pay the taxes and penalties levied by RCW 66.24.210 and/or 66.24.290. (v) As an option to obtaining a surety bond, a licensee may create an assignment of savings account for the board in the same amount as required for a surety bond. Requests for this option must be submitted in writing to the board's financial division. (b) **When will the board require a surety bond?** The board may require a surety bond from a Washington beer and/or wine distributor, domestic microbrewery, domestic brewery, public house, domestic winery, wine shipper, or a beer or wine certificate of approval holder that has a direct shipment privilege. If any of the following occur, the board may require the licensee or permit holder to obtain a surety bond or assignment of savings account, within twenty-one days after an administrative violation notice is issued: (i) A report or tax payment is missing, as defined in WAC 314-19-010, for two or more consecutive months; or (ii) A report or tax payment is missing, as defined in WAC 314-19-010, two or more times within a two year period. (c) **What will happen if the licensee does not acquire the surety bond or savings account?** Failure to meet the bonding or savings account requirements outlined in subsections (a) and (b) of this rule may result in immediate suspension of license privileges until all missing reports are filed and late taxes have been paid and the surety bond is acquired or the savings account is established.

	(d) **In what amount and for how long will the board require a surety bond?** The amount of a surety bond or savings account required by this chapter must be either $3,000, or the total of the highest four months' worth of tax liability for the previous twelve month period, whichever is greater. (i) The licensee or permit holder must maintain the bond for at least two years. After the two year period the licensee or permit holder may request an exemption as outlined in subsection (f) of this rule. (ii) Surety bond and savings account amounts may be reviewed annually and compared to the last twelve months' tax liability of the licensee. If the current bond or savings account amount does not meet the requirements outlined in this section, the licensee or permit holder will be required to increase the bond amount or amount on deposit within twenty-one days. (e) **What action will the board take when a licensee or permit holder holds a surety bond and does not pay taxes due or pays late?** If a licensee or permit holder holds a surety bond or savings account, the board will immediately start the process to collect overdue taxes from the surety company or assigned account. If the exact amount of taxes due is not known due to missing reports, the board will estimate the taxes due based on previous production, receipts, and/or sales. (f) **Can a licensee or permit holder request an exemption to the surety bond or savings account requirement?** A licensee or permit holder may make a written request to the board's financial division for an exemption from the surety bond or assignment of savings account requirements. The board will grant an exemption once the following criteria are met: (i) The licensee or permit holder has filed reports and paid applicable taxes to the board for at least two years immediately prior to the exemption request; and (ii) There have been no late or missing reports or tax payments during the previous two years. (iii) In order to remain exempt from the surety bond or assignment of savings account requirements, the licensee must continue to meet the tax reporting and payment requirements outlined in this title (outlined in WAC 314-19-015, RCW 66.24.206, 66.24.210, 66.24.270, 66.24.290, and 66.24.580).

AMENDATORY SECTION (Amending WSR 13-07-085, filed 3/20/13, effective 4/20/13)

WAC 314-23-022 What if a distributor licensee fails to report or pay, or reports or pays late? (1) Failure of a spirits distributor licensee to submit its monthly reports and payment to the board as required in WAC 314-23-021(1) will be sufficient grounds for the board to suspend or revoke the liquor license.

(2) 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 Washington state liquor control board, or designee, will be used to determine if penalties are to be assessed.

AMENDATORY SECTION (Amending WSR 12-12-065, filed 6/5/12, effective 7/6/12)

WAC 314-23-042 What if a certificate of approval licensee fails to report or pay, or reports or pays late? (1) If a spirits certificate of approval licensee does not submit its monthly reports and payment to the board as required by this subsection (1), the licensee is subject to penalties.

(2) 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 Washington state liquor control board, or designee, will be used to determine if penalties are to be assessed.

AMENDATORY SECTION (Amending WSR 13-07-085, filed 3/20/13, effective 4/20/13)

WAC 314-28-080 What if a distillery or craft distillery licensee fails to report or pay, or reports or pays late? Failure of a distillery or craft distiller to submit its monthly reports and payment to the board as required in WAC 314-28-070(1) will be sufficient grounds for the board to suspend or revoke the liquor license.

