WSR 18-19-039

PERMANENT RULES

NORTHWEST CLEAN AIR AGENCY

[Filed September 13, 2018, 3:05 p.m., effective October 14, 2018]

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

Purpose: This rule revision has five primary objectives:

- Clarify gasoline station (referred to as gasoline dispensing facility (GDF)) requirements and include periodic testing to ensure gasoline tanks at GDFs are operated and maintained in a vapor-tight condition and in good working order (NWCAA Section 580.6),
- Create a regulatory program to reduce emissions from spray coating operations including work practices and controls (NWCAA Section 508),
- Clarify and update the public records program to reflect recent changes in chapters 42.56 RCW and 44-14 WAC (NWCAA Section 106),
- Update general definition section to remove terms that are not used in the regulation, incorporate definitions from NWCAA Section 580, and add terms related to the GDF change (NWCAA Section 200), and
- Update adoption by reference list to allow NWCAA to implement the most recent version of the referenced state and federal rules and remove citations that do not need to be adopted by reference or have been deleted from WAC (NWCAA Section 104).

Citation of Rules Affected by this Order: New Section 508 of the Regulation of NWCAA; amending Sections 104, 106, 200, and 580.6 of the Regulation of NWCAA.

Statutory Authority for Adoption: Chapter 70.94 RCW.

Adopted under notice filed as WSR 18-14-004 on June 21, 2018.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 0, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.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: September 13, 2018.

Mark Buford
Executive Director

AMENDATORY SECTION

SECTION 104 - ADOPTION OF STATE AND FEDERAL LAWS AND RULES

104.1 All provisions of ((~~State Law~~)) the following state rules that are in effect as of June 21, 2018 ((~~8, 2016, which are pertinent to the operation of the NWCAA,~~)) are hereby adopted by reference and made part of the Regulation of the NWCAA((~~. Specifically, there is adopted by reference the portions pertinent to the operation of the NWCAA of the Washington State Clean Air Act (chapter 70.94 RCW), the Administrative Procedure Act (chapter 34.05 RCW) and chapters 43.21A and 43.21B RCW and the following state rules~~)): chapter 173-400 WAC, (except - -025, -030, -035, -036, -040(1)((~~,~~)) & (7), -045, -075, -099, -100, -101, -102, -103, -104, -105(7), -110, -114, -115, -116, -171, -930), chapter 173-401 WAC, chapter 173-407 WAC, chapter 173-420 WAC, chapter 173-425 WAC, chapter 173-430 WAC, chapter 173-433 WAC, chapter 173-434 WAC, chapter 173-435 WAC, chapter 173-441 WAC, chapter 173-442 WAC, chapter 173-450 WAC, chapter 173-460 WAC, chapter 173-476 ((~~470 WAC, chapter 173-474~~)) WAC, chapter 173-((~~475~~))480 WAC, chapter 173-481 WAC, chapter 173-485((~~490~~)) WAC, chapter 173-491 WAC((~~, chapter 173-492 WAC, and chapter 173-495 WAC~~)). The requirements of the NWCAA Regulation apply in addition to the state-wide regulations adopted and enforced under this paragraph.

104.2 All provisions of the following federal rules that are in effect as of June 21, 2018 ((~~8, 2016~~)) are hereby adopted by reference and made part of the Regulation of the NWCAA: ((~~40 CFR Part 50 (National Primary and Secondary Ambient Air Quality Standards);~~)) 40 CFR Part 51 (Requirements for Preparation, Adoption, and Submittal of Implementation Plans) Appendix M; 40 CFR Part 60 (Standards of Performance For New Stationary Sources) subparts A, D, Da, Db, Dc, E, Ea, Eb, Ec, F, G, Ga, H, I, J, Ja, K, Ka, Kb, L, M, N, Na, O, P, Q, R, T, U, V, W, X, Y, Z, AA, AAa, CC, DD, EE, GG, HH, KK, LL, MM, NN, PP, QQ, RR, SS, TT, UU, VV, VVa, WW, XX, AAA, BBB, DDD, FFF, GGG, GGGa, HHH, III, JJJ, KKK, LLL, NNN, OOO, PPP, QQQ, RRR, SSS, TTT, UUU, VVV, WWW, XXX, AAAA, CCCC, EEEE, IIII, JJJJ, KKKK, LLLL, OOOO, OOOOa, QQQQ, and Appendix A - I; 40 CFR Part 61 (National Emission Standards For Hazardous Air Pollutants) Subparts A, C, D, E, F, J, L, M, N, O, P, V, Y, BB, FF; 40 CFR Part 62 (Approval and Promulgation of State Plans for Designated Facilities and Pollutants) Subpart LLL; 40 CFR Part 63 (National Emission Standards for Hazardous Air Pollutants for Source Categories) Subparts A, B, C, D, F, G, H, I, L, M, N, O, Q, R, T, U, W, X, Y, AA, BB, CC, DD, EE, GG, HH, II, JJ, KK, OO, PP, QQ, RR, SS, TT, UU, VV, WW, XX, YY, CCC, DDD, EEE, GGG, HHH, III, JJJ, LLL, MMM, NNN, OOO, PPP, QQQ, TTT, UUU, VVV, XXX, AAAA, CCCC, DDDD, EEEE, FFFF, GGGG, HHHH, IIII, JJJJ, KKKK, MMMM, NNNN, OOOO, PPPP, QQQQ, RRRR, SSSS, TTTT, UUUU, VVVV, WWWW, XXXX, YYYY, ZZZZ, AAAAA, BBBBB, CCCCC, DDDDD, EEEEE, FFFFF, GGGGG, HHHHH, IIIII, LLLLL, MMMMM, NNNNN, PPPPP, QQQQQ, RRRRR, SSSSS, TTTTT, UUUUU, WWWWW, YYYYY, ZZZZZ, BBBBBB, CCCCCC, EEEEEE, FFFFFF,

GGGGGG, HHHHHH, JJJJJJ, MMMMMM, NNNNNN, QQQQQQ, SSSSSS, TTTTTT, VVVVVV, WWWWWW, XXXXXX, ZZZZZZ, AAAAAAA, DDDDDDD, EEEEEEE, and HHHHHHH; ((~~40 CFR Part 65 (Consolidated Federal Air Rule);~~)) and 40 CFR Parts 72, 73, 74, 75, 76, 77 and 78 (Acid Rain Program).

PASSED: July 8, 1970 AMENDED: April 14, 1993, September 8, 1993, December 8, 1993, October 13, 1994, May 11, 1995, February 8, 1996, May 9, 1996, March 13, 1997, May 14, 1998, November 12, 1998, November 12, 1999, June 14, 2001, July 10, 2003, July 14, 2005, November 8, 2007, June 10, 2010, June 9, 2011, November 17, 2011, August 9, 2012, March 14, 2013, September 11, 2014, August 13, 2015, August 11, 2016, September 13, 2018

AMENDATORY SECTION

SECTION 106 - PUBLIC RECORDS

((~~106.1 The purpose of this section is to implement the requirements of RCW 42.56 Public Records.~~

~~106.2 Definitions~~

~~106.21 The terms "agency", "public record", and "writing" shall have the same meaning as stated in RCW 42.17.020.~~

~~106.3 Public records available~~

~~106.31 All public records of the NWCAA are available for public inspection and copying at its office located at 1600 South Second Street, Mount Vernon, Washington 98273-5202 pursuant to these rules subject to subsections 106.32, 106.33, and 106.34 of this section.~~

~~106.32 Availability of public records is subject to exemptions and requirements of RCW 42.56.070.~~

~~106.33 When a public record includes information, the disclosure of which would lead to an unreasonable invasion of personal privacy, and the NWCAA becomes aware of this fact, the NWCAA shall delete such information before making the record available.~~

~~106.34 Within 5 days of receiving a public records request the NWCAA will respond by either:~~

~~(a) Providing the records requested~~

~~(b) Acknowledging the request and providing a reasonable estimate of time the agency needs to respond to the request, or~~

~~(c) Denying the public request.~~

~~106.4 Records Index. The NWCAA does not maintain an index of just the public records listed in RCW 42.56.070. The NWCAA's Board of Directors are of the opinion that the establishment of such an index would be unduly burdensome and interfere with the NWCAA's operation because a significant and integral portion of the NWCAA's records are exempt from public inspection and copying pursuant to RCW 42.56.070. The release of such records would be an unreasonable invasion of personal privacy or the violation of the confidentiality of records and information provisions of the State Clean Air Act (RCW 70.94.205).~~

~~The NWCAA is in substantive compliance with RCW 42.56.070 by making available for public inspection and copying public records listed in RCW 42.56.070 (7)(a)(b), (8) and (9). These include promulgated regulations of the NWCAA, final opinions made in adjudicated cases, minutes and resolutions of the Board of Directors, monthly activity reports, policy memorandums of the Control Officer, logs of Notice of Violations issued, upset, breakdown and startup reports, assessment of penalties, index of registered sources, annual emission inventory summaries and summaries of ambient air monitoring data, annual state and federal grant applications, including the annual program plan, certification to operate, inspection reports for air pollution sources, variance and notice of construction records with confidential records and information deleted in accordance with RCW 70.94.205.~~

~~The Control Officer or designee shall assist any person to obtain public records requested from the NWCAA's record files.~~

~~106.5 Request for public records.~~

~~106.51 All requests for inspection or copying of public records shall be made on a form as follows:~~

~~106.52 REQUEST FOR PUBLIC RECORDS~~

~~Date: Time:~~
~~Name:~~
~~Address:~~
~~Telephone No.:~~
~~Description of Records:~~

~~I certify that lists of individuals obtained through this request for public records will not be used for commercial purposes.~~

~~Signature~~

~~**FOR NWCAA USE:**~~
~~Number of Copies:~~
~~Number of Pages:~~
~~Per Page Charge: $~~
~~Total Charge: $~~

~~All requests made in person may be made at the NWCAA office during regular business hours, Monday through Friday, exceluding legal holidays.~~

~~A request for inspection or copying of public records may be made by mail, email or fax containing the following information:~~

~~(a) The name and address of the person making the request and the organization the person represents.~~

~~(b) The time of day and calendar date on which the person wishes to inspect the public records.~~

~~(c) A description of the public records requested.~~

~~(d) A statement whether access to copying equipment is desired.~~

~~(e) A phone number where the person can be reached in case the Control Officer or designee needs to contact the person for further description of the material or any other reason.~~

~~(f) A signed statement certifying that the person making the request will not use, for commercial purposes, any information which identifies an individual or individuals.~~

~~All requests must be received by the NWCAA at least three business days before the requested date of inspection to allow the Control Officer or designee to make certain the requested records are available and not exempt and, if necessary, to contact the person requesting inspection.~~

~~106.6 Fees. No fee shall be charged for the inspection of public records. For printed, typed and written material a maximum size of 8 1/2" by 14", the NWCAA shall charge a reasonable fee, determined from time to time by the Control Officer, for providing copies of public records and for use of the NWCAA's copy equipment, payable at the time copies are furnished. This charge is the amount necessary to reimburse the NWCAA for its actual costs incident to such copying. Copies of maps, photos, reports, and other nonstandard items shall be furnished at the regular price established by the NWCAA. When other special copy work for nonstandard items is requested, the fee charged will reflect the total cost, including the time of NWCAA personnel.~~

~~106.7 Statement of reason for denial of public records request. When the NWCAA refuses, in whole or part, a written request for inspection of any public record, it shall include a statement of the specific exemption authorizing the refusal and a brief explanation of how the exemption applies to the record withheld.~~

~~106.8 Review of denials of public records request.~~

~~106.81 Any person who objects to the refusal of a written request for a public record may petition for prompt review of such decision by tendering a written request for review. The written request shall specifically refer to the written statement by the Control Officer or designee which constituted or accompanied the refusal.~~

~~106.82 Immediately after receiving a written request for review of a decision denying a public record, the Control Officer or designee denying the request shall refer it to the NWCAA Board of Directors. The Board shall promptly consider the matter and either affirm or reverse such refusal. The final decision shall be sent to the objecting persons.~~

~~106.83 Whenever the agency concludes that a public record is exempt from disclosure and denies a person opportunity to inspect or copy a public record for that reason, the person may request judicial review of the agency decision.~~

~~106.9 Protection of public records. In order to adequately protect the public records of the NWCAA, the following guidelines shall be adhered to by any person inspecting such public records:~~

~~106.91 No public records shall be removed from the NWCAA premises.~~

~~106.92 Inspection of any public record shall be conducted in the presence of a designated NWCAA employee.~~

~~106.93 No public records may be marked or defaced in any manner during inspection.~~

~~106.94 Public records, which are maintained in a file or jacket, or chronological order, may not be dismantled except for purposes of copying and then only by the Control Officer or designee.~~

~~106.95 Access to file cabinets, shelves, and other storage areas is restricted to NWCAA personnel, unless other arrangements are made with the Control Officer or designee.~~))

106.1 AUTHORITY AND PURPOSE.

(A) The Northwest Clean Air Agency (NWCAA) will make available for inspection and copying nonexempt public records in accordance with the Public Records Act, chapter 42.56 RCW. The Public Records Act defines public records to include any writing containing information relating to the conduct of government or the performance of any governmental or proprietary function prepared, owned, used, or retained by the agency.

(B) The purpose of this section is to establish the procedures the NWCAA will follow in order to provide full access to nonexempt public records. These sections provide information to persons wishing to request access to public records of the NWCAA and establish processes for both requesters and NWCAA staff that are designed to best assist members of the public in obtaining records.

106.2 AGENCY CONTACT INFORMATION

(A) Any person wishing to request access to public records of the NWCAA, or seeking assistance in making such a request should contact the Public Records Officer of the NWCAA:

Public Records Officer
Northwest Clean Air Agency
1600 S Second St
Mount Vernon, WA 98273-5202
Phone: 360-428-1617
Facsimile: 360-428-1620
Email: PublicInformationRequests@nwcleanairwa.gov
Requests may be submitted on the NWCAA website at www.nwcleanairwa.gov.

(B) Duties of Public Records Officer. The Public Records Officer will oversee compliance with this section but another NWCAA staff member may process the request. Therefore, any reference to the Public Records Officer in this section may refer to the Public Records Officer or designee.

106.3 AVAILABILITY OF PUBLIC RECORDS.

(A) Public records are available for inspection Monday through Friday during the hours of 8:30 a.m. to 4:00 p.m., excluding legal holidays. Records must be inspected at the NWCAA office. Arrangements to inspect records should be made in advance with the Public Records Officer.

(B) The NWCAA finds that maintaining an index is unduly burdensome and would interfere with agency operations due to the agency's small size and the high volume and types of public records generated and received by the agency.

(C) The NWCAA will maintain its records in a reasonably organized manner. The NWCAA will take reasonable actions to protect records from damage and disorganization.

(D) Making a Request for Public Records. Any person wishing to inspect or to have copies made of public records should make this request in writing by letter, email sent to PublicInformationRequests@nwcleanairwa.gov, or through the NWCAA website at www.nwcleanairwa.gov.

(1) The request should include the following information:

(a) Name of requester;

(b) Address of requester;

(c) Other contact information, including telephone number and email address;

(d) Identification of the information or records sought adequate to locate the records; and

(e) The date and time of day of the request.

(2) The Public Records Officer may accept requests for public records by telephone or in person. The Public Records

Officer will confirm receipt of the request and summarize the request in writing.

(3) If requesters refuse to identify themselves or provide sufficient contact information, the NWCAA will respond to the extent feasible and consistent with the law.

106.4 PROCESSING OF PUBLIC RECORDS REQUESTS

(A) The Public Records Officer will provide the fullest assistance to requesters and prevent excessive interference with other essential functions of the NWCAA.

(B) Within 5 business days of receipt of a request, the Public Records Officer will do one or more of the following:

(1) Make the records available for inspection.

(2) Provide a copy of the record.

(a) If photocopies or scanned copies are requested, the Public Records Officer will notify the requester with an estimated cost of the copies and make arrangements for payment.

(b) If the records are available on the NWCAA website, the Public Records Officer will provide an internet address to the specific records requested.

(3) Provide a reasonable estimate of when records or an installment of records will be available.

(4) Ask the requester to provide clarification for a request that is unclear. If the requester fails to respond to a request for clarification and the entire request is unclear, the NWCAA need not respond to it. The NWCAA will respond to those portions of a request that are clear.

(5) Deny the request.

(C) If the NWCAA does not respond within 5 business days of receipt of the request, the requester should contact the Public Records Officer to determine the reason for the failure to respond.

(D) The NWCAA will notify the requester when records are available for inspection and provide space to review documents. No member of the public may remove a document from the designated reviewing area or from the file. The requester shall indicate which documents he or she wishes the NWCAA to copy.

(E) The Public Records Officer will evaluate the request according to the nature and volume of the request. The Public Records Officer will process requests in the order allowing the most requests to be processed in the most efficient manner.

(F) When the request is for a large number of records, the Public Records Officer may provide access for inspection or send copies in installments.

(G) If, after the NWCAA has informed the requester that it has provided all available records, the NWCAA becomes aware of additional responsive documents existing at the time of the request, the Public Records Officer will promptly inform the requester of the additional documents and provide them on an expedited basis.

(H) When the requester either withdraws the request, fails to clarify an unclear request, fails to pay the deposit, fails to make final payment for the requested copies, or fails to inspect or claim the requested records within 30 days after notification, the Public Records Officer may close the request and refile the records.

106.5 COSTS OF PROVIDING COPIES OF PUBLIC RECORDS

(A) There is no fee for inspecting public records or for the NWCAA's time spent locating public documents and making them available. There is no fee for providing electronic records if they already exist in an electronic format.

(B) The NWCAA is not calculating actual costs for copying its records because to do so would be unduly burdensome for the following reasons: the NWCAA does not have the resources to conduct a study to determine actual copying costs for all its records and to conduct such a study would interfere with other essential agency functions. Therefore, in order to timely implement a fee schedule consistent with the public records act, it is more cost efficient, expeditious and in the public interest for the NWCAA to adopt the state legislature's approved fees and costs for most of the NWCAA records, as authorized in RCW 42.56.120 and as published in NWCAA 106.5(C).