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 Washington state liquor control board, or designee, will be used to determine if penalties are to be assessed.

WSR 14-12-102
PERMANENT RULES
LIQUOR CONTROL BOARD
[Filed June 4, 2014, 11:27 a.m., effective July 5, 2014]

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

Purpose: The purpose of this rule making is to revise the brief adjudicatory proceedings (BAP) rules to include marijuana application denials and suspensions in the BAP process.

Statutory Authority for Adoption: RCW 66.08.030.

Adopted under notice filed as WSR 14-09-025 on April 9, 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 2, 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: June 4, 2014.

Sharon Foster
Chairman

AMENDATORY SECTION (Amending WSR 12-24-032, filed 11/28/12, effective 12/29/12)

WAC 314-42-110 Brief adjudicative proceedings. The Administrative Procedure Act provides for brief adjudicative proceedings in RCW 34.05.482 through 34.05.494. The board will conduct brief adjudicative proceedings where it does not violate any provision of law and where protection of the public interest does not require the board to give notice and an opportunity to participate to persons other than the parties. If an adjudicative proceeding is requested, a brief adjudicative proceeding will be conducted where the matter involves one or more of the following:

(1) Liquor license suspensions due to nonpayment of spirits taxes per RCW 66.24.010;

(2) Liquor license denials per WAC 314-07-065(2);

(3) Liquor license denials per WAC 314-07-040;

(4) Special occasion license application denials per WAC 314-07-040;

(5) Special occasion license application denials per WAC 314-07-065(7);

(6) MAST provider or trainer denials for noncompliance with a support order in accordance with RCW 66.20.085;

(7) MAST provider denials or revocations per WAC 314-17-070;

(8) Liquor license suspensions due to nonpayment of beer or wine taxes per WAC 314-19-015;

(9) One-time event denials for private clubs per WAC 314-40-080;

(10) Banquet permit denials per WAC 314-18-030;

(11) The restrictions recommended by the local authority on a nightclub license are denied per WAC 314-02-039 (a local authority may request a BAP);

(12) The restrictions recommended by a local authority are approved per WAC 314-02-039 (an applicant for a nightclub license may request a BAP);

(13) Liquor license suspensions due to noncompliance with a support order per RCW 66.24.010;

(14) Liquor license suspensions due to noncompliance with RCW 74.08.580(2), electronic benefits cards, per RCW 66.24.013;

(15) License suspension due to nonpayment of spirits liquor license fees per RCW 66.24.630;

(16) License suspension due to nonpayment of spirits distributor license fees per RCW 66.24.055; ((~~and~~))

(17) Tobacco license denials per WAC 314-33-005;

(18) Marijuana license denials per WAC 314-55-050(2);

(19) Marijuana license denials per WAC 314-55-050(4);

(20) Marijuana license denials per WAC 314-55-050(8);

(21) Marijuana license denials per WAC 314-55-050(10);

(22) Marijuana license suspensions per WAC 314-55-050(11);

(23) Marijuana license denials per WAC 314-55-050(12); and

(24) Marijuana license denials per WAC 314-55-050(13).

AMENDATORY SECTION (Amending WSR 12-24-032, filed 11/28/12, effective 12/29/12)

WAC 314-42-115 Preliminary record in brief adjudicative proceedings. (1) The preliminary record with respect to a liquor license suspension due to nonpayment of spirits taxes in RCW 66.24.010 shall consist of:

(a) All correspondence from department of revenue requesting missing taxes or reports; and

(b) Request from department of revenue to the liquor control board requesting suspension of the liquor license.

(2) The preliminary record with respect to a liquor license intent to deny under WAC 314-07-065(2) where the applicant has failed to submit information or documentation shall consist of:

(a) All correspondence between the applicant and the board pertaining to requests for information or documentation; and

(b) A copy of the application report prepared by licensing division staff.