(C) The costs for copying and conveying records are as follows:

Public Records Fee Schedule	
15 cents/ standard page	Photocopies provided by NWCAA staff using agency equipment - no fee for first 100 pages per request
10 cents/ standard page	Scanned documents provided by NWCAA staff using agency equipment (if the documents are not already in electronic format) - no fee for first 100 pages per request
Actual cost	Digital storage media or devices
Actual cost	Any container or envelope used to mail copies
Actual cost	Postage or delivery charges
Actual cost	Copying or scanning charged by an outside vendor
Actual cost	Expertise to prepare data compilations or provide customized electronic access services
Actual cost	Retrieving documents out of storage
Other	Other charges allowed in RCW 42.56.120

(D) Payment may be made with a credit card on-line, cash, check, or money order made out to the Treasurer of the NWCAA.

106.6 EXEMPT RECORDS

(A) The Public Records Act provides that some records are exempt in whole or in part from public inspection and copying. In addition to the list of exemptions in RCW 42.56.050, RCW 42.56.210 through RCW 42.56.400, and WAC 44-14-060, common exemptions include:

(1) Confidential business information. The owner or operator of a source may certify that a record or information provided to the agency is confidential because it relates to a process or production unique to the owner or operator or is likely to affect adversely the competitive position if released. Emission and ambient air quality data are excluded from any confidential claim. (RCW 70.94.205)

(2) Attorney-client communications. Communication between an attorney, who is acting as counsel or advisor, and NWCAA staff is confidential unless a member of the public is copied on that communication (RCW 5.60.060 (2)(a))

(3) Preliminary drafts, notes, recommendations, and intra-agency memorandums (RCW 42.56.280)

(4) List of individuals (private or natural persons) for commercial purpose. The NWCAA is prohibited by statute from disclosing lists of individuals for commercial purposes (RCW 42.56.070(8))

(5) Investigative records and information pertaining to ongoing investigations where premature disclosure could jeopardize effective law enforcement or any person's right to privacy. (RCW 42.56.240(1))

(6) Identity of persons who file a complaint with the NWCAA if disclosure would endanger any person's life, physical safety or property. If at the time a complaint is filed, the complainant indicates a desire for nondisclosure, such desire shall govern (RCW 42.56.240(2))

(B) For records or portions of records that are withheld, the Public Records Officer will document the applicable exemption and provide a brief written explanation as to why the record or portion of the record is being withheld.

(C) In the event that the requested public records contain information that may affect rights of others and may be exempt from disclosure, the Public Records Officer may, prior to providing the public records, give notice to such others whose rights may be affected by the disclosure.

106.7 REVIEW OF DENIALS OF PUBLIC RECORD

(A) Any person who objects to the initial denial or partial denial of a records request may petition in writing to the Control Officer of the NWCAA for a review of that decision. The petition shall include a copy of the written statement by the Public Records Officer denying the request.

(B) The Control Officer or designee will either affirm or reverse the denial within 10 business days following the NWCAA's receipt of the petition.

(C) Any person may petition the Skagit County Superior Court for a review of denials of public records requests pursuant to RCW 42.56.550 at the conclusion of 10 business days after the initial denial regardless of any internal appeal process.

PASSED: August 9, 1978 AMENDED: November 8, 2007, September 13, 2018

AMENDATORY SECTION

SECTION 200 - DEFINITIONS

The terms used in the Regulation of the NWCAA are defined in this section as follows:

ACTUAL EMISSIONS - The actual rate of emissions of a pollutant from an emission unit, as determined in accordance with ((~~a~~)) (A) through ((~~e~~)) (C) of this definition.

((~~a~~)) (A) In general, the actual emissions as of a particular date shall equal the average rate, in tons per year, at which the emissions unit actually emitted the pollutant during a two-year period which precedes the particular date and which is representative of normal stationary source operation. The NWCAA shall allow the use of a different time period upon a determination by the NWCAA that it is more representative of normal stationary source operation. Actual emissions shall be calculated using the emissions unit's actual operating hours, production rates, and types of materials processed, stored, or combusted during the selected time period.

((~~b~~)) (B) The NWCAA may presume that stationary source-specific allowable emissions for the unit are equivalent to the actual emissions of the emissions unit.

((~~c~~)) (C) For any emissions unit that ((~~which~~)) has not begun normal operations on the particular date, actual emissions shall equal the potential to emit of the emissions unit on that date.

((~~ADVERSE IMPACT ON VISIBILITY - Adverse impact on visibility is defined in WAC 173-400-117.~~))

AIR CONTAMINANT or AIR POLLUTANT - Dust, fumes, mist, smoke, other particulate matter, vapor, gas, odorous substance, or any combination thereof. ((~~"Air pollutant" means the same as "air contaminant."~~))

AIR POLLUTION - The presence in the outdoor atmosphere of one or more air contaminants in sufficient quantities and of such characteristics and duration as is, or is likely to be, injurious to human health, plant, or animal life, or property, or which unreasonably interfere with enjoyment of life and property. For the purposes of ((~~this r~~)) the NWCAA Regulation, air pollution shall not include air contaminants emitted in compliance with chapter 17.21 RCW, the Washington Pesticide Application Act, which regulates the application and control of the use of various pesticides.

AIR QUALITY OBJECTIVE - The concentration and exposure time of one or more air contaminants in the ambient air below which, according to available knowledge, undesirable effects will not occur.

((~~AIR QUALITY STANDARD - An established concentration, exposure time and frequency of occurrence of one or more air contaminants in the ambient air which shall not be exceeded.~~))

ALLOWABLE EMISSIONS - The emission rate of a stationary source calculated using the maximum rated capacity of the stationary source (unless the stationary source is subject to federally enforceable limits which restrict the operating rate, or hours of operation, or both) and the most stringent of the following:

((~~a~~)) (A) The applicable standards as in 40 CFR Part 60, 61 or 63;

((~~b~~)) (B) Any applicable SIP emissions limitation including those with a future compliance date; or

((~~c~~)) (C) The emissions rate specified as a federally enforceable permit condition, including those with a future compliance date.

AMBIENT AIR - The surrounding outside air.

AMBIENT AIR QUALITY STANDARD or AIR QUALITY STANDARD - An established concentration, exposure time, and frequency of occurrence of one or more air contaminants((~~s~~)) in the ambient air which shall not be exceeded.

AMBIENT AIR MONITORING STATION - A station so designated by the Control Officer for the purpose of measuring air contaminant concentrations in the ambient air. ((~~The station location and sampling probe locations shall be designated by the Control Officer utilizing as a guide 40 CFR Part 58, Appendix "D" Network Design and Appendix "E" Probe Siting Criteria.~~))

ATTAINMENT AREA - A geographic area designated by EPA at 40 CFR Part 81 as having attained the National Ambient Air Quality Standard (NAAQS) for a given criteria pollutant.

BEGIN ACTUAL CONSTRUCTION - In general, initiation of physical on-site construction activities on an emissions unit which are of a permanent nature. Such activities include, but are not limited to, installation of building supports and foundations, laying underground pipe work, and construction of

permanent storage structures. With respect to a change in method of operation, this term refers to those on-site activities other than preparatory activities which mark the initiation of the change.

BEST AVAILABLE CONTROL TECHNOLOGY (BACT) - An emission limitation based on the maximum degree of reduction for each air pollutant subject to regulation under chapter 70.94 RCW emitted from or which results from any new or modified stationary source, which the NWCAA, on a case-by-case basis, taking into account energy, environmental, and economic impacts, and other costs, determines is achievable for such stationary source or modification through application of production processes and available methods, systems, and techniques, including fuel cleaning, clean fuels, or treatment or innovative fuel combustion techniques for control of each such pollutant. In no event shall application of the ((")Best Available Control Technology((")) result in emissions of any pollutants which will exceed the emissions allowed by any applicable standard under 40 CFR Parts 60, 61, and 63. Emissions from any stationary source utilizing clean fuels, or any other means, to comply with this paragraph shall not be allowed to increase above levels that would have been required under the definition of BACT in the Federal Clean Air Act as it existed prior to enactment of the Clean Air Act Amendments of 1990.

BOARD - Board of Directors of the NWCAA.

BOTTOM LOADING - The filling of a tank through a line entering the bottom of the tank.

BUBBLE - A set of emission limits which allows an increase in emissions from a given emissions unit in exchange for a decrease in emissions from another emissions unit, pursuant to RCW 70.94.155 and WAC 173-400-120.

BULK GASOLINE PLANT - A gasoline storage and transfer facility that receives more than 90 percent of its annual gasoline throughput by transport tank and reloads gasoline into transport tanks.

BUSINESS ESTABLISHMENT - A facility and/or place where commercial and/or professional dealings are conducted.

CATALYTIC CRACKING UNIT - A petroleum refinery cracking unit of the fluid or compact moving bed type consisting of a reactor, regenerator, and fractionating tower and, where employed, a carbon monoxide boiler.

((~~CLASS I AREA - Any area designated under section 162 or 164 of the Federal Clean Air Act as a Class I area. The following areas are the Class I areas in Washington state:~~

~~a) Alpine Lakes Wilderness;~~

~~b) Glacier Peak Wilderness;~~

~~c) Goat Rocks Wilderness;~~

~~d) Mount Adams Wilderness;~~

~~e) Mount Rainier National Park;~~

~~f) North Cascades National Park;~~

~~g) Olympic National Park;~~

~~h) Pasayten Wilderness; and~~

~~i) Spokane Indian Reservation~~))

((~~COMBUSTION and INCINERATION UNITS - Units using combustion for waste disposal, steam production, chemical recovery or other process requirements; but excludes open burning.~~

~~COMMENCE - As applied to construction, the owner or operator has either:~~

~~(1) Begun, or caused to begin, a continuous program of actual on-site construction of the stationary source, to be completed within a reasonable time; or~~

~~(2) Entered into binding agreements or contractual obligations, which cannot be cancelled or modified without substantial loss to the owner or operator, to undertake a program of actual construction of the stationary source to be completed within a reasonable time.~~))

CLOSED REFINERY SYSTEM - A disposal system that will process or dispose of those VOC collected from another system.

COMMERCIAL COMPOSTING FACILITY - A facility that is operated for the purpose of selling or off-site distribution of compost produced via the controlled biological degradation of organic material.

((~~COMPLAINANT - Any person who files a complaint.~~))

COMPLIANCE ORDER - An order issued by the NWCAA pursuant to the authority of RCW 70.94.332 and 70.94.141 (3) that addresses or resolves a compliance issue regarding any requirement of chapter 70.94 RCW or the rules adopted thereunder. Compliance orders may include, but are not limited to, time schedules and/or necessary actions for preventing, abating, or controlling emissions.

CONCEALMENT - Any action taken to reduce the observed or measured concentrations of a pollutant in a gaseous effluent while, in fact, not reducing the total amount of pollutant discharged.

CONTROL FACILITY - Includes any treatment works, control devices and disposal systems, machinery equipment, structures, property or any part of accessories thereof, installed or acquired for the primary purpose of reducing, controlling, or disposing of industrial waste which, if released to the outdoor atmosphere, could cause air pollution.

CONTROL OFFICER - Air Pollution Control Officer of the NWCAA, also known as Director.

CRITERIA POLLUTANT - A pollutant for which there is established a National Ambient Air Quality Standard at 40 CFR Part 50. The criteria pollutants are carbon monoxide (CO), particulate matter, ozone (O_3), sulfur dioxide (SO_2), lead (Pb), and nitrogen dioxide (NO_2).

CUTBACK ASPHALT - An asphalt that has been blended with more than 7 percent petroleum distillates by weight.

DAYLIGHT HOURS - The hours between official sunrise and official sunset.

DISPOSAL SYSTEM - A process or device that reduces the mass quantity of the uncontrolled VOC emissions by at least 90 percent.

ECOLOGY - Washington State Department of Ecology (WDOE).

EMISSION - A release of air contaminants into the ambient air.

EMISSION REDUCTION CREDIT (ERC) - A credit granted pursuant to WAC 173-400-131. This is a voluntary reduction in emissions.

EMISSION POINT - The location (place in horizontal plane and vertical elevation) from which an emission enters the atmosphere.

EMISSION STANDARD, ((~~and~~)) EMISSION LIMITATION, or EMISSION LIMIT - A requirement established under the Federal Clean Air Act or chapter 70.94 RCW which limits the quantity, rate, or concentration of emissions of air contaminants on a continuous basis, including any requirement relating to the operation or maintenance of a stationary source to assure continuous emission reduction and any design, equipment work practice, or operational standard adopted under the Federal Clean Air Act or chapter 70.94 RCW.

EMISSIONS UNIT - Any part of a stationary source or source which emits or would have the potential to emit any pollutant subject to regulation under the Federal Clean Air Act, ((~~C~~)) chapter 70.94 RCW, ((~~C~~)) chapter 70.98 RCW, or the Regulation of the NWCAA.

EQUIPMENT - Any stationary or portable device or any part thereof capable of causing the emission of any contaminant into the atmosphere or ambient air.

EXCESS EMISSIONS - Emissions of an air pollutant in excess of any applicable emission standard.

((~~EXISTING STATIONARY FACILITY - Is defined in WAC 173-400-151.~~))

FEDERAL CLEAN AIR ACT (FCAA) - The Federal Clean Air Act, also known as Public Law 88-206, 77 Stat. 392, December 17, 1963, 42 U.S.C. 7401 et seq., as last amended by the Clean Air Act Amendments of 1990, P.L. 101-549, November 15, 1990.

((~~FEDERAL CLASS I AREA - Any federal land that is classified or reclassified Class I area. The following areas are the Class I areas in Washington state:~~

~~a) Alpine Lakes Wilderness;~~

~~b) Glacier Peak Wilderness;~~

~~c) Goat Rocks Wilderness;~~

~~d) Mount Adams Wilderness;~~

~~e) Mount Rainier National Park;~~

~~f) North Cascades National Park;~~

~~g) Olympic National Park; and~~

~~h) Pasayten Wilderness~~

~~FEDERAL LAND MANAGER - The secretary of the department with authority over federal lands in the United States. This includes, but is not limited to, the U.S. Department of the Interior - National Park Service, the U.S. Department of Agriculture - Forest Service, and/or the U.S. Department of the Interior - Bureau of Land Management.~~))

FEDERALLY ENFORCEABLE - All limitations and conditions which are enforceable by EPA, including those requirements developed under 40 CFR Parts 60, 61 and 63, requirements within the Washington SIP, requirements within any permit established under 40 CFR 52.21 or order of approval under a SIP-approved new source review regulation, or any voluntary limits on emissions pursuant to WAC 173-400-091.

((~~FIRE CHIEF - A state, county, or city fire marshal, city fire chief, chief of each County Fire Protection District or authorized forestry officials from the Washington State Department of Natural Resources.~~))

FUEL BURNING EQUIPMENT - ((~~Equipment that produces hot air, hot water, steam, or other heated fluids by external combustion of fuel.~~)) Any device used for the external combustion of fuel for the primary purpose of producing useful heat or power.

FUGITIVE DUST - A particulate emission made airborne by forces of wind, man's activity, or both. Unpaved roads, construction sites, and tilled land are examples of areas that generate ((~~originate~~)) fugitive dust. Fugitive dust is a type of fugitive emission.

FUGITIVE EMISSIONS - Emissions which could not reasonably pass through a stack, chimney, vent, or other functionally equivalent opening.

GASOLINE - A petroleum distillate that is liquid at standard conditions, has a true vapor pressure greater than 4 psia at 20 degrees C, and is used as a fuel for internal combustion engines.

GASOLINE DISPENSING FACILITY (GDF) - Any stationary facility that dispenses gasoline into the fuel tank of a motor vehicle, motor vehicle engine, nonroad vehicle, or nonroad engine, including a nonroad vehicle or nonroad engine used solely for competition. These facilities include, but are not limited to, facilities that dispense gasoline into on- and off-road, street, or highway motor vehicles, lawn equipment, boats, test engines, landscaping equipment, generators, pumps, and other gasoline-fueled engines and equipment.

GASOLINE LOADING TERMINAL - A gasoline transfer facility that receives more than 10 percent of its annual gasoline throughput solely or in combination by pipeline, ship, or barge, and loads gasoline into transport tanks.

GREENHOUSE GASES (GHGs) - Includes carbon dioxide, methane, nitrous oxide, hydrofluorocarbons, perfluorocarbons, and sulfur hexafluoride.

HAZARDOUS AIR POLLUTANT (HAP) - Any air pollutant listed in or pursuant to Section 112(b) of the Federal Clean Air Act, 42 U.S.C. §7412.

((~~HEARINGS BOARD - The state Pollution Control Hearings Board or equivalent local hearings board as set forth in RCW 43.21B.~~))

HEAT INPUT CAPACITY - ((~~Is the~~)) The maximum actual or design heat capacity, whichever is greater, stated in British thermal units per hour (BTU/hr), generated by the stationary source and ((~~shall be~~)) expressed using the higher heating value of the fuel unless otherwise specified.

((~~HOG FUEL BOILER - A boiler that utilizes wood, commonly called "hog fuel", as one source of fuel.~~))

INCINERATOR - A furnace used primarily for the thermal destruction of waste.

INSTALLATION - The placement, assemblage, or construction of equipment or control equipment at the premises where the equipment or control equipment will be used, and includes all preparatory work at such premises.

((~~LOWEST ACHIEVABLE EMISSION RATE (LAER) - For any stationary source that rate of emissions which reflects the more stringent of:~~

~~a) The most stringent emission limitation which is contained in the implementation plan of any state for such class or category of source, unless the owner or operator of the proposed new or modified stationary source demonstrates that such limitations are not achievable; or~~

~~b) The most stringent emission limitation which is achieved in practice by such class or category of source.~~

~~In no event shall the application of this term permit a proposed new or modified stationary source to emit any pol-~~

~~lutant in excess of the amount allowable under applicable New Source Performance Standards.~~))

MAJOR MODIFICATION - ((~~a~~)) (A) ((~~"~~))Major modification((~~"~~)) as it applies to stationary sources subject to requirements for new stationary sources in nonattainment areas, is defined in WAC 173-400-112. ((~~b~~)) (B) ((~~"~~))Major modification((~~"~~)) as it applies to stationary sources subject to requirements for new stationary sources in attainment or unclassified areas is defined in WAC 173-400-113.

MAJOR STATIONARY SOURCE - ((~~a~~)) (A) ((~~"~~))Major stationary source((~~"~~)) as it applies to stationary sources subject to requirements for new stationary sources in nonattainment areas is defined in WAC 173-400-112. ((~~B~~)) (B) ((~~"~~))Major stationary source((~~"~~)) as it applies to stationary sources subject to requirements for new stationary sources in attainment or unclassified areas is defined in WAC 173-400-113.

((~~MANDATORY CLASS I FEDERAL AREA - any area defined in Section 162(a) of the Federal Clean Air Act. The following areas are the mandatory Class I federal areas in Washington state:~~

~~a) Alpine Lakes Wilderness;~~

~~b) Glacier Peak Wilderness;~~

~~c) Goat Rocks Wilderness;~~

~~d) Mount Adams Wilderness;~~

~~e) Mount Rainier National Park;~~

~~f) North Cascades National Park;~~

~~g) Olympic National Park; and~~

~~h) Pasayten Wilderness~~))

MASKING - The mixing of a chemically nonreactive control agent with a malodorous gaseous effluent to change the perceived odor.

MATERIAL((~~S~~)) HANDLING - The handling, transporting, loading, unloading, storage, and transfer of materials with no significant chemical or physical alteration.

((~~MERCURY - The element mercury, excluding any associated elements and includes mercury in particulates, vapors, aerosols, and compounds.~~

~~MERCURY ORE - A mineral mined specifically for its mercury content.~~))

MODIFICATION - Any physical change in, or change in the method of operation of, a stationary source that increases the amount of any air contaminant emitted by such stationary source or that results in the emissions of any air contaminant not previously emitted. The term modification shall be construed consistent with the definitions of modification in Section 7411, Title 42, United States Code, and with rules implementing that section.

MULTIPLE CHAMBER INCINERATOR - Any incinerator consisting of two or more combustion chambers in series, employing adequate design parameters necessary for maximum combustion of the material to be burned.

NATIONAL AMBIENT AIR QUALITY STANDARDS (NAAQS) - An ambient air quality standard set by EPA at 40 CFR Part 50 and includes standards for carbon monoxide (CO), particulate matter, ozone (O_3), sulfur dioxide (SO_2), lead (Pb), and nitrogen dioxide (NO_2).

NATIONAL EMISSION STANDARDS FOR HAZARDOUS AIR POLLUTANTS (NESHAP((~~S~~))) - The federal rules in 40 CFR Part 61.

NATIONAL EMISSION STANDARDS FOR HAZARDOUS AIR POLLUTANTS FOR SOURCE CATEGORIES - The federal rules in 40 CFR Part 63.

NATIONAL POLLUTION DISCHARGE ELIMINATION SYSTEM (NPDES) - ((~~Shall be referred to as NPDES.~~)) The permit program that addresses water pollution by regulating facilities that discharge to waters of the United States.

((~~NATURAL CONDITIONS - Naturally occurring phenomena that reduce visibility as measured in terms of light extinction, visual range, contrast, or coloration.~~

~~NET EMISSIONS INCREASE - a) Net emissions increase as it applies to stationary sources subject to requirements for new sources in nonattainment areas, is defined in WAC 173-400-112. b) Net emissions increase as it applies to stationary sources subject to requirements for new sources in attainment or unclassified areas, is defined in WAC 173-400-113.~~))

NEW SOURCE - means one or more of the following:

((~~a~~)) (A) The construction or modification of a stationary source that increases the amount of any air contaminant emitted by such stationary source or that results in the emission of any air contaminant not previously emitted((~~,~~))

((~~b~~)) (B) The restart of a stationary source after permanent shutdown

((~~c~~)) (C) Any other project that constitutes a new stationary source under the Federal Clean Air Act((~~,~~))

NEW SOURCE PERFORMANCE STANDARDS (NSPS) - The federal rules in 40 CFR Part 60.

NONATTAINMENT AREA - A geographic area designated by EPA at 40 CFR Part 81 as exceeding a National Ambient Air Quality Standard (NAAQS) for a given criteria pollutant. An area is nonattainment only for the pollutants for which the area has been designated nonattainment.

((~~NON HIGHWAY MOBILE SOURCE - A source which is neither used on nor does ordinarily travel on the public roadways and is powered by an internal combustion or other type engine. These sources include, but are not limited to, farm tractors, bulldozers, earthmovers, ships, boats, railroad locomotives and non-commercial aircraft.~~))

NONROAD ENGINE - ((~~a~~)) (A) Except as discussed in ((~~b~~)) (B) of this definition, a nonroad engine is any internal combustion engine:

((~~1~~)) (1) In or on a piece of equipment that is self-propelled or serves a dual purpose by both propelling itself and performing another function (such as garden tractors, off-highway mobile cranes and bulldozers); or

((~~2~~)) (2) In or on a piece of equipment that is intended to be propelled while performing its function (such as lawnmowers and string trimmers); or

((~~3~~)) (3) That, by itself or in or on a piece of equipment, is portable or transportable, meaning designed to be and capable of being carried or moved from one location to another. Indicia of transportability include, but are not limited to, wheels, skids, carrying handles, dolly, trailer, or platform.

((~~b~~)) (B) An internal combustion engine is not a nonroad engine if:

((~~1~~)) (1) The engine is used to propel a motor vehicle or a vehicle used solely for competition, or is subject to standards promulgated under section 202 of the Federal Clean Air Act; or

((~~2~~)) (2) The engine is regulated by a New Source Performance Standard (NSPS) promulgated under section 111 of the Federal Clean Air Act; or

((~~3~~)) (3) The engine otherwise included in (((~~a~~))A) (3) of this definition remains or will remain at a location for more than ((~~twelve~~)) 12 consecutive months or a shorter period of time for an engine located at a seasonal source. A location is any single site at a building, structure, facility, or installation. Any engine (or engines) that replaces an engine at a location and that is intended to perform the same or similar function as the engine replaced will be included in calculating the consecutive time period. An engine located at a seasonal source is an engine that remains at a seasonal source during the full annual operating period of the seasonal source. ((~~As~~)) A seasonal source is a stationary source that remains in a single location on a permanent basis (i.e., at least two years) and that operates at that single location approximately three months (or more) each year. This paragraph does not apply to an engine after the engine is removed from the location.

NOTICE OF CONSTRUCTION APPLICATION - A written application to ((~~permit~~)) allow construction of a new source, modification of an existing stationary source or replacement or substantial alteration of control technology at an existing stationary source.

ODOR - That property ((~~or~~)) of a substance ((~~which~~)) that enables ((~~allows~~)) its detection((~~s~~)) by the sense of smell and/or taste.

ODOR SOURCE - Any source that incurs two verified odor nuisance complaints within a ((~~twelve~~)) 12 month time period. Odor nuisance complaints are verified by a NWCAA representative according to the criteria ((~~of the~~)) in NWCAA ((~~Regulation~~)) Sections 530((~~.1~~)) and 535((~~.3~~)).

OPACITY - The degree to which an object seen through a plume is obscured, stated as a percentage.

ORDER - Any order issued by the NWCAA pursuant to chapter 70.94 RCW, including, but not limited to RCW 70.94.332, 70.94.152, 70.94.153, and 70.94.141(3), and includes, where used in the generic sense, the terms order, compliance order, order of approval, and regulatory order.

ORDER OF APPROVAL((~~, APPROVAL ORDER~~)) or ORDER OF APPROVAL TO CONSTRUCT (OAC) - A regulatory order issued by the NWCAA to approve the notice of construction application for a proposed new source or modification or the replacement or substantial alteration of control technology at an existing stationary source.

OWNER, OPERATOR, OR AGENT - Includes the person who leases, supervises, or operates the equipment or control facility.

OZONE DEPLETING SUBSTANCE - Substance listed in Appendices A and B to Subpart A of 40 CFR Part 82.

PARTICLE - A small discrete mass of solid or liquid matter.

PARTICULATE MATTER or PARTICULATES - Any airborne finely divided solid or liquid material with an aerodynamic diameter smaller than 100 micrometers.

PARTS PER MILLION (PPM) - parts of a contaminant per million parts of gas, by volume, exclusive of water or particulates.

((~~PATHOLOGICAL WASTE - Human and animal remains consisting of carcasses, organs and solid organic wastes, consisting of up to 85% moisture, 5% incombustible solids.~~))

PERMANENT SHUTDOWN - Permanently stopping or terminating all processes at a "stationary source" or "emissions unit." Except as provided in subsections ((~~a~~)) (A) and ((~~b~~)) (B), whether a shutdown is permanent depends on the intention of the owner or operator at the time of the shutdown as determined from all facts and circumstances, including the cause of the shutdown.

((~~a~~)) (A) A shutdown is permanent if the owner or operator files a report of shutdown, as provided in NWCAA ((~~Regulation~~)) Section((~~s~~)) 325. Failure to file such a report does not mean that a shutdown was not permanent.

((~~b~~)) (B) Any shutdown lasting ((~~two (2)~~)) 2 or more years is considered to be permanent.

((~~PERMITTING AGENCY - Ecology or the local air pollution control authority with jurisdiction over the source.~~))

PERSON - An individual, firm, public or private corporation, association, partnership, political subdivision, municipality, or government agency.

PETROLEUM LIQUIDS - Petroleum, condensate, and any finished or intermediate products manufactured in a petroleum refinery but does not mean Numbers 2 through ((~~Number~~)) 6 fuel oils as specified in ((~~A.S.T.M.~~)) ASTM D396-((~~69~~))78, 89, 90, 92, 96, or 98, gas turbine fuel oils Numbers 2-GT through 4-GT as specified in ((~~A.S.T.M.~~)) ASTM D2880-((~~71~~))78 or 96, or diesel fuel oils Numbers 2-D and 4-D as specified in ((~~A.S.T.M.~~)) ASTM D975-((~~68~~))78, 96, or 98a.

PETROLEUM REFINERY - A facility engaged in producing gasoline, kerosene, distillate fuel oils, residual fuel oils, lubricants, asphalt, or other products by distilling crude oils or redistilling, cracking, extracting, or reforming unfinished petroleum derivatives.

$PM_{2.5}$ - Particulate matter with an aerodynamic diameter less than or equal to a nominal 2.5 micrometers as measured by a reference method based on 40 CFR Part 50 Appendix L and designated in accordance with 40 CFR Part 53 or by an equivalent method designated in accordance with 40 CFR Part 53.

$PM_{2.5}$ EMISSIONS - Finely divided solid or liquid material, including condensable particulate matter, with an aerodynamic diameter less than or equal to a nominal 2.5 micrometers emitted to the ambient air as measured by an applicable reference method, or an equivalent or alternate method, specified in 40 CFR Part 51 or by a test method specified in the SIP. $PM_{2.5}$ emissions are also known as primary $PM_{2.5}$, direct $PM_{2.5}$, total $PM_{2.5}$, or combined filterable $PM_{2.5}$ and condensable PM. These solid particles are emitted directly from an air emissions source or activity, or are the gaseous emissions or liquid droplets from an air emissions source or activity that condense to form PM at ambient temperatures.

PM_{10} - Particulate matter with an aerodynamic diameter less than or equal to a nominal 10 micrometers as measured by a reference method based on 40 CFR Part 50 Appendix J and designated in accordance with 40 CFR Part 53 or by an equivalent method designated in accordance with 40 CFR Part 53.

PM_{10} EMISSIONS - Finely divided solid or liquid material, including condensible particulate matter, with an aerodynamic diameter less than or equal to a nominal 10 micrometers emitted to the ambient air as measured by an applicable reference method, or an equivalent or alternate method, specified in Appendix M of 40 CFR Part 51 or by a test method specified in the SIP.

PORTLAND CEMENT PLANT - Any facility manufacturing ((~~P~~)) portland cement by either the wet or dry process.

POTENTIAL TO EMIT (PTE) - The maximum capacity of a stationary source to emit a pollutant under its physical and operational design. Any physical or operational limitation on the capacity of the stationary source to emit a pollutant, including air pollution control equipment and restrictions on hours of operation or on the type or amount of material combusted, stored, or processed, shall be treated as part of its design only if the limitation or the effect it would have on emissions is federally enforceable. Secondary emissions do not count in determining the potential to emit of a stationary source.

PREVENTION OF SIGNIFICANT DETERIORATION (PSD) - The program in WAC 173-400-((~~720~~))700 through 750.

PROCESS - A physical and/or chemical modification or treatment of a material from its previous state or condition.

((~~REASONABLY ATTRIBUTABLE - Attributable by visual observation or any other technique the state deems appropriate.~~))

PROCESS UNIT - All the equipment essential to a particular production process.

PROPER ATTACHMENT FITTINGS - Connecting hardware for the attachment of fuel transfer or vapor lines that meets or exceeds industrial standards or specifications and the standards of other agencies or institutions responsible for health and safety.

REASONABLY AVAILABLE CONTROL TECHNOLOGY (RACT) - The lowest emission limit that a particular stationary source or source category is capable of meeting by the application of control technology that is reasonably available considering technological and economic feasibility. RACT is determined on a case-by-case basis for an individual stationary source or source category taking into account the impact of the stationary source upon air quality, the availability of additional controls, the emission reduction to be achieved by additional controls, the impact of additional controls on air quality, and the capital and operating costs of the additional controls. RACT requirements for any stationary source or source category shall be adopted only after notice and opportunity for comment are afforded.

REFUSE - Putrescible and non-putrescible solid waste including garbage, rubbish, ashes, dead animals, abandoned automobiles, solid market wastes, street cleanings, and industrial wastes including waste disposal in industrial salvage.

REFUSE BURNING EQUIPMENT - Equipment designed to burn waste (refuse) material, scrap or combustion remains.

REGISTRATION - ((~~t~~)) The process of identifying, delineating, and itemizing all air contaminant sources within the jurisdiction of the NWCAA including the making of periodic reports, as required, by the persons operating or responsible for such sources and may contain information concerning location, size, height of contaminant outlets, processes employed, nature of the contaminant emissions and such other information as is relevant to air pollution and available or reasonably capable of being assembled.

REGULATORY ORDER - An ((~~o~~)) Order issued by the NWCAA to an air contaminant source or sources pursuant to chapter 70.94 RCW including, but not limited to, RCW 70.94.141(3). A ((~~r~~)) Regulatory ((~~o~~)) Order includes an ((~~o~~)) Order ((~~which applies to~~)) that ((~~source or sources~~)) requires compliance with any applicable provision of chapter 70.94 RCW ((~~or the~~)), rules adopted thereunder, or the NWCAA Regulation.

SMOKE - Gas borne particulate matter in a sufficient amount to be observable.

SOLID WASTE - All putrescible and nonputrescible solid and semisolid wastes, including but not limited to garbage, rubbish, ashes, industrial wastes, swill, demolition and construction wastes, abandoned vehicles or parts thereof, and discarded commodities. This includes all liquid, solid, and semisolid materials, which are not primary products of public, private, industrial, commercial, mining, and agricultural operations. Solid waste includes but is not limited to septage from septic tanks, dangerous waste, and problem wastes. Solid waste does not include wood waste or sludge from ((~~waste water~~)) wastewater treatment plants.

SOURCE - All of the emissions unit(s) including quantifiable fugitive emissions, that are located on one or more contiguous or adjacent properties, and are under the control of the same person or persons under common control, whose activities are ancillary to the production of a single product or functionally related groups of products. Activities shall be considered ancillary to the production of a single product or functionally related group of products if they belong to the same major group (i.e., which have the same two digit code) as described in the Standard Industrial Classification Manual, 1972, as amended by the 1977 Supplement.

SOURCE CATEGORY - All sources of the same type or classification.

STACK - Any point in a stationary source designed to emit solids, liquids, or gases into the air, including a pipe or duct.

((~~STACK HEIGHT - The height of an emission point measured from the ground-level elevation at the base of the stack.~~))

STAGE I VAPOR RECOVERY - Vapor recovery system that captures gasoline vapors during gasoline transfer operations at gasoline dispensing facilities, except during motor vehicle refueling.

STAGE II VAPOR RECOVERY - Vapor recovery system that captures gasoline vapors during motor vehicle refueling operations from stationary tanks at gasoline dispensing facilities.

STANDARD CONDITIONS - A temperature of 20 degrees C (68 degrees F) and a pressure of 760 mm (29.92 inches) of mercury.

STANDARD CUBIC FOOT OF GAS - That amount of gas which would occupy a cube having dimensions of one foot on each side, if the gas were free of water vapor at a pressure of 14.7 psia and a temperature of 68 degrees F.

STATE ACT - Washington Clean Air Act (((~~RCW~~)) chapter 70.94 RCW) and chapter 43.21B RCW.

STATE IMPLEMENTATION PLAN (SIP) ((~~or WASHINGTON SIP~~)) - Washington and NWCAA SIP in 40 CFR Part 52, subpart WW. The SIP contains state, local, and federal regulations and orders, the state plan, and compliance schedules approved and promulgated by EPA((~~,~~)) for the purpose of implementing, maintaining, and enforcing National Ambient Air Quality Standards.

STATIONARY SOURCE - Any building, structure, facility, or installation which emits or may emit any air contaminant. This term does not include emissions resulting directly from an internal combustion engine for transportation purposes or from a nonroad engine or nonroad vehicle as defined in Section 216(11) of the Federal Clean Air Act.

((~~STRAW - All vegetative material of agricultural origin other than seed removed by swathing, combining or cutting.~~))

SUBMERGED FILL LINE - Any discharge pipe or nozzle that meets either of the following conditions:

(A) Where the tank is filled from the top, the end of the discharge pipe or nozzle must be totally submerged when the liquid level is 6 inches from the bottom of the tank, or

(B) Where the tank is filled from the side, the discharge pipe or nozzle must be totally submerged when the liquid level is 18 inches from the bottom of the tank.