(3) The preliminary record with respect to a liquor license application intent to deny where the applicant failed to meet the criminal history standards outlined in WAC 314-07-040 shall consist of:

(a) A copy of the application report prepared by licensing division staff;

(b) The personal/criminal history statement(s) submitted by the applicant;

(c) Any interoffice correspondence reporting criminal history of applicant(s); and

(d) Copies of any correspondence submitted by the applicant explaining or rebutting the criminal history findings.

(4) The preliminary record with respect to a special occasion liquor license application (chapter 314-05 WAC) intent to deny where the applicant failed to meet the criminal history standards outlined in WAC 314-07-040 shall consist of:

(a) A copy of the application report prepared by licensing division staff;

(b) The personal/criminal history statement(s) submitted by the applicant(s);

(c) Any interoffice correspondence reporting criminal history of applicant(s); and

(d) Copies of any correspondence submitted by the applicant explaining or rebutting the criminal history findings.

(5) The preliminary record with respect to a special occasion liquor license application (chapter 314-05 WAC) intent to deny where the application was objected to by the local authority wherein the event is scheduled (WAC 314-07-065(7)) shall consist of:

(a) A copy of the special occasion license application and supporting materials;

(b) A copy of the notice sent to the local authority by licensing division staff;

(c) A copy of the objection received from the local authority; and

(d) A copy of any correspondence from the applicant rebutting the objection from the local authority.

(6) The preliminary record with respect to suspension of mandatory alcohol server, provider or trainer, for noncompliance with a support order in accordance with RCW 66.20.085 shall consist of:

(a) A copy of the license suspension certification from the department of social and health services; and

(b) A copy of all documents received from or on behalf of the permit holder rebutting the identification of the server, provider, or trainer.

(7) The preliminary record with respect to suspension of mandatory alcohol server, provider or trainer, for failing to meet the criminal history standards outlined in WAC 314-07-070(1) shall consist of:

(a) A copy of the personal/criminal history statement submitted by the applicant;

(b) Any interoffice correspondence reporting criminal history of applicant; and

(c) Copies of any correspondence submitted by the applicant, permit holder, provider or trainer explaining or rebutting the criminal history findings.

(8) The preliminary record with respect to liquor license suspensions due to nonpayment of beer or wine taxes per WAC 314-19-015 shall consist of:

(a) Copies of any correspondence requesting missing taxes, fees, or penalties when identified after processing reporting form monthly; and

(b) Copies of backup documentation including envelopes showing late filing, corrections on reporting form, and audit findings.

(9) The preliminary record with respect to one-time event denials for private clubs in WAC 314-40-080 shall consist of:

(a) A copy of the written request for a one-time event;

(b) A copy of the written denial including the reason(s) for the denial; and

(c) Copies of all correspondence.

(10) The preliminary record with respect to banquet permit denials in WAC 314-18-030 shall consist of:

(a) The application for a banquet permit;

(b) A copy of the written denial including the reason(s) for denial; and

(c) All correspondence.

(11) The preliminary record with respect to denial of restrictions requested on a nightclub license by a local authority under the provisions in WAC 314-02-039 shall consist of:

(a) A copy of the application report prepared by licensing division staff and the threshold decision by the licensing director or his/her designee;

(b) A copy of all correspondence from the local authority requesting restrictions on the nightclub premises; and

(c) Copies of any correspondence submitted by the nightclub applicant or license holder rebutting the request for restrictions.

(12) The preliminary record with respect to licensing's approval of a request for restrictions on a nightclub license under the provisions of WAC 314-02-039 shall consist of:

(a) A copy of the application report prepared by licensing division staff and the threshold decision by the licensing director or his/her designee;

(b) A copy of all correspondence from the local authority requesting restrictions on the nightclub premises; and

(c) Copies of any correspondence submitted by the nightclub applicant or license holder rebutting the request for restrictions.

(13) The preliminary record with respect to a liquor license suspension due to noncompliance with a support order from the department of social and health services under RCW 66.24.010 shall consist of:

(a) The written request from department of social and health services to suspend the liquor license;

(b) A copy of the written liquor control board suspension order; and

(c) Copies of all correspondence.

(14) The preliminary record with respect to a liquor license suspension due to noncompliance with RCW 74.08.580, electronic benefits cards, per RCW 66.24.013 shall consist of:

(a) The written request from department of social and health services to suspend the liquor license;

(b) The complete investigation from department of social and health services to support the suspension;

(c) A copy of the written liquor control board suspension order; and

(d) Copies of all correspondence.

(15) The preliminary records with respect to liquor license suspension due to nonpayment of spirits liquor license fees per RCW 66.24.630 shall consist of:

(a) All correspondence relating to discrepancies in fees and/or penalties when identified after processing reporting forms; and

(b) All backup documentation including envelopes showing late filing, corrections on reporting forms, and audit findings.

(16) The preliminary records with respect to liquor license suspensions due to nonpayment of spirits distributor license fees per RCW 66.24.055 shall consist of:

(a) All correspondence requesting missing fees and/or penalties when identified after processing reporting forms; and

(b) All backup documentation including envelopes showing late filing, corrections on reporting forms, and audit findings.

(17) The preliminary record with respect to tobacco license denials shall consist of:

(a) The license application from business license services;

(b) The personal/criminal history statement submitted by the applicant;

(c) The judicial information system criminal history and division recommendation;

(d) The letter of denial from the liquor control board;

(e) The notice of intent to deny statement to the applicant; and

(f) All correspondence.

(18) The preliminary record with respect to a marijuana license intent to deny due to failure or refusal to submit information per WAC 314-55-050(2) shall consist of:

(a) All correspondence between the applicant and the board pertaining to requests for information or documentation; and

(b) A copy of the application report prepared by licensing division staff.

(19) The preliminary record with respect to a marijuana license application intent to deny where the applicant failed to meet the criminal history standards outlined in WAC 314-55-050(4) shall consist of:

(a) A copy of the application report prepared by licensing division staff;

(b) The personal/criminal history statement(s) submitted by the applicant;

(c) Any communication from the Washington state patrol or Federal Bureau of Investigation pertaining to the criminal history of the applicant;

(d) Any interoffice correspondence reporting criminal history of applicant(s); and

(e) Copies of any correspondence submitted by the applicant explaining or rebutting the criminal history findings.

(20) The preliminary record with respect to a marijuana license intent to deny due to denial, suspension, or cancellation of a marijuana license in another jurisdiction per WAC 314-55-050(8) shall consist of:

(a) A copy of the application report prepared by licensing division staff; and

(b) Documentation from any other state or jurisdiction demonstrating the action taken against the applicant.

(21) The preliminary record with respect to a marijuana license intent to deny due to proximity to the perimeter of entities listed in WAC 314-55-050(10) shall consist of:

(a) A copy of the application report prepared by licensing division staff;

(b) Any interoffice correspondence reporting the measurement from the proposed business location to the facility within one thousand feet;

(c) Documentation of measurement data including Geographic Positioning System (GPS) and related calculations; and

(d) Correspondence from the applicant illustrating alternative measurement data and/or rebuttal of the LCB's measurement data.

(22) The preliminary record with respect to a marijuana license intent to suspension due to nonpayment of marijuana excise taxes per WAC 314-55-050(11) shall consist of:

(a) All correspondence relating to discrepancies in fees and/or penalties when identified after processing reporting forms; and

(b) All backup documentation including envelopes showing late filing, corrections on reporting forms, and audit findings.

(23) The preliminary record with respect to a marijuana license intent to deny due to failure to submit an attestation concerning current tax obligations per WAC 314-55-050(12) shall consist of:

(a) A copy of the application report prepared by licensing division staff; and

(b) All correspondence with the applicant related to the request for this information.

(24) The preliminary record with respect to a marijuana license intent to deny due to denial, suspension, or revocation of a liquor license per WAC 314-55-050(13) shall consist of:

(a) A copy of the application report prepared by licensing division staff; and

(b) Documentation from liquor control board records or any other state demonstrating the action taken against the applicant.