SUBMERGED LOADING - The filling of a tank with a submerged fill line.

SUITABLE CLOSURE or SUITABLE COVER - A door, hatch, cover, lid, pipe cap, pipe blind, valve, or similar device that prevents the accidental spilling or emitting of VOC. Pressure relief valves, aspirator vents, or other devices specifically required for safety and fire protection are not included.

SULFURIC ACID PLANT - Any facility producing sulfuric acid by the contact process by burning elemental sulfur, alkylation acid, hydrogen sulfide, or acid sludge.

SYNTHETIC MINOR - Any stationary source whose potential to emit has been limited below applicable thresholds by means of a federally enforceable order, rule, or permit condition.

TEMPORARY SOURCE - An emissions unit that remains or will remain at one location for less than 12 consecutive months. A location is any single site at a building, structure, facility, or installation. A nonroad engine is not considered a temporary source.

THROUGHPUT - means the amount of material passing through a facility.

TON - Short ton or 2,000 pounds (a long ton is considered 2,240 pounds).

TOTAL SUSPENDED PARTICULATE - Particulate matter as measured by the method described in 40 CFR Part 50 Appendix B.

TOXIC AIR POLLUTANT (TAP) or TOXIC AIR CONTAMINANT - Any toxic air pollutant listed in WAC 173-460-150. The term toxic air pollutant may include particulate matter and volatile organic compounds if an individual substance or a group of substances within either of these classes is listed in WAC 173-460-150. The term toxic air pollutant does not include particulate matter and volatile organic compounds as generic classes of compounds.

TRANSPORT TANK - A container with a capacity greater than 264 gallons used for transporting gasoline, including, but not limited to, tank truck, tank trailer, railroad car, and metallic or nonmetallic tank or cell conveyed on a flatbed truck, trailer, or railroad car.

TRUE VAPOR PRESSURE - The equilibrium partial pressure exerted by a hydrocarbon at storage conditions.

TURNAROUND or PROCESS UNIT TURNAROUNDS - The shutting down and starting up of process units for periodic major maintenance and repair of equipment, or other planned purpose.

UNCLASSIFIABLE AREA - An area that cannot be designated attainment or nonattainment on the basis of available information as meeting or not meeting the National Ambient Air Quality Standard for the criteria pollutant and that is listed by EPA at 40 CFR Part 81.

UNITED STATES ENVIRONMENTAL PROTECTION AGENCY - ((~~Shall be referred~~)) Referred to as EPA.

VAPOR BALANCE SYSTEM - A combination of pipes or hoses that create a closed system between the vapor spaces of an unloading tank and receiving tank such that the vapors displaced from the receiving tank are transferred to the tank being unloaded.

VAPOR RECOVERY SYSTEM - A process and equipment that prevents emission to the atmosphere of volatile organic compounds released by the operation of any transfer, storage, or process equipment.

VOLATILE ORGANIC COMPOUND (VOC) - Any carbon compound that participates in atmospheric photochemical reactions as defined in WAC 173-400-030(95). ((~~Any carbon compound that participates in atmospheric photochemical reactions. a) Exceptions. The following compounds are not a VOC: Acetone; carbon monoxide; carbon dioxide; carbonic acid; metallic carbides or carbonates; ammonium carbonate, methane; ethane; methylene chloride (dichloromethane); 1,1,1-trichloroethane (methyl chloroform); 1,1,2-trichloro 1,2,2-trifluoroethane (CFC-113); trichlorofluoromethane (CFC-11); dichlorodifluoromethane (CFC-12); chlorodifluoromethane (HCFC-22); trifluoromethane (HFC-23); 1,2-dichloro 1,1,2,2-tetrafluoroethane (CFC-114); chloropentafluoroethane (CFC-115); 1,1,1-trifluoro 2,2-dichloroethane (HCFC-123); 1,1,1,2-tetrafluoroethane (HFC-134a); 1,1-dichloro 1-fluoroethane (HCFC-141b); 1-chloro 1,1-difluoroethane (HCFC-142b); 2-chloro 1,1,1,2-tetrafluoroethane (HCFC- 124); pentafluoroethane (HFC-125); 1,1,2,2-tetrafluoroethane (HFC-134); 1,1,1-trifluoroethane (HFC-143a); 1,1-difluoroethane (HFC-152a); parachlorobenzotrifluoride (PCBTF); cyclic, branched, or linear completely methylated siloxanes; perchloroethylene (tetrachloroethylene); 3,3-dichloro-1,1,1,2,2-pentafluoropropane (HCFC-225ca); 1,3-dichloro-1,1,2,2,3- pentafluoropropane (HCFC-225cb); 1,1,1,2,3,4,4,5,5,5-decafluoropentane (HFC-43-10mee); difluoromethane (HFC-32); ethylfluoride (HFC-161); 1,1,1,3,3,3-hexafluoropropane (HFC-236fa); 1,1,2,2,3-pentafluoropropane (HFC-245ca); 1,1,2,3,3-pentafluoropropane (HFC-245ea); 1,1,1,2,3-pentafluoropropane (HFC- 245eb); 1,1,1,3,3-pentafluoropropane (HFC-245fa); 1,1,1,2,3,3-hexafluoropropane (HFC-236ea); 1,1,1,3,3-pentafluorobutane (HFC-365mfc); chlorofluoromethane (HCFC-31); 1 chloro-1-fluoroethane (HCFC-151a); 1,2-dichloro-1,1,2-trifluoroethane (HCFC-123a); 1,1,1,2,2,3,3,4,4-nonafluoro-4-methoxy-butane (C4F9OCH3); 2-(difluoromethoxymethyl)-1,1,1,2,3,3,3-heptafluoropropane ((CF3)2CFCF2OCH3); 1-~~

~~ethoxy-1,1,2,2,3,3,4,4,4-nonafluorobutane (C4F9OC2H5); 2-(ethoxydifluoromethyl)-1,1,1,2,3,3,3-heptafluoropropane((CF3)2CFCF2OC2H5); methyl acetate, 1,1,1,2,2,3,3-heptafluoro-3-methoxy-propane (n-C3F7OCH3 or HFE-7000); 3-ethoxy-1,1,1,2,3,4,4,5,5,6,6,6-dodecafluoro-2-(trifluoromethyl) hexane (HFE-7500) 1,1,1,2,3,3,3-heptafluoropropane (HFC-227ea); methyl formate (HCOOCH3); 1,1,1,2,2,3,4,5,5,5-decafluoro-3-methoxy-4-trifluoromethylpentane (HFE-7300); dimethyl carbonate; propylene carbonate; dimethyl carbonate; *trans*- 1,3,3,3-tetrafluoropropene; HCF_2OCF_2H (HFE-134); $HCF_2OCF_2OCF_2H$ (HFE-236ca12); $HCF_2OCF_2CF_2OCF_2H$ (HFE-338pcc13); $HCF_2OCF_2OCF_2CF_2OCF_2H$ (H-Galden 1040x or alden ZT 130 (or 150 or 180)); *trans* 1 chloro 3,3,3 trifluoroprop 1 ene; 2,3,3,3-tetrafluoropropene; 2-amino-2-methyl-1-propanol; and perfluorocarbon compounds that fall into these classes:~~

~~1) Cyclic, branched, or linear completely fluorinated alkanes;~~

~~2) Cyclic, branched, or linear completely fluorinated ethers with no unsaturations;~~

~~3) Cyclic, branched, or linear completely fluorinated tertiary amines with no unsaturations; and~~

~~4) Sulfur containing perfluorocarbons with no unsaturations and with sulfur bonds only to carbon and fluorine.~~

~~b) For the purpose of determining compliance with emission limits, VOC will be measured by the appropriate methods in 40 CFR Part 60 Appendix A. Where the method also measures compounds with negligible photochemical reactivity, these negligibly-reactive compounds may be excluded as VOC if the amount of the compounds is accurately quantified, and the exclusion is approved by Ecology, the NWCAA, or EPA.~~

~~c) As a precondition to excluding these negligibly-reactive compounds as VOC or at any time thereafter, Ecology or the NWCAA may require an owner or operator to provide monitoring or testing methods and results demonstrating, to the satisfaction of Ecology or the NWCAA, or EPA, the amount of negligibly-reactive compounds in the source's emissions.~~

~~d) The following compounds are VOC for purposes of all recordkeeping, emissions reporting, photochemical dispersion modeling and inventory requirements which apply to VOC and shall be uniquely identified in emission reports, but are not VOC for purposes of VOC emissions limitations or VOC content requirements: Tertiary-butyl acetate.~~))

WASHINGTON ADMINISTRATIVE CODE (WAC) - Regulations of executive branch agencies in the state of Washington, such as the Department of Ecology.

WAXY, HEAVY POUR CRUDE OIL - A crude oil with a pour point of 10 degrees C or higher (determined by the ASTM Standard D97-66, "Test for Pour Point of Petroleum Oils").

WOOD WASTE BURNER - A sheet metal or other type of enclosure to form a truncated cone or a single chamber cylindrically shaped incinerator line or constructed of suitable refractory material that ((~~which employs controlled fuel feed, tangential overfire and underfire air supply system, and~~)) is designed and used for the disposal of wood and bark wastes by incineration.

PASSED: January 8, 1969 AMENDED: October 31, 1969, September 3, 1971, June 14, 1972, July 11, 1973, February 14, 1973, January 9, 1974, October 13, 1982, November 14, 1984, October 13, 1994, February 8, 1996, May 9, 1996, March 13, 1997, November 12, 1998, June 14, 2001, July 10, 2003, July 14, 2005, November 8, 2007, November 17, 2011, March 14, 2013, August 13, 2015, August 11, 2016, September 13, 2018

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

NEW SECTION

SECTION 508 - SPRAY COATING OPERATIONS

508.1 PURPOSE

This section of the NWCAA Regulation establishes a program of work practice standards and controls for spray coating operations in order to reduce particulate emissions from coating overspray, lessen public exposure to toxic air pollutants, decrease emissions of precursors to the formation of tropospheric ozone, and encourage pollution prevention.

508.2 APPLICABILITY

(A) This section applies to spray coating operations at a source and at portable spray coating operations except as provided in NWCAA 508.2(B).

(B) This section does not apply to spray application of:

(1) Architectural or maintenance coatings to stationary structures (e.g., bridges, water towers, buildings, stationary machinery, mobile homes, pavement/curbs, or similar structures).

(2) Maintenance coatings to farm equipment and mining equipment for which it is not practical or feasible to move to a dedicated spray coating facility.

(3) Asphaltic or plastic liners including undercoating, sound deadening coating, and spray-on truck bed liners.

(4) Fiberglass resin and gel coat.

508.3 DEFINITIONS

Unless a different meaning is clearly required by context, words and phrases used in this section shall have the following meaning:

AIRLESS or AIR-ASSISTED AIRLESS SPRAY EQUIPMENT - Any paint spray technology that relies solely on the fluid pressure of the paint to create an atomized paint spray pattern and does not apply any atomizing compressed air to the paint before it leaves the paint nozzle. Air-assisted airless spray uses compressed air to shape and distribute the fan of atomized paint, but still uses fluid pressure to create the atomized paint.

COATING - A material or formulation of materials that is applied to or impregnated into a surface in order to beautify, protect, enhance the function, or otherwise cover the surface.

CONTAINER - An individual receptacle that holds a coating or coating component for storage or distribution.

ELECTROSTATIC APPLICATION - Application of coatings where an electrostatic potential is created between the part to be coated and the paint particles.

ENCLOSED SPRAY AREA - An enclosed area used for spray coating including, but not limited to, spray booth, preparation station, or portable enclosure.

HIGH VOLUME, LOW PRESSURE (HVLP) SPRAY EQUIPMENT - Equipment used to apply coatings by means of a spray gun that is designed and operated between 0.1 and 10.0 pounds per square inch gauge air pressure measured at the nozzle.

MOBILE EQUIPMENT - Any device that may be drawn and/or driven on a roadway including, but not limited to, heavy-duty trucks, truck trailers, fleet delivery trucks, buses, mobile cranes, bulldozers, street cleaners, agriculture equipment, motor homes, and other recreational vehicles (including camping trailers and fifth wheels).

OTHER SPRAY COATING - Spray coating of items other than complete motor vehicles and complete mobile equipment.

SPRAY COATING OPERATION - Application of coatings using a hand-held device that creates an atomized mist of coating and deposits the coating on a substrate. For the purposes of this section, a spray coating operation does not include the following materials or activities:

(A) Use of air-brush spray equipment with a maximum cup capacity of 3 fluid ounces.

(B) Use of aerosol spray cans.

(C) Surface coating application using powder coating or non-atomizing application technology, including, but not limited to, paint brushes, rollers, hand wiping, flow coating, dip coating, electrodeposition coating, web coating, coil coating, touch-up markers, or marking pens.

(D) Thermal spray operations (also known as metallizing, flame spray, plasma arc spray, and electric arc spray, among other names) in which solid metallic or non-metallic material is heated to a molten or semi-molten state and propelled to the work piece or substrate by compressed air or other gas, where a bond is produced upon impact.

508.4 GENERAL REQUIREMENTS FOR SPRAY COATING OPERATIONS

(A) Except as in NWCAA 508.4(B), it shall be unlawful for any person subject to this section to cause or allow spray coating unless all of the following requirements are met as applicable:

(1) Enclosures. Except as in NWCAA 508.4 (A)(1)(d) & (f), spray coating shall take place inside an enclosed spray area that is capable of capturing all visible paint overspray.

(a) Refinishing Complete Motor Vehicles and Complete Mobile Equipment. An enclosed spray area for refinishing complete motor vehicles and complete mobile equipment shall be one of the following:

(i) A negative pressure enclosure equipped with a full roof and four complete walls or complete side curtains and ventilated at a negative pressure so that air is drawn into any openings in the enclosed spray area, or

(ii) A positive pressure enclosure equipped with seals on all doors and other openings and an automatic pressure balancing system. The pressure balancing system shall be operated at a pressure not more than 0.05 inches water gauge positive pressure as measured by a functioning gauge that displays the pressure to the nearest 0.01 inches water column.

(b) Other Spray Coating. Except as in NWCAA 508.4 (A)(1)(c) through (f), an enclosed spray area for other spray coating shall be equipped with a full roof, at least three complete walls or complete side curtains, and shall be ventilated at a negative pressure so that air is drawn into the enclosed spray area. The enclosed spray area may have openings, if needed, to allow for conveyors and parts to pass through the enclosed spray area during the spray coating process.

(c) Other Spray Coating in an Existing Enclosed Spray Area Located Outdoors. Enclosed spray areas used for other spray coating with complete three-walled/curtain and a full roof located outdoors that are not equipped with a negative pressure ventilation system as of April 20, 2018 are not required to install such system provided the spray coating operation does not create a nuisance.

(d) Other Spray Coating of Large Objects. Conducting other spray coating of large objects outside an enclosed spray area is allowed when it is impractical to totally enclose the large object, provided that reasonable precautions are employed to enclose the object to the extent practicable and to avoid creating a nuisance.

(e) Portable Other Spray Coating Operations. An enclosed spray area for a portable other spray coating operation shall be equipped with a frame-and-fabric shelter consisting of a fabric roof and three fabric sides or similar shelter.

(f) Inside Exhaust. An enclosed spray area is not required if the Department of Labor & Industries and fire protection agency with jurisdiction approve inside exhaust of spray coating operations.

(2) Filtration. Except as in NWCAA 508.4 (A)(1)(c) & (e), all enclosed spray areas shall employ either:

(a) Water-wash curtains with a continuous water curtain to control the overspray or

(b) Properly-seated filter(s) that have a capture efficiency of at least 98 percent as described in NWCAA 508.4 (A)(8)(c). A gauge shall be installed, operated, and maintained that displays the pressure drop across the filter(s). The acceptable pressure drop range shall be clearly marked on the gauge or posted next to the gauge. The enclosed spray area shall be operated such that the pressure drop across the filter(s) is within the acceptable range and the filter(s) are properly seated with no holes or tears.

(3) Spray Application Methods. The spray application methods in NWCAA 508.4 (A)(3)(a) shall be used for spray coating unless the exemption in NWCAA 508.4 (A)(3)(b) applies.

(a) Required Spray Application Methods.

(i) HVLP spray equipment;

(ii) Airless or air-assisted airless spray equipment;

(iii) Electrostatic application; or

(iv) A method that has a transfer efficiency of 65% or higher using ASTM Standard D 5327-92 or a test method approved in writing by the NWCAA.

(b) If the required spray application methods under NWCAA 508.4 (A)(3)(a) cannot be used in a certain situation, the situation is exempt from using a required spray application method provided that the facility maintains appropriate records (e.g., manufacturing specifications) to demonstrate that the required spray application methods cannot be used.

(4) Vertical Unobstructed Exhaust Vent. Except as provided in NWCAA 508.4 (A)(1)(c) & (e), emissions from an enclosed spray area shall be vented to the atmosphere through an unobstructed vertical exhaust vent. If the exhaust

vent exits horizontally out of the side of the building, then the exhaust vent shall bend to vent vertically above the eave of the roof. There shall be no flow obstructions that will impede upward vertical flow of the exhaust.

(5) Visible Emissions. Visible emissions from an enclosed spray area exhaust vent shall not exceed 0% opacity for more than an aggregate of 3 minutes in any consecutive 60-minute period as determined by Ecology Method 9A.

(6) Equipment Cleanup. Spray guns shall be cleaned in an enclosed cleaning device or disassembled and cleaned in a container. Each gun cleaning device and container shall be kept closed when not in use. Guns and spray equipment must not atomize solvent into the air during cleanup.

(7) Storage and Disposal. VOC-containing materials shall be kept in closed containers except when materials are actively being added or removed. Rags and paper towels contaminated with VOC-containing materials shall be collected immediately after use and kept in closed containers. Empty containers as defined in WAC 173-303-160 are exempt from this requirement.

(8) Recordkeeping. All records required by this section shall be maintained onsite for at least 3 years from the date of generation and made available to NWCAA personnel upon request. Maintain the following records as applicable:

(a) Data Sheets. Environmental data sheets (EDS) or other data sheets that clearly indicate the contents of the spray coatings and solvents used.

(b) Usages. Records of total coating and solvent purchases or usages for the calendar year.

(c) Filter Efficiency. For those facilities utilizing filter(s) pursuant to NWCAA 508.4 (A)(2)(b), documentation that demonstrates the filter(s) being used have a capture efficiency of at least 98 percent. The procedure used to demonstrate filter efficiency must be consistent with the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE) Method 52.1, Method 52.2, or an alternate test method approved by the NWCAA in writing. Published filter efficiency data provided by filter vendors may be used to demonstrate compliance with this requirement.

(d) Filter Condition. For those facilities utilizing filter(s) pursuant to NWCAA 508.4 (A)(2)(b), weekly observations of the filter(s) including: date, time, confirmation that filters are properly seated and in good condition, any corrective actions taken, and initials of person making the record. Weekly observations are not required for weeks that the enclosed spray area was not operated. Instead, the record must reflect the enclosed spray area was not in operation that week.

(e) Pressure Drop. For those facilities utilizing a pressure gauge pursuant to NWCAA 508.4 (A)(1)(a)(ii) and/or NWCAA 508.4 (A)(2)(b), weekly observations of pressure drop readings while operating including: date, time, pressure drop value, corrective action taken if the pressure drop is outside of the normal range (e.g., filter change), and initials of person making the record. Weekly observations are not required for weeks that the enclosed spray area was not operated. Instead, the record must reflect the enclosed spray area was not in operation that week.

(f) Disposal. Disposal records of waste materials, including volumes of waste solvents and coatings transferred to authorized waste haulers.

(B) Compliance Date. Subject sources shall be in compliance with NWCAA 508.4 (A)(1)(a) & (b), (A)(2), and (A)(4) by no later than October 12, 2020.

PASSED: September 13, 2018

AMENDATORY SECTION

580.6 ((~~Gasoline Stations~~)) GASOLINE DISPENSING FACILITIES

(A) NWCAA 580.6(B) ((~~61 Section 580.62~~)) shall apply to((~~:~~

~~580.611 All~~)) all gasoline ((~~stations~~)) dispensing facilities (GDF) with ((~~a total~~)) an annual 12-consecutive month gasoline throughput equal to or greater than ((~~seven hundred and fifty-seven thousand liters (200~~)) 120,000 gallons((~~) and~~)).

((~~580.612 All gasoline stations installed or reconstructed after January 1, 1990 with a nominal total gasoline storage capacity greater than thirty-eight thousand liters (10,000 gallons).~~

~~580.62~~)) (B) It shall be unlawful for any person to cause or allow the transfer of gasoline from any transport tank into any stationary storage tank, except as provided in NWCAA 580.6(C) ((~~63 of this section~~)), unless all of the following conditions are met:

((~~580.621~~)) (1) Such stationary storage tank is equipped with a permanent submerged or bottom loading fill ((~~pipe~~)) line and ((~~approved~~)) a vapor recovery system((~~, and~~)).

(2) Vapor recovery system equipment, including, but not limited to, caps, adaptors, drain valves, and poppets, shall be installed and maintained to be vapor tight and in good working order.

((~~580.622~~)) (3) Such transport tank is equipped ((~~to~~)) with a vapor balance ((~~vapors~~)) system and is maintained in a vapor-tight condition in accordance with ((~~Section~~)) NWCAA 580.10 ((~~and~~)).

((~~580.623~~)) (4) All vapor return lines are connected between the transport tank and the stationary storage tank and the vapor recovery system is functional and operating during loading.

((~~580.63 Notwithstanding the requirements of 580.61 of this regulation, the following~~)) (C) The following stationary gasoline storage tanks are exempt from the requirements of 580.6 (A), (B), (D), and (F): ((~~62:~~))

((~~580.631~~)) (1) All tanks with a capacity less than ((~~seven thousand five hundred liters (~~))2,000 gallons((~~)~~)) installed before January 1, 1990.

((~~580.632~~)) (2) All tanks with offset fill lines installed before January 1, 1990.

((~~580.633~~)) (3) All tanks with a capacity less than ((~~one thousand liters (260~~)) 264 gallons((~~)~~)).

((~~580.64 It shall be unlawful for any person to cause or allow the transfer of gasoline from a stationary tank into a motor vehicle fuel tank except as provided in WAC 173-491.~~))

(D) Except for gasoline storage tanks specified in NWCAA 580.6(C), all gasoline tank vent pipes at gasoline

dispensing facilities shall be equipped with properly functioning pressure vacuum vent (PV) caps.

(E) All gasoline storage tanks at gasoline dispensing facilities shall be maintained in a vapor-tight condition and in good working order. This includes, but is not limited to, caps, adaptors, and drain valves.

(F) All gasoline dispensing facilities that have Stage I vapor recovery shall conduct static pressure decay tests on all gasoline storage tanks, except those specified in NWCAA 580.6(C).

(1) The static pressure decay tests shall be conducted on the following frequency unless more frequent testing is required by an Order of Approval or General Order of Approval:

GDF Throughput	Frequency
30,000 to 119,999 gal/yr	Every 5 calendar years
120,000 to 1,200,000 gal/yr	Every 3 calendar years
> 1,200,000 gal/yr	Every calendar year

(2) The pressure decay tests shall be conducted in accordance with California Air Resources Board (CARB) TP-201.3 (dated 7/26/12) for underground storage tanks and CARB TP-201.3B (dated 4/12/96) for above ground tanks, or test procedures that have been approved by CARB as equivalent.

(3) Any person conducting a compliance test must be certified by the International Code Council or other association approved by the NWCAA in writing.

(4) Failed Compliance Tests. If the defective gasoline dispensing facility equipment cannot be repaired within 14 calendar days of failing a test, the owner or operator must stop receiving and/or dispensing gasoline from the defective equipment until it is repaired and retested, and passes all required compliance tests.

(5) Test Reports

(a) The owner or operator shall submit a written test report to the NWCAA within 30 calendar days after the testing has been completed that includes the following information:

(i) Identification of the facility,

(ii) Name and address of the person(s) who conducted each test,

(iii) Current certification credential information for each person who conducted each test,

(iv) Date of each test,

(v) Equipment tested,

(vi) Test procedures or methods used,

(vii) Results of each test conducted (pass/fail), and

(viii) Any maintenance, repairs, or corrective actions taken necessary to pass the tests.

(b) Owners or operators shall keep a copy of all test reports on-site for at least 5 years after the date of testing that shall be made available for inspection upon request.

PASSED: February 14, 1990 AMENDED: April 14, 1993, October 13, 1994, March 13, 1997, May 14, 1998, November 12, 1998, September 13, 2018

WSR 18-20-001
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed September 19, 2018, 12:00 p.m., effective October 20, 2018]

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

Purpose: The department is amending WAC 388-106-1920 What is the maximum amount of step three services I may receive a month?, in WAC 388-106-1920 (1)(a), the department incorrectly used three thousand three hundred and forty-five dollars instead of three thousand three hundred and forty-eight dollars (six months x $558). The department filed a CR-105 expedited rule making as WSR 18-14-003 on June 20, 2018.

Citation of Rules Affected by this Order: Amending WAC 388-106-1920.

Statutory Authority for Adoption: RCW 74.08.090.

Adopted under notice filed as WSR 18-14-003 on June 20, 2018.

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 the 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: September 19, 2018.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-08-033, filed 3/27/18, effective 4/27/18)

WAC 388-106-1920 What is the maximum amount of step three services I may receive a month? (1) Unless the department authorizes additional funds through an exception to rule under WAC 388-440-0001, the maximum amount of step three services you and your caregiver may receive in MAC and TSOA:

(a) From January 1, 2018 through June 30, 2018 is an average of five hundred and fifty-eight dollars per month not to exceed three thousand three hundred and ((~~forty-five~~)) forty-eight dollars in a six month period.

(b) Beginning July 1, 2018 is an average of five hundred and seventy-three dollars per month not to exceed three thousand four hundred and thirty-eight dollars in a six month period.

(2) If you are a care receiver who does not have an available unpaid caregiver, you are receiving TSOA personal

assistance services, and the department has not authorized additional funds through an exception to rule under WAC 388-440-0001, the maximum amount of step three services you may receive:

(a) From January 1, 2018 through June 30, 2018 is five hundred and fifty-eight dollars per month.

(b) Beginning July 1, 2018 is five hundred and seventy-three dollars per month.

WSR 18-20-002
PERMANENT RULES
UTILITIES AND TRANSPORTATION COMMISSION

[Docket A-130355, General Order R-593—Filed September 19, 2018, 12:22 p.m., effective October 20, 2018]

In the matter of amending/adopting/repealing chapter 480-07 WAC relating to the commission's procedural rules, governing the conduct of business before the commission, including rules governing formal proceedings.

1 **STATUTORY OR OTHER AUTHORITY:** The Washington utilities and transportation commission (commission) takes this action under Notice No. WSR 18-16-093, filed with the code reviser on July 31, 2018. The commission brings this proceeding pursuant to RCW 80.01.040 and 80.04.160.

2 **STATEMENT OF COMPLIANCE:** This proceeding complies with the Administrative Procedure Act (chapter 34.05 RCW), the State Register Act (chapter 34.08 RCW), the State Environmental Policy Act of 1971 (chapter 43.21C RCW), and the Regulatory Fairness Act (chapter 19.85 RCW).

3 **DATE OF ADOPTION:** The commission adopts these rules on the date this order is entered.

4 **CONCISE STATEMENT OF PURPOSE AND EFFECT OF THE RULE:** RCW 34.05.325(6) requires the commission to prepare and publish a concise explanatory statement about an adopted rule. The statement must identify the commission's reasons for adopting the rule, describe the differences between the version of the proposed rules published in the register and the rules adopted (other than editing changes), summarize the comments received regarding the proposed rule changes, and state the commission's responses to the comments reflecting the commission's consideration of them.

5 To avoid unnecessary duplication in the record of this docket, the commission designates the discussion in this order, including appendices, as its concise explanatory statement, supplemented where not inconsistent by the staff memoranda preceding the filing of the CR-102 proposal and the adoption hearing. Together, these documents provide a complete but concise explanation of the agency actions and its reasons for taking those actions.

6 **REFERENCE TO AFFECTED RULES:** This order amends WAC 480-07-160 Confidential and other restricted information and 480-07-420 Discovery—Protective orders.

7 **PREPROPOSAL STATEMENT OF INQUIRY AND ACTIONS THEREUNDER:** The commission filed a preproposal statement of inquiry (CR-101) on March 20, 2013, at WSR 13-07-071. The statement advised interested persons that the commission was considering undertaking a rule making to consider possible corrections and changes to certain sections in chapter 480-07 WAC, the commission's procedural rules governing the conduct of business before the commission, including informal proceedings. The commission also informed persons of this inquiry by providing notice of the subject and the CR-101 to everyone on the commission's list of persons requesting such information pursuant to RCW 34.05.320(3), to all interested persons in the previous procedural rules rule-making docket A-050802, and to all persons on the commission's list of utility attorneys, transportation attorneys, and telecommunications attorneys. Pursuant to the notice, but rescheduled at later dates, the commission received comments on May 17, 2013, and held a stakeholder workshop on August 21, 2013.

8 **SUBSEQUENT COMMENTS AND WORKSHOPS:** The commission received additional comments on the rules that are the subject of this order on or about September 29, 2017, and July 11, 2018. The commission also held additional workshops on these rules on January 15 and November 19, 2014.[1]

[1] Due to the number of rules and breadth of subject matter in chapter 480-07 WAC the commission considered the rules in stages. The commission entered General Order R-588 in this docket on March 2, 2017, amending, repealing, and adopting rules in Parts I through III A of this chapter. On August 31, 2018, the commission entered General Order R-592 amending, repealing, and adopting rules in Parts III B through IV. This is the third and final set of rules the commission will consider in this rule making.

9 **SMALL BUSINESS ECONOMIC IMPACT ANALYSIS:** On July 3, 2018, the commission issued a small business economic impact questionnaire to all interested persons. The commission received responses on July 30, 2018, from CenturyLink, Northwest Natural Gas Company (NW Natural), and Puget Sound Energy (PSE). These companies expressed concern with the additional administrative costs that would result from identifying exempt information separately from confidential information, and CenturyLink and PSE provided estimates of those costs. The commission considered those responses and the available data and determined that the proposed revisions to WAC 480-07-160 and 480-07-420 will have only a minor impact on the costs to the industries the commission regulates. Most of the restricted information the commission receives is designated as confidential or highly confidential and thus any additional costs to separately designate exempt information will not be substantial. Under these circumstances, a small business economic impact statement is not required.

10 The commission nevertheless undertook a small business economic impact analysis using the factors in RCW 19.85.040. The commission found that companies will incur additional costs to comply with revised WAC 480-07-160 and 480-07-420, but those costs will not disproportionately impact small businesses. The commission has included provisions in the rule to minimize the impact on individuals and companies providing information about themselves. The remaining provisions are necessary for compliance with the Public Records Act and other applicable law, which justifies the additional costs.

11 **NOTICE OF PROPOSED RULE MAKING:** The commission filed a notice of proposed rule making (CR-102) on July 31, 2018, at WSR 18-16-093. The commission scheduled this matter for oral comment and adoption under Notice No. WSR

18-16-093 at 9:30 a.m., Monday, September 10, 2018, in the Commission's Hearing Room, Second Floor, Richard Hemstad Building, 1300 South Evergreen Park Drive S.W., Olympia, WA. The notice provided interested persons the opportunity to submit written comments to the commission.

12 **WRITTEN COMMENTS:** The commission received comments on the proposed rules on or about August 31, 2018, from PSE, NW Natural, and Pacific Power & Light Company (Pacific Power). Those comments and the commission's determinations are summarized in paragraphs 15-17 below.

13 **RULE-MAKING HEARING:** The commission considered the proposed rules for adoption at a rule-making hearing on September 10, 2018, before Chairman David W. Danner, Commissioner Ann E. Rendahl, and Commissioner Jay M. Balasbas. The commission heard a presentation and comments from Gregory J. Kopta, administrative law judge, representing commission staff (staff), and oral comments from representatives of Pacific Power, PSE, the public counsel unit of the office of the Washington attorney general (public counsel), and NW Natural.

14 **SUGGESTED CHANGES:** Written and oral comments suggested two changes to the proposed rules. The commission declines to adopt those changes for the reasons discussed below.

15 NW Natural in its written comments expressed concern with the administrative burden imposed by the requirement to separately identify exempt information.[2] As discussed in paragraphs 10-11 above, we find that the costs companies will incur to comply with the proposed rule are minor and necessary for compliance with applicable law. In addition, the requirement to separately identify exempt information should not be a substantial burden in most cases, and the benefits of facilitating the commission's compliance with the Public Records Act outweighs that burden. We therefore adopt the rules as proposed.

[2] At the adoption hearing, NW Natural stated that it could and would work with the proposed rules if the commission adopts them without changes.

16 Pacific Power proposes that the commission expand the scope of WAC 480-07-420 to allow the commission to enter protective orders outside of adjudicative proceedings. The company contends that such orders would facilitate proceedings other than adjudications, such as commission review of energy company integrated resource plans (IRPs), by allowing interested persons to access confidential information pursuant to commission oversight. PSE and public counsel agree. The commission is well aware of the issues of access to confidential information that have arisen in the context of IRPs and other proceedings, but we are also concerned about the practical application of expanding the types of proceedings in which we enter protective orders.

17 The commission considers the vast majority of the matters that come before it outside of adjudications. In addition, not all of the industries the commission regulates are covered by the provisions of RCW 80.04.095 and 81.77.210, and thus may not file confidential documents with the commission under those statutes. Making protective orders more broadly available could unnecessarily complicate commission consideration of nonadjudicative matters and tax the resources of the commission and regulated companies alike. In addition, protective orders in adjudications allow parties in those proceedings to access confidential information. There are no parties in nonadjudicative proceedings. The commission thus would be required to determine which interested persons could sign a protective order in those proceedings, including resolving company objections to requests from members of the media and the general public. The commission also could be required to enforce the obligations of such persons who are permitted to access confidential information. Given these concerns, we are not willing to venture into such uncharted territory at this point in the proceeding or based on the record before us. Accordingly, we adopt the rule as proposed in the CR-102.

18 **COMMISSION ACTION:** After considering all of the information regarding this proposal, the commission finds and concludes that it should amend and adopt the rules as proposed in the CR-102 at WSR 18-16-093.

19 **STATEMENT OF ACTION; STATEMENT OF EFFECTIVE DATE:** After reviewing the entire record, the commission determines that the sections in chapter 480-07 WAC listed in paragraph 6 above should be amended as applicable to read as set forth in Appendix A, as rules of the Washington utilities and transportation commission, to take effect pursuant to RCW 34.05.380(2) on the thirty-first day after filing with the code reviser.

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 the 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.

ORDER

THE COMMISSION ORDERS:

20 The commission amends and adopts WAC 480-07-160 and 480-07-420 to read as set forth in Appendix A, as rules of the Washington utilities and transportation commission, to take effect on the thirty-first day after the date of filing with the code reviser pursuant to RCW 34.05.380(2).

21 This order and the rule set out below, after being recorded in the register of the Washington utilities and transportation commission, shall be forwarded to the code reviser for filing pursuant to chapters 80.01 and 34.05 RCW and 1-21 WAC.

DATED at Olympia, Washington, September 19, 2018.

Washington Utilities and Transportation Commission

David W. Danner, Chairman
Ann E. Rendahl, Commissioner
Jay M. Balasbas, Commissioner

APPENDIX A
Revised Rules

AMENDATORY SECTION (Amending WSR 17-06-051, filed 2/28/17, effective 3/31/17)

WAC 480-07-160 Confidential and other restricted information ((~~under RCW 80.04.095 or 81.77.210~~)). Several statutory provisions limit or prevent disclosure of certain information provided to the commission, including provisions exempting specified public records from disclosure or preventing the release of confidential information until affected parties have an opportunity to obtain a court order forbidding the release. The commission will provide special handling of, and ((~~will limit~~)) restrict access to, ((~~confidential~~)) information ((~~submitted in compliance with this rule or WAC 480-07-423~~)) provided to the commission under these statutory provisions. This rule ((~~applies to any information the provider claims to be confidential under RCW 80.04.095 or 81.77.210. Title 81 RCW, other than RCW 81.77.210, does not contain a similar statute, and the commission will not accept documents marked as confidential pursuant to this rule and submitted on behalf of companies regulated under Title 81 RCW other than solid waste collection companies.~~

(~~1) **Implementation.**~~

(~~a) *Designated official.*~~)) addresses each of these types of restricted information, including how to designate documents as containing exempt information, confidential information, or highly confidential information. Chapter 480-04 WAC governs the commission's specific process for responding to requests for public records that seek restricted information. WAC 480-07-420 governs access to, and exchange of, restricted information by parties in commission adjudicative proceedings.

(1) **Designated official.** The commission's secretary is the designated official responsible for the commission's compliance with the Public Records Act, chapter 42.56 RCW, and for the implementation of this rule. The secretary may designate one or more persons to serve as public records officer to assist in the implementation and application of this rule.

(((~~b) *Provider.* Any person who submits information to the commission or commission staff under a claim of confidentiality pursuant to this rule or a commission protective order is a provider, as that term is used in this rule.~~

(~~c) *Requester.* Any person who submits a request for public records under the Public Records Act, chapter 42.56 RCW, or a data request in an adjudicative proceeding is a requester, as that term is used in this rule.~~

(~~2) **Confidential information defined.** Confidential information is information that meets any of the following criteria:~~

(~~a) Information protected from inspection or copying under an exemption from disclosure requirements under the Public Records Act, chapter 42.56 RCW.~~

(~~b) Information protected under the terms of a protective order in an adjudicative proceeding.~~

(~~c) Valuable commercial information, including trade secrets or confidential marketing, cost, or financial information, or customer-specific usage and network configuration and design information, as provided in RCW 80.04.095 or 81.77.210. Only information that satisfies this definition may be designated as confidential.~~

(~~3) **Highly confidential information.** The commission may authorize protection of information as highly confidential only pursuant to a protective order. Highly confidential information is confidential information to which even more restricted access is necessary to ensure the information is not disclosed to the detriment of the provider (or the party designating the information as confidential, if not the provider). Highly confidential information remains subject to the requirements in RCW 80.04.095 or 81.77.210, and the provisions of this section apply to highly confidential information as well as confidential information unless this rule or the protective order authorizing highly confidential treatment of information states otherwise.~~

(~~4) **How to designate and seek protection of confidential information under this section.**~~)) (2) **Definitions.**

(a) *Document* means any writing as the legislature has defined that term in the Public Records Act, chapter 42.56 RCW.

(b) *Confidential information* means valuable commercial information, including trade secrets or confidential marketing, cost, or financial information, or customer-specific usage and network configuration and design information, as provided in RCW 80.04.095 and 81.77.210.

(c) *Exempt information* means information protected from inspection or copying under an exemption from disclosure under chapter 42.56 RCW or any other provisions of law providing an exemption from public disclosure.

(d) *Highly confidential information* means confidential information subject to heightened protection pursuant to a commission-issued protective order with provisions governing such information.

(e) *Provider* means any person who submits information to the commission or commission staff under a claim that disclosure of the information is restricted pursuant to this rule; provided that for purposes of complying with subsection (5) of this section, "provider" does not include individuals who provide their own financial or personally identifiable information to the commission.

(f) *Redacted version* means the version of a document submitted to the commission with restricted information masked.

(g) *Requester* means any person who submits a request for public records under the Public Records Act, chapter 42.56 RCW.

(h) *Restricted information* means exempt, confidential, or highly confidential information.

(i) *Unredacted version* means the version of a document submitted to the commission with all information unmasked and visible.

(3) **Waiver.** A provider may claim the protection of this rule only by strict compliance with ((~~the following~~)) its requirements. The commission may refuse to accept for filing any document that fails to comply with these requirements. Failure to properly designate confidential or highly confidential information as ((~~confidential also~~)) required in this rule, WAC 480-07-420, or a commission protective order may result in disclosure of the information ((~~not being treated as~~

~~confidential.~~)) in response to a request for public records or in discovery. If a provider fails to properly designate, or otherwise does not properly treat, exempt, confidential, or highly confidential information that belongs to another person, that person may petition or file a motion with the commission seeking to protect the information and requesting any other appropriate relief.

(4) **Exempt information.**

(a) *Designating information as exempt from disclosure.* Any provider claiming that information provided to the commission is exempt from disclosure must make that claim in writing at the time the provider submits the document containing the information. The provider must also state the basis for the claim of exemption at the time the provider submits information claimed to be exempt.

(b) *Provision of documents with information designated as exempt.* Any provider claiming that a document contains exempt information must submit both a redacted and an unredacted version to the commission.

(c) *Marking and submission.*

(i) The provider must clearly designate information claimed to be exempt on each page of the unredacted version by highlighting the text with no more than twenty percent gray shading. The provider must clearly mark each copy of the document with the designation, "Shaded information is designated as exempt per WAC 480-07-160" on the first page of a multipage document and on each specific page that the provider claims contains exempt information, except as modified pursuant to subsection (7)(a) of this section or WAC 480-07-420 and except as provided in subsection (8) of this section.

(ii) The provider must print on yellow paper any required paper copy of the pages of the unredacted version of a document that contain information designated as exempt and submit that document, in its entirety, in a sealed envelope. A provider submitting more than one document containing information designated as exempt as part of the same filing must collate all of these documents into a set, and to the extent feasible, must enclose each entire set in a separate envelope. If the commission requires more than one paper copy of documents to be submitted, the provider must submit each set of documents containing information designated as exempt in a separate envelope to the extent feasible.

(iii) The provider must label the redacted version of the document as redacted. The provider must either completely black out the information claimed to be exempt or leave a blank space where that information is located in the redacted version. The redacted and unredacted versions of a document must have the same pagination, and the text on each page must appear on the same lines. If the provider submits a document under a claim that all of the substantive information contained on multiple contiguous pages is exempt, the provider may submit a single page in the redacted version for the contiguous exempt pages if that page identifies the pages claimed to contain exempt information.

(iv) The provider must file the redacted and unredacted versions with the commission in the same web portal submission. If using another type of submission, the provider must file the redacted and unredacted versions at the same time but in separate submissions. When submitting electronic unredacted versions, the provider must state in the description field of the web portal submission, in the subject line of the transmitting email, or on a visible portion of the disc or electronic storage medium, whichever is applicable, that one or more documents in the filing contain information designated as exempt under this section.

(d) *Procedures upon a request for information designated as exempt.* If a requester submits a public records request for information that a provider has designated as exempt, the commission will follow the procedures outlined in chapter 480-04 WAC.

(e) *Challenges to designations of information as exempt.* The commission or a party to a proceeding in which a provider submits a document with information designated as exempt may challenge that designation. The commission will provide an opportunity to the provider and the parties to any adjudication to respond before ruling on the challenge. The commission may express its ruling orally on the record in an adjudicative proceeding, or in a written order.

(5) **Confidential information.**

(a) ((~~*Contents.* The~~)) *Designating information as confidential information.* Any provider ((~~must submit the claim of confidentiality~~)) claiming that information provided to the commission is confidential must make that claim in writing at the same time the provider submits the document containing the information ((~~claimed to be confidential is submitted. The provider~~)) and must state the basis ((~~on which the information is claimed to be confidential, and if the document is not submitted pursuant to a protective order in an adjudicative proceeding,~~)) for the claim. To the extent feasible, the provider also must identify any person (other than the provider) who might be directly affected by disclosure of the confidential information.

(b) *Provision of documents with information designated as confidential ((~~or information designated as highly confidential~~)).* ((~~The~~)) Any provider claiming that a document contains confidential information must submit ((~~two versions of all documents claimed to include either (but not both) confidential or highly confidential information:~~

~~(i) An electronic copy (as required in WAC 480-07-140(6)), and any paper copies the commission has required, of the version of the document that contains all information designated as confidential (confidential version) or highly confidential (highly confidential version); and~~

~~(ii) An electronic copy in .pdf format, and any paper copies the commission has required, of the version of the document that masks the information claimed to be confidential or highly confidential (redacted version).~~

~~(c) *Documents with information designated as confidential and information designated as highly confidential.* The provider must submit three versions of all documents claimed to include both highly confidential and confidential information:~~

~~(i) An electronic copy (as required in WAC 480-07-140(6)), and any paper copies the commission has required, of the version of the document that contains all information designated as highly confidential or confidential (highly confidential version);~~

~~(ii) An electronic copy (as required in WAC 480-07-140(6)), and any paper copies the commission has required,~~

~~of the version of the document that contains all information designated as confidential and masks all information designated as highly confidential (confidential version); and~~

~~(iii) An electronic copy in .pdf format, and any paper copies the commission has required, of the version of the document that masks all information claimed to be highly confidential or confidential (redacted version).~~

~~(d)~~))) both a redacted and an unredacted version to the commission.

(c) *Marking and submission.*

(i) ((~~Documents containing information designated as confidential or highly confidential must be marked as follows:~~

~~(A)~~))) The provider must clearly designate information claimed to be confidential on each page of the unredacted version by highlighting the text with no more than twenty percent gray shading. The provider must clearly mark each copy of the ((~~confidential~~)) unredacted version of the document with the designation, "((~~Designated~~)) Shaded information is designated as confidential ((~~per protective order in Docket [insert docket number]" if the provider submits confidential information under the provisions of a protective order, or "Designated information is confidential~~)) per WAC 480-07-160" ((~~if not submitted under the terms of a protective order. The provider must clearly mark each copy of the highly confidential version of the document with the designation "Designated information is highly confidential per protective order in Docket [insert docket number]." The provider must place the applicable mark~~)) on the first page of a multipage document and on each specific page ((~~on which~~)) the provider claims ((~~there is confidential or highly~~)) contains confidential information((~~. In the subject line of the email or in a visible portion of the disc or electronic storage medium containing the electronic copies of the document, the provider also must state that one or more documents contain information designated as confidential or highly confidential under a protective order or WAC 480-07-160, as applicable.~~

~~(B) Each page of the electronic document and any required paper copies of the confidential version that includes information claimed to be confidential must clearly designate that information on each page by highlighting the text with no more than twenty percent grey shading or other clearly visible designation. Each such page of any paper copies must be printed on yellow paper.~~

~~(C) Each page of the electronic document and any required paper copies of the highly confidential version that contains information designated as highly confidential under a protective order must clearly designate the highly confidential information by highlighting the text with no more than twenty percent grey shading or other clearly visible designation. Each such page of any paper copies must be printed on light blue paper.~~

~~(D) If a document includes both confidential and highly confidential information, each page of any paper copies of the confidential version that contains only information designated as confidential must be printed on yellow paper, and pages containing information designated as highly confidential must be printed on light blue paper, including pages that contain both highly confidential and confidential information. The provider is responsible for ensuring that highly confidential information is clearly distinguished from confidential information when a document includes both highly confidential and confidential information.~~

~~(E)~~)) except as modified pursuant to subsection (7)(a) of this section or WAC 480-07-420 with respect to confidential information provided pursuant to a protective order and except as provided in subsection (8) of this section.

(ii) The provider must print on yellow paper any required paper copy of the ((~~confidential or highly confidential~~)) pages of the unredacted version of a document that contain information designated as confidential and submit that document, in its entirety, ((~~must be submitted~~)) in a sealed envelope. A ((~~person~~)) provider submitting more than one ((~~confidential or highly confidential document in a single submission~~)) document containing information designated as confidential as part of the same filing must collate all of ((~~the confidential documents into a set and all of the highly confidential~~)) these documents into a set, and to the extent feasible, must enclose each entire set in a separate envelope. If the commission requires more than one paper copy of documents to be submitted, the provider must submit each set of documents containing information designated as confidential ((~~or highly confidential documents must be submitted~~)) in a separate envelope to the extent feasible.

(((~~(F)~~))) (iii) The provider must label the redacted version of the document ((~~must be labeled~~)) as redacted ((~~and submitted simultaneously with the corresponding confidential or highly confidential document~~)). The ((~~redacted version~~)) provider must either completely black out the information claimed to be confidential ((~~or highly confidential~~)) or leave a blank space where that information is located in the document. The redacted and ((~~confidential or highly confidential~~)) unredacted versions of a document must have the same pagination, and the text on each page must appear on the same lines. If the provider submits a document under a claim that all of the substantive information contained on multiple contiguous pages is confidential ((~~or highly confidential~~)), the provider may submit a single page in the redacted version for the contiguous confidential pages if that page identifies the pages claimed to ((~~be confidential or highly~~)) contain confidential information.

(((~~(ii) Documents containing information designated as confidential or highly confidential must be submitted as follows:~~

~~(A) All documents containing information designated as confidential that are required or intended to be submitted to meet a single deadline must be submitted at the same time and in the same message or on the same disc or electronic storage medium, separately from documents that include information designated as highly confidential or that do not include any information designated as confidential.~~

~~(B) All documents containing information designated as highly confidential that are required or intended to be submitted to meet a single deadline must be submitted at the same time and in the same message or on the same disc or electronic storage medium, separately from documents that include information designated as confidential or that do not include any such information.~~

~~(C) The fully redacted versions of all documents containing information designated as confidential or highly confi-~~

~~dential, along with any other nonconfidential documents that are part of the filing, must be submitted separately from the documents containing information designated as confidential or highly confidential, and all of the nonconfidential documents must be submitted in a single message or on the same electronic storage medium.~~

~~(D) If the volume of documents of any type exceeds the size constraints of the commission's web portal or email system for a single submission, those documents may be submitted in multiple submissions as provided in WAC 480-07-140 (6)(c).~~

~~(E) All submissions comprising a single filing must be made as close to simultaneously as practicable.~~

~~(5)~~)) (iv) The provider must file the redacted and unredacted versions with the commission in the same web portal submission. If using another type of submission, the provider must file the redacted and unredacted versions at the same time but in separate submissions. When submitting electronic unredacted versions, the provider must state in the description field of the web portal submission, in the subject line of the transmitting email, or on a visible portion of the disc or electronic storage medium, whichever is applicable, that one or more documents in the filing contain information designated as confidential under this section.

(d) *Request for information designated as confidential.* If a requester submits a public records request for information that a provider has designated as confidential, the commission will follow the applicable process in chapter 480-04 WAC, WAC 480-07-420, or applicable protective order.

(e) *Challenges to ((~~claims of confidentiality~~)) designations of information as confidential.* The commission or a party to a proceeding in which a provider submits a document with ((~~a claim of confidentiality may challenge the claim. When a challenge is made,~~)) information designated as confidential may challenge that designation. The commission will provide an opportunity to the provider and the parties to any adjudication to respond before ruling on the challenge. ((~~If a confidential designation is challenged,~~)) The provider of the ((~~confidential~~)) information designated as confidential bears the burden to show that part or all of ((~~a document~~)) that information should be protected from disclosure ((~~under chapter 42.56 RCW, RCW 80.04.095, 81.77.210, or a protective order~~)). The commission may express its ruling orally on the record in an adjudicative proceeding, or in a written order.

(6) ((~~**Requests for information designated as confidential.** Subject to the requirements of this subsection, the commission will release information designated as confidential or highly confidential in response to a written request for public records made in compliance with WAC 480-04-090.~~

~~(a) *Avoidance of disclosure.* If the public records officer and the requester agree that the commission can satisfy the request for information without disclosing information designated as confidential or highly confidential, the public records officer will provide or make available for review the publicly available information in the commission's possession that is responsive to the request.~~

~~(b) *Notice of request for, and release of, information designated confidential.* If the requester does not agree that the commission can satisfy the request without disclosing information designated as confidential or highly confidential, the commission will implement the following procedure:~~

~~(i) Pursuant to RCW 80.04.095 or 81.77.210, as applicable, the commission will provide written notice of any request for information designated as confidential or highly confidential to the provider and any person that has been identified as a person who might be directly affected by release of the information. The commission will issue such notice not more than two business days after receiving confirmation that the requester requests information designated as confidential or highly confidential. The commission will send a copy of the notice to the requester at the same time it sends a copy to the provider.~~

~~(ii) The commission need not assist any person in seeking or resisting judicial intervention to protect from disclosure any information designated as confidential or highly confidential, but the commission may participate in any such proceeding.~~

~~(iii) If the provider consents in writing to the release of the information designated as confidential or highly confidential or does not restrain disclosure of that information by obtaining a court order within ten days following the commission's notice of the request, the commission will consider the information public, remove the confidential or highly confidential designation from its files, and release the information to the requester.~~

~~(7)~~)) **Highly confidential information.**

(a) *Designating information as highly confidential.* Any provider claiming that information provided to the commission is highly confidential must make that claim in writing at the time the provider submits the document containing the information. The provider also must identify the highly confidential protective order providing the basis for the claim.

(b) *Provision of documents containing highly confidential information.* Any provider claiming that a document contains highly confidential information must submit a redacted and an unredacted version to the commission.

(c) *Marking and submission.*

(i) The provider must clearly designate information claimed to be highly confidential on each page of the unredacted version by highlighting the text with no more than twenty percent gray shading. The provider must clearly mark each copy of the document with the designation, "Shaded information designated as highly confidential per protective order in Docket (insert docket number)" on the first page of a multipage document and on each specific page which the provider claims contains highly confidential information, except as modified pursuant to subsection (7)(a) of this section or WAC 480-07-420 and except as provided in subsection (8) of this section.

(ii) The provider must print on blue paper any required paper copy of the pages of the unredacted version of a document that contain information designated as highly confidential and submit that document, in its entirety, in a sealed envelope. A provider submitting more than one document containing information designated as highly confidential as part of the same filing must collate all of these documents into a set, and to the extent feasible, must enclose each entire set in a separate envelope. If the commission requires more than one paper copy of documents to be filed, the provider must

submit each set of documents containing information designated as highly confidential in a separate envelope to the extent feasible.

(iii) The provider must label the redacted version of the document as redacted. The provider must either completely black out the information claimed to be highly confidential or leave a blank space where that information is located in the redacted document. The redacted and unredacted versions of a document must have the same pagination, and the text on each page must appear on the same lines. If the provider submits a document under a claim that all of the substantive information contained on multiple contiguous pages is highly confidential, the provider may submit a single page in the redacted version for the contiguous restricted pages if that page identifies the pages claimed to be highly confidential.

(iv) The provider must file the redacted and unredacted versions with the commission in the same web portal submission. If using another type of submission, the provider must file the redacted and unredacted versions at the same time but in separate submissions. When submitting electronic unredacted versions, the provider must state in the description field of the web portal submission, in the subject line of the transmitting email, or on a visible portion of the disc or electronic storage medium, whichever is applicable, that one or more documents in the filing contain information designated as highly confidential under the applicable protective order.

(d) *Request for information designated as highly confidential.* If a requester submits a public records request for information that a provider has designated as highly confidential, the commission will follow the applicable procedures in chapter 480-04 WAC, WAC 480-07-420, or the applicable protective order.

(e) *Challenges to designations of information as highly confidential.* The commission or a party to a proceeding in which a provider submits a document that the provider claims contains highly confidential information may challenge that designation. The commission will provide an opportunity to the provider and the parties to respond before ruling on any challenge. The provider of the information designated as highly confidential bears the burden to show that a part or all of that information should be protected from disclosure under the terms of the protective order. The commission may express its ruling orally on the record or in a written order.

(f) *Initial filing.* A provider may withhold information from an initial filing that the provider intends to designate as highly confidential after the commission enters a protective order under the following conditions:

(i) The provider describes the withheld information with reasonable particularity;

(ii) The provider files and serves complete unredacted and redacted versions of all documents that contain information designated as highly confidential as soon as practicable after the commission enters a protective order; and

(iii) The initial filing otherwise complies with all filing requirements in these rules including, but not limited to, the general rate proceeding filing requirements in subpart B. The commission may reject an initial filing if the withheld information is necessary for the commission to determine whether the filing complies with applicable filing requirements.

(7) **Procedures for documents containing multiple types of restricted information.** Documents submitted to the commission may contain more than one type of restricted information. For example, a document may contain exempt information on one page and highly confidential information on another page. Any provider submitting a document containing more than one type of restricted information must comply with the provisions of this rule for each type of restricted information, subject to the provisions of this subsection. When the commission receives a request for a document containing more than one type of restricted information, the commission will also follow the procedures listed above for each relevant type of restricted information.

(a) *Differentiating types of restricted information.* The provider is responsible for distinguishing each type of restricted information from another when a document contains more than one type of restricted information. Possible methods for doing so include, but are not limited to, underlining or bracketing one type of information. The provider must identify the method used on each page of the document that contains that type of restricted information, e.g., by modifying the required designations to state, "Underlined and shaded information designated as highly confidential per protective order in Docket (insert docket number)," and "Shaded only information designated as exempt under WAC 480-07-160." The method used must be visible on both the redacted and unredacted versions of the document.

(b) *Documents containing no highly confidential information.* When a document contains both exempt and confidential information but no highly confidential information, the provider must submit a single unredacted version with all restricted information marked in accordance with subsections (4)(c), (5)(c), and (7)(a) of this section except as provided in subsection (8) of this section. The provider must submit a single redacted version with all restricted information masked.

(c) *Documents containing highly confidential information in addition to other types of restricted information.* When the document contains highly confidential information in addition to one or more other types of restricted information, the provider must submit a single unredacted version with all restricted information marked in accordance with subsections (4)(c), (5)(c), (6)(c), and 7(a) of this section, as applicable, except as provided in subsection (8) of this section. The provider must submit at least two different redacted versions of the document. The first redacted version must mask all highly confidential information, but leave all other restricted information unmasked. The second must mask all highly confidential information and all other restricted information.

(8) **Spreadsheets.** If the cells in a spreadsheet or other tabular document include information that has been designated as exempt, confidential, or highly confidential and that would be impractical or unduly burdensome to mark as required in subsections (4) through (7) of this section, the provider need not comply with those requirements but must identify that information in a way that reasonably provides the commission with sufficient identification of the information to be protected and the basis for that protection.

(9) **Designation or redesignation of exempt, confidential, or highly confidential information**. No later than the

time for filing briefs or, if no briefs are filed, within ten days after the close of the record in an adjudication in which a party has designated information as exempt, confidential, or highly confidential, that party must verify the accuracy of all ((~~confidential~~)) such designations in the record and in the exhibit list for the proceeding, and submit to the commission any proposed corrections or changes. Absent a statement of proposed corrections or changes, the designations in the record and in the exhibit list are final, and the commission will change those designations only if the provider ((~~(or the party that has designated the information as confidential or highly confidential, if different)~~)) voluntarily removes, or is required by law to remove, ((~~a confidential~~)) the designation. ((~~If there is conflict between designations, the commission will adopt the designation that is least restrictive to public access.~~))

AMENDATORY SECTION (Amending WSR 17-06-051, filed 2/28/17, effective 3/31/17)

WAC 480-07-420 Discovery—Protective orders. (1) **Standard form.** The commission may enter a standard form of protective order designed to promote the free exchange of information and development of the factual record in a proceeding when the commission finds that parties reasonably anticipate that discovery or evidentiary ((~~submissions~~)) filings will require ((~~the disclosure of~~)) information designated as confidential as defined in WAC 480-07-160((~~. Parties must strictly limit the information they designate as confidential to information that is or may be exempt from public disclosure under RCW 80.04.095, 81.77.210, or the Public Records Act, chapter 42.56 RCW, including RCW 42.56.330~~)) to be disclosed to other parties in the adjudication. Parties must ((~~follow the instructions~~)) comply with the requirements in the protective order and in WAC 480-07-160 for ((~~properly~~)) designating, marking, and ((~~submitting~~)) filing documents ((~~with the commission~~)) containing information ((~~designated as~~)) claimed to be confidential ((~~in a proceeding governed by a protective order~~)). In addition, parties must modify the designation required in WAC 480-07-160 (5)(c)(1) to state, "Shaded information designated as confidential per protective order in Docket (insert docket number)." When submitting the electronic unredacted versions, the provider must state in the description field of the web portal submission, in the subject line of the transmitting email, or on a visible portion of the disc or electronic storage medium, whichever is applicable, that one or more documents in the filing contain information designated as confidential under the protective order.

(2) **Amendment.** The commission may, upon motion by a party, or on its own initiative, amend its standard form of protective order to meet the parties' and the commission's needs in individual cases.

(a) *Protection for highly confidential information.* A party that wishes to designate information as highly confidential must make a motion, orally at the prehearing conference or in writing, for an amendment to the standard protective order, supported by a declaration, testimony, or representations of counsel that set forth the specific factual and legal basis for the requested level of protection and an explanation of why the standard protective order is inadequate. The motion and declaration or testimony must identify specific parties, persons, or categories of persons, if any, to whom a party wishes to restrict access, and state the reasons for such proposed restrictions. If the commission amends its standard protective order to include protections for highly confidential information, parties must comply with the requirements in the protective order and in WAC 480-07-160 for designating, marking, and filing documents containing information designated as highly confidential.

(b) ((~~*Limitations.* If~~)) *Protection for exempt information.* The commission ((~~modifies~~)) may modify the standard protective order to include protection for ((~~highly confidential~~)) exempt information((~~, parties must strictly limit the information they designate as highly confidential to the information identified in the amendment to the protective order and must follow the instructions in WAC 480-07-160 for properly marking and submitting documents with the commission as highly confidential~~)) if the commission finds that parties' access to information designated as exempt as defined in WAC 480-07-160 is necessary for development of the factual record in the adjudication. Parties must comply with the requirements in the protective order and in WAC 480-07-160 for designating, marking, and filing documents containing information designated as exempt. In addition, parties must modify the designation required in WAC 480-07-160 (4)(c)(i) to state, "Shaded information designated as exempt per protective order in Docket (insert docket number)." When submitting the electronic unredacted versions, the provider must state in the description field of the web portal submission, in the subject line of the transmitting email, or on a visible portion of the disc or electronic storage medium, whichever is applicable, that one or more documents in the filing contain information designated as exempt under the protective order.

(c) *Other information.* The commission reserves the right to restrict access to other types of information on a case-by-case basis through the use of a protective order.

(3) **Special order.** Upon motion by a party or by the person from whom discovery is sought that establishes a need to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense, the presiding officer may order appropriate limitations on discovery including, but not necessarily limited to, one or more of the following:

(a) The discovery will not be allowed;

(b) The discovery will be allowed only on specified terms and conditions;

(c) The discovery will be allowed only by a method of discovery other than the method selected by the party seeking discovery; or

(d) Certain matters may not be inquired into, or the scope of the discovery will be limited to certain matters.

(4) **Denial of motion for protective order.** The presiding officer may order that any party or person provide or permit discovery on such terms and conditions as are just if the commission denies a motion for a protective order in whole or in part.

(5) **Challenges to designations.** The commission or a party to a proceeding may challenge a designation of information as confidential, highly confidential, exempt, or other-

wise protected from disclosure pursuant to a protective order. The commission will provide an opportunity for the provider of the information and other interested parties to respond before ruling on any challenge. The provider bears the burden to show that a part or all of the information should be protected from disclosure under the terms of the protective order. The commission may render its ruling orally on the record or in a written order. If the commission sustains the challenge to the designation, the commission will determine how and when the designated information must be disclosed.

(6) **Public record request for protected information.** If a requester submits a public records request during the pendency of an adjudicative proceeding, including any judicial review, for information that a provider has designated as confidential, highly confidential, exempt, or otherwise protected from disclosure pursuant to a protective order, the commission will review that request pursuant to the procedures in subsection (5) of this section. If a requester submits a public records request after an adjudicative proceeding has concluded, including any judicial review, for information that a provider has designated as confidential, highly confidential, exempt, or otherwise protected from disclosure pursuant to a protective order, the commission will follow the procedures in WAC 480-04-095.

WSR 18-20-007
PERMANENT RULES
UTILITIES AND TRANSPORTATION COMMISSION

[Docket A-180513, General Order R-594—Filed September 19, 2018, 3:15 p.m., effective October 20, 2018]

In the matter of amending, adopting and repealing sections of chapter 480-04 WAC relating to the commission's public access to information and records.

1 **STATUTORY OR OTHER AUTHORITY:** The Washington utilities and transportation commission (commission) takes this action under Notice No. WSR 18-16-096, filed with the code reviser on July 31, 2018. The commission brings this proceeding pursuant to RCW 80.01.040 and 80.04.160**.**

2 **STATEMENT OF COMPLIANCE:** This proceeding complies with the Administrative Procedure Act (chapter 34.05 RCW), the State Register Act (chapter 34.08 RCW), the State Environmental Policy Act of 1971 (chapter 43.21C RCW), and the Regulatory Fairness Act (chapter 19.85 RCW).

3 **DATE OF ADOPTION:** The commission adopts this rule on the date this order is entered.

4 **CONCISE STATEMENT OF PURPOSE AND EFFECT OF THE RULE:** RCW 34.05.325(6) requires the commission to prepare and publish a concise explanatory statement about an adopted rule. The statement must identify the commission's reasons for adopting the rule, describe the differences between the version of the proposed rules published in the register and the rules adopted (other than editing changes), summarize the comments received regarding the proposed rule changes, and state the commission's responses to the comments reflecting the commission's consideration of them.

5 To avoid unnecessary duplication in the record of this docket, the commission designates the discussion in this order, including appendices, as its concise explanatory statement, supplemented where not inconsistent by the commission staff (staff) memoranda preceding the filing of the CR-102 proposal and the adoption hearing. Together, these documents provide a complete but concise explanation of the agency actions and its reasons for taking those actions.

6 **REFERENCE TO AFFECTED RULES:** This order adopts WAC 480-04-005 Authority and purpose; amends WAC 480-04-020 Definitions, 480-04-035 Contact information, 480-04-050 Public information available without making a request for public records, 480-04-060 Public records available; hours for inspection and copying, 480-04-065 Index of significant decisions, 480-04-090 Requests for public records, 480-04-095 Responding to requests for public records, 480-04-100 Copying charges, 480-04-120 Review of denials of public records requests and 480-04-130 Protection of public records; and repeals WAC 480-04-030 Organization of the Washington utilities and transportation commission.

7 **PREPROPOSAL STATEMENT OF INQUIRY AND ACTIONS THEREUNDER:** The commission filed a preproposal statement of inquiry (CR-101) on June 8, 2018, at WSR 18-13-020. The statement advised interested persons that the commission was considering making additions and amendments to certain sections in chapter 480-04 WAC, Public access to information and records. The statement further explained that the commission last updated this chapter of its rules in 2006 and believes that the current rules may need to be supplemented, improved, or clarified to better reflect changes in the law and commission practices since that time. The commission also informed persons of this inquiry by providing notice of the subject and the CR-101 to everyone on the commission's list of persons requesting such information pursuant to RCW 34.05.320(3), to all interested persons in the current procedural rules rule-making docket A-130355, to all regulated companies and lists of attorneys, as well as to all lists of persons interested in commission rule makings. Pursuant to the notice, the commission received comments on or around July 10, 2018**.**

8 **SMALL BUSINESS ECONOMIC IMPACT ANALYSIS:** On July 3, 2018, the commission issued a small business economic impact questionnaire to all interested persons. The commission received no responses to this questionnaire. The proposed rules primarily reflect current commission practice, and the commission has no basis to find that any costs businesses will incur to comply with the rules will be more than minor. Pursuant to RCW 19.85.030 (1)(a), therefore, no small business economic impact statement is required.

9 **NOTICE OF PROPOSED RULE MAKING:** The commission filed a notice of proposed rule making (CR-102) on July 31, 2018, at WSR 18-16-096. The commission scheduled this matter for oral comment and adoption under Notice No. WSR 18-16-096 at 9:30 a.m., Monday, September 10, 2018, in the Commission's Hearing Room, Second Floor, Richard Hemstad Building, 1300 South Evergreen Park Drive S.W., Olympia, WA. The notice provided interested persons the opportunity to submit written comments to the commission.

10 **WRITTEN COMMENTS:** The commission requested written comments on the proposed rules on or about August 31, 2018. The commission received no comments.

11 **RULE-MAKING HEARING:** The commission considered the proposed rules for adoption at a rule-making hearing on Monday, September 10, 2018, before Chairman David W. Danner, Commissioner Ann E. Rendahl, and Commissioner Jay M. Balasbas. The commission heard a presentation and comments from Gregory J. Kopta, administrative law judge, representing staff. No other person made any comments.

12 **CHANGE TO PROPOSED RULE:** At the adoption hearing, staff noted that two subsections of proposed WAC 480-04-100 refer to a commission internal policy on public records that is not publicly accessible. Staff, therefore, recommended that the commission delete those references from the rule and simply refer inquiries concerning fees for obtaining copies of documents to the commission's records center. We agree with staff's recommendation and amend the proposed rule accordingly.

13 **COMMISSION ACTION:** After considering all of the information regarding this proposal, the commission finds and concludes that it should amend, repeal, and adopt the rules as proposed in the CR-102 at WSR 18-16-096 with the following changes discussed in paragraph 12 above:

WAC 480-04-100:

In subsection (2), substitute "Persons may obtain the" for "The commission publishes its"; delete "the commission's" before "copying charges"; and delete "in Administrative Policy 5.1c, which is available on the commission's website or."

In subsection (5), delete "as provided in Administrative Policy 5.1c" at the end of the first sentence.

14 **STATEMENT OF ACTION; STATEMENT OF EFFECTIVE DATE:** After reviewing the entire record, the commission determines that the sections in chapter 480-04 WAC should be repealed, amended, and adopted to read as set forth in Appendix A, as rules of the Washington utilities and transportation commission, to take effect pursuant to RCW 34.05.380(2) on the thirty-first day after filing with the code reviser.

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 the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 1, Amended 10, Repealed 1.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 1, Amended 10, 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.

ORDER

THE COMMISSION ORDERS:

15 The commission amends, repeals, and adopts chapter 480-04 WAC to read as set forth in Appendix A, as rules of the Washington utilities and transportation commission, to take effect on the thirty-first day after the date of filing with the code reviser pursuant to RCW 34.05.380(2).

16 This order and the rule set out below, after being recorded in the register of the Washington utilities and transportation commission, shall be forwarded to the code reviser for filing pursuant to chapters 80.01 and 34.05 RCW and 1-21 WAC.

DATED at Olympia, Washington, September 19, 2018.

Washington State Utilities and Transportation Commission

David W. Danner, Chairman
Ann E. Rendahl, Commissioner
Jay M. Balasbas, Commissioner

Appendix A
Revised Rules

NEW SECTION

WAC 480-04-005 Authority and purpose. The Public Records Act, chapter 42.56 RCW, requires state agencies to make available for inspection and copying nonexempt public records in accordance with published rules. The sections in this chapter establish the procedures the Washington utilities and transportation commission will follow to provide full access to public records.

AMENDATORY SECTION (Amending WSR 03-24-028, filed 11/24/03, effective 1/1/04)

WAC 480-04-020 Definitions. (1) "Identifiable public record" is a public record that exists at the time the commission receives the request for public records and that commission staff can reasonably locate.

(2) "Public record" includes any writing (((~~defined in subsection (5) of this section) prepared, owned, used, or retained by the commission, which contains~~)) containing information relating to the conduct of government or the performance of any governmental or proprietary function prepared, owned, used, or retained by the commission regardless of physical form or characteristics.

(((~~(2)~~))) (3) "Public records officer" means the official responsible for the commission's compliance with the Public Records Act, chapter ((~~42.17~~)) 42.56 RCW, and for the implementation of this chapter. The commission's secretary is designated as its public records officer. The secretary may designate one or more persons to assist in the implementation and application of this ((~~rule~~)) chapter, and "public records officer" as used in this chapter includes such persons.

(((~~(3)~~))) (4) "Secretary," also referred to as "executive secretary," means the secretary of the commission appointed pursuant to RCW 80.01.030. Unless otherwise restricted, the term "secretary" also refers to the acting secretary and to the secretary's designee.

(((~~(4)~~))) (5) "Washington utilities and transportation commission," also referred to in this chapter as "the commission," is the ((~~commission appointed by the governor under RCW 80.01.010~~)) agency established in Titles 80 and 81 RCW to regulate the rates, services, facilities, and practices of persons engaging in this state in the business of supplying any utility service or commodity, or of the transportation of persons or property, to the public for compensation. Where appropriate,

the term "commission" also refers to the staff and employees of the Washington utilities and transportation commission.

(((~~(5)~~))) (6) "Writing" ((~~means any information (e.g., words, numbers, symbols, images, and sounds) recorded in any media (e.g., handwritten, typewritten, printed, electronic, photographic, and video and audio recording), as defined in RCW 42.17.020(42).~~

~~(6) The word "you," or "your," when used in this chapter, refers to a person who requests access to public records~~)) is any means of recording any form of communication or representation as provided in RCW 42.56.010(4).

AMENDATORY SECTION (Amending WSR 03-24-028, filed 11/24/03, effective 1/1/04)

WAC 480-04-035 ((~~Physical address—Telephone—Facsimile—E-mail—Internet.~~)) Contact information. ((~~The~~)) Any person may obtain information about the commission or request access to its public records by contacting the commission using the contact information provided in WAC 480-07-125. That information ((~~included in this section~~)) is current at the time of rule adoption((~~,~~)) but may change. Current information and additional contact information are available on the commission's ((~~internet~~)) web site, in person at the commission's offices, or by ((~~telephone call to~~)) calling the commission's main public telephone number.

((~~Physical address; address for U.S. mail or hand-delivery~~	~~Washington Utilities and Transportation Commission~~ ~~1300 S. Evergreen Park Drive S.W.~~ ~~P.O. Box 47250~~ ~~Olympia, WA 98504-7250~~
~~Telephone (general)~~	~~360-664-1160~~
~~Telephone (records center)~~	~~360-664-1234~~
~~Telefacsimile (records center)~~	~~360-586-1150~~
~~Electronic mail (records center)~~	~~records@wutc.wa.gov~~
~~Internet~~	~~www.wutc.wa.gov~~))

AMENDATORY SECTION (Amending WSR 03-24-028, filed 11/24/03, effective 1/1/04)

WAC 480-04-050 Public information((~~, public submissions or requests other than~~)) available without making a request((~~s~~)) for public ((~~documents~~)) records. ((~~Anyone who wishes to obtain general information concerning topics within~~)) Many of the commission's ((~~jurisdiction may find such information~~)) public records are publicly accessible on the commission's ((~~internet site or may contact the commission by letter, telephone, or email, as described in this section. The commission will route all inquiries to staff who can best respond to the inquiry.~~

~~(1) Written requests for information should be sent to the commission's public records officer at the commission's mailing address.~~

~~(2) Electronic mail and telefacsimile requests for information should be sent to the commission's records center.~~

~~(3) Telephone requests for information may be made by contacting~~)) web site. Such documents include, but are not limited to, commission orders and notices, party filings in commission adjudications, regulated company filings, and documents containing general information about the commission, the industries and companies the commission regulates, and consumer assistance. Persons seeking commission documents should view the documents available on the commission's web site prior to submitting a public records request. Persons who need help finding such information may contact the commission's records center((~~, or by call to~~)) by calling the commission's general telephone number or sending an email to records@utc.wa.gov.

AMENDATORY SECTION (Amending WSR 03-24-028, filed 11/24/03, effective 1/1/04)

WAC 480-04-060 Public records available; hours for inspection and copying. (1) All of the commission's public records are available for inspection and copying unless the public record is exempt from disclosure under chapter ((~~42.17~~)) 42.56 RCW (the Public Records Act)((~~,~~)) or protected from disclosure under RCW 80.04.095 or 81.77.210 (records that contain valuable commercial information), WAC 480-07-160 (Confidential information), a protective order the commission enters pursuant to WAC 480-07-420 (Discovery—Protective orders), or ((~~under~~)) other provision of law. Except as provided in RCW ((~~42.17.260(6)~~)) 42.56.070(8), the commission will not give, sell, or provide access to lists of individuals if the information is requested for commercial purposes.

(2) The commission will promptly respond to requests for inspection and copying of public records as provided in this chapter.

(3) Public records are available for inspection and copying during the commission's customary office hours ((~~which are from 8:00 a.m. to 5:00 p.m., Monday through Friday, excluding official state holidays as defined in RCW 1.16.050 (legal holidays and legislatively recognized days)~~)) specified in WAC 480-07-120.

AMENDATORY SECTION (Amending WSR 03-24-028, filed 11/24/03, effective 1/1/04)

WAC 480-04-065 ((~~Records~~)) Index of significant decisions. ((~~The commission will publish and index its significant adjudicative decisions; declaratory orders; interpretive statements; and policy statements.~~)) (1) **Content.** The commission will ((~~publish~~)) maintain and make available to the public ((~~its adjudicative orders that resolve contested issues or which it believes will be of interest or significance, its~~)) an index of the following:

(a) Final orders the commission has entered after June 30, 1990, in adjudicative proceedings that contain an analysis or decision of substantial importance to the agency in carrying out its duties;

(b) Declaratory orders((~~, its~~)) the commission has entered after June 30, 1990, that contain an analysis or deci-

sion of substantial importance to the agency in carrying out its duties; and

(c) Interpretive and policy statements((~~, and its policy statements~~)) the commission has issued since June 30, 1990.

(2) **Availability.** The commission will publish ((~~these documents~~)) the index by the means it deems best suited to achieve broad availability, consistent with staff resources and technology((~~, including distribution of paper copies, electronic mail, and internet web site posting. The commission will contemporaneously publish a summary of the decisions, orders, and statements.~~

~~(2) The commission will annually publish indices of the principles that are applied in the text of published decisions, orders, and statements.~~

~~(3) The commission will make paper copies of its indices available for sale at the commission's estimated actual cost of reproduction and distribution~~)). The documents contained in the index will also be included in the searchable document library on the commission's public web site.

AMENDATORY SECTION (Amending WSR 03-24-028, filed 11/24/03, effective 1/1/04)

WAC 480-04-090 Requests for public records. (1) ((~~Many requests for public records can be handled quickly and informally without the need for a formal written request. You may ask orally, in person, or by telephone to look at a document, or get a copy of a document. You may also ask informally in writing, by letter or electronic mail. Requests may be made by electronic mail to the commission records center. Commission staff will advise you if a formal written request, as described in subsection (4) of this section, is required.~~

~~(2) The commission may require any person who seeks access to public records to present a formal written request. The commission may require a formal written request, for example, if you ask for large quantities of information or make an unusual request. The formal written request helps the commission make sure that you get all the information you have requested and that any charges for copies are proper.~~

~~(3) The commission may require a formal written request if the information you ask for might be within one of the exceptions to the law requiring disclosure. In this situation, your formal written request helps the commission make sure that its decision to disclose or withhold the information is made properly and that you get the public records you are entitled to receive. Examples of information that might be exempt from disclosure include documents that have been designated "confidential" by the person providing them to the commission, documents containing private or personal information, and documents that may be involved in litigation or hearings.~~

~~(4) If you need to make a formal written request for information, you may use a "public records request" form provided by the commission or you may write a letter that~~)) **Definition.** Except for requests for assistance to review or obtain documents on the commission's web site, any request for identifiable public records is a request for public records to which the commission must respond in compliance with the Public Records Act. Requests for public records do not include:

(a) Requests for general information about a subject or company that the commission regulates;

(b) Standing or ongoing requests for records that do not exist at the time the commission receives the request;

(c) Requests that the commission create a new document that compiles, organizes, collates, analyzes, summarizes, or is otherwise derived from existing commission records; or

(d) Requests for all or substantially all records prepared, owned, used, or retained by the commission.

(2) **Form of request.**

(a) *Public records request form.* Any person making a request for public records should complete the commission's Online Records Request Form. Persons can access this form on the commission's web site and may contact the records center for assistance.

(b) *Other writing.* A person who is unable or elects not to use the commission's Online Records Request Form may submit a letter or email to the records center. Such a request should contain((~~s~~)) the information listed ((~~below. If you want to use the form, you can get a copy at the commission's internet site or office, or you can ask to have it sent to you.~~

~~(5) Formal written requests must~~)) in subsection (3) of this section.

(c) *Telephone or in-person requests.* The commission will honor requests for public records made in person or by telephone to the public records officer during the commission's customary business hours. Any such request should include the information listed in subsection (3) of this section. The public records officer will subsequently confirm receipt of this information and the substance of the request in a written communication to the requester.

(3) **Needed information.** Any request for public records should include the following information that the commission needs to respond to the request:

(a) ((~~Your~~)) The requester's name, physical address, email address, and telephone number((~~.~~));

(b) The date on which ((~~you submit your request.~~)) the requester submits the request;

(c) The identity of any individual, business, or other organization for whom ((~~you are~~)) the requester is making the request, if not only for ((~~yourself~~)) the requester personally((~~.~~));

(d) A clear ((~~indication, such as a document heading or title that you are~~)) statement that the requester is requesting public records((~~, to help make sure that the request is handled properly.~~

~~(e) Whether you~~));

(e) An election of whether the requester wants to inspect the public records ((~~or get~~)), obtain copies, or both((~~.~~));

(f) A clear description of the identifiable public records ((~~you want so that commission staff can find the records. If you know how the public records are described in the index maintained by the commission, provide that description to assist the commission to identify the public records you want to review.~~)) the requester is requesting; and

(g) A statement of whether ((~~you are making the request in order to obtain~~)) the requester is requesting a list of individuals to be used for any commercial purposes.

(((~~(6) Commission staff will make a reasonable effort to assist in identifying and providing all public records that you request.~~

~~(7) The commission may waive the need for a completed form when doing so supports the commission's administrative convenience and is not inconsistent with legal requirements or public policies.~~)) (4) **Requester's failure or refusal to provide information.** The public records officer will identify any information the commission needs that a requester has not included in a request for public records and will work with the requester to provide that information. If a requester refuses to provide his or her identity or sufficient other information, the commission will respond to the request to the extent feasible and consistent with applicable law.

AMENDATORY SECTION (Amending WSR 03-24-028, filed 11/24/03, effective 1/1/04)

WAC 480-04-095 ((~~Disclosure procedure.~~)) Responding to requests for public records. The commission will provide the fullest assistance to requesters and the most timely possible action in response to requests for public records consistent with the intent of the Public Records Act to provide full public access to public records, to protect public records from damage or disorganization, and to prevent excessive interference with other essential commission functions.

(1) **Tracking.** Upon receiving a request for public records, the public records officer will ((~~promptly notify you if your request is found to be incomplete, and will tell you what the problem is.~~)) assign it a tracking number and log it into the commission's public records request tracking system.

(2) **Task assignment.** Unless the request clearly seeks only documents that are contained in the commission's records center, the public records officer will ((~~assist you to complete or correct your request. Notifying you of a deficiency is not a denial of your request. The public records officer may act on a deficient request to the extent that doing so is reasonable.~~

~~(2) Upon receiving a complete request,~~)) assign the request as a task to commission management personnel:

(a) To assess whether the request is sufficiently clear in identifying the records the requester seeks;

(b) To determine whether the commission has or may have documents that are responsive to the request;

(c) To develop a reasonable estimate of the time required to search for any responsive documents; and

(d) To provide any responsive documents to the public records officer for processing.

(3) **Initial response.** Within five business days of receiving a request for public records, the public records officer will take one or more of the following actions:

(a) Inform the requester that the commission has no public records that are responsive to the request;

(b) Make the requested records available to the requester for inspection and copying, either via a link to the document(s) on the commission's web site, or by providing a paper or electronic copy of the document(s);

(c) Acknowledge receipt of the request and provide the requester with a reasonable estimate of the date by which the commission will make the records, or an installment of the records, available for inspection and copying;

(d) Acknowledge receipt of the request, ask the requester to clarify any portion of the request that is unclear, and to the extent possible, provide a reasonable estimate of when the commission will make the requested records, or an installment of the records, available for inspection and copying if the request is not clarified; or

(e) Deny the request. If the public records officer denies the public records request in whole or in part, the public records officer will provide the requester with a written explanation of the basis for the denial. The requester may contest the denial by requesting commission review as provided in WAC 480-04-120.

(4) **Additional time to respond.** The commission may extend an estimated date by which it will make the requested records, or an installment of the records, available for inspection and copying based on the need to clarify the request, to locate and assemble the records requested, to notify third persons or agencies affected by the request, or to determine whether any of the records are exempt or otherwise protected from public disclosure, or for other good cause. The public records officer will promptly notify the requester in writing of any revised estimate and will explain the reason for the revised estimate.

(5) **Exempt or protected information.** The public records officer will review the requested records to determine whether ((~~the record or a portion of it~~)) any record, in whole or in part, includes information that is exempt from disclosure under the Public Records Act, chapter ((~~42.17~~)) 42.56 RCW, or protected from disclosure under RCW 80.04.095 or 81.77.210 (records that contain valuable commercial information), WAC 480-07-160 (Confidential and other restricted information), a protective order the commission enters pursuant to WAC 480-07-420 (Discovery—Protective orders), or ((~~under~~)) another provision of law.

(((~~(3)~~))) (a) *Exempt information.* The commission will ((~~delete identifying details from a~~)) redact from the public records ((~~to protect the personal privacy interests as provided by law when it makes the record available or publishes it. The commission will explain the reasons for any such deletion.~~

~~(4) Only the public records officer is authorized to deny requests for public records. Any action other than granting access to public records, when taken by a person other than the public records officer, is a deferral of action and not a denial of a request. Any commission staff member who does not grant access to a public record when a complete written request is made must immediately take or send the requested document, together with the written request, to the public records officer for a prompt decision granting or denying the request.~~

~~(5) If the public records officer does not grant access to all or part of a requested public record, the public records officer will give you a written statement identifying the exemption authorizing the action and how it applies to the requested record. Any portion of the record that is not subject to exemption shall be promptly disclosed.~~

~~(6) If you~~)) it makes available for inspection and copying any information that is exempt from disclosure under the Public Records Act or any other applicable law. The public

records officer will provide the requester with a withholding log that identifies the specific exemption applicable to each redaction and briefly explains how the exemption applies. Except as otherwise provided in this section, the public records officer will make available for inspection and copying all records and portions of records that are not exempt from public disclosure.

(b) *Information designated as confidential.* The following process will apply if the requester requests a public record that contains information that has been designated as confidential under RCW 80.04.095, 81.77.210, or WAC 480-07-160((~~, or a protective order, and you have not specifically asked to be provided with confidential information,~~)).

(i) The public records officer will ((~~tell you that material~~)) inform the requester that information in one or more public records that are responsive to the request has been designated as confidential, ((~~and ask whether you~~)) will offer to provide a version of the document from which that information has been redacted, and will ask if the requester wants the confidential information((~~, before processing your request.~~

~~The commission will process any request for a record designated as confidential under RCW 80.04.095 or WAC 480-07-160 in accordance with those provisions of law.~~

~~(7) If the public records officer denies your public records request in whole or in part, the public records officer will provide you a written explanation of the basis for the denial. If you want to contest the denial, you may request a review under WAC 480-04-120~~)).

(ii) If the requester informs the public records officer that the request necessarily includes information designated as confidential, the commission will follow the procedure in RCW 80.04.095 or 81.77.210, whichever is applicable, as set forth below.

(A) The public records officer will send a written notice of the request to the provider of the confidential information, as well as to any other person who has been identified as being directly affected by any public disclosure of the information, and will send a copy of the notice to the requester. The commission will send the notice electronically and, to the extent practicable, will confirm that the provider received that notice. The notice will state that the commission will disclose the requested confidential information to the requester unless within ten days after the date of the notice, the provider obtains a court order prohibiting that disclosure. The commission will issue that notice not more than two business days after receiving confirmation that the requester wants the confidential information.

(B) If the provider of the confidential information has not obtained a court order prohibiting its disclosure within ten days from the date of the commission's notice or the commission has not received notification from the requester withdrawing the request or stating that the commission can satisfy the request without disclosing confidential information, the public records officer will make the entirety of the public records that are responsive to the request available for inspection and copying, including all information that had been designated as confidential, as provided in subsection (6) of this section. The public records officer will also remove the confidential designations from the records, and the commission will maintain those records as publicly available in their entirety.

(c) *Information subject to protective order.* The following process will apply if a requester requests a public record that contains information that is protected from public disclosure pursuant to a protective order the commission enters.

(i) The public records officer will inform the requester that information in one or more public records that are responsive to the request is protected from disclosure pursuant to a protective order and will ask whether the requester wants the protected information. If the requester agrees that the commission can satisfy the request without disclosing that information, the public records officer will provide or make available for inspection the public records that are responsive to the request and from which the information protected by the protective order has been redacted.

(ii) If the requester informs the public records officer that the request necessarily includes information that is protected by a protective order, the commission will follow one of the following processes:

(A) If the adjudication in which the commission entered the protective order has concluded, the procedure in (b)(ii) of this subsection will apply.

(B) If the adjudication has not concluded, the public records officer will notify the presiding officer in the adjudication of the request. The presiding officer will establish by notice or order the process the commission will use to receive written or oral comments or argument on the request from the requester and the parties and will enter an order determining whether the commission will make any information subject to the protective order available for inspection and copying.

(d) *Information affecting rights of others.* If the requested records contain information that may affect rights of others and may be exempt from disclosure, the public records officer may notify those persons of the request prior to making the records available for inspection and copying. If the public records officer elects to provide such notice, the process in (b)(ii) of this subsection shall apply.

(6) **Providing responsive records.**

(a) *Inspection.* Consistent with other demands on the agency's resources, the commission will promptly provide space for requesters to inspect the public records they have requested.

(b) *Copies.* Upon request, the commission will provide copies of responsive documents to the requester, subject to the requester paying any copying charges the commission assesses as provided in WAC 480-04-100. The commission will provide copies of documents in the same form in which the agency retains the record (i.e., the commission will provide paper copies of paper records and electronic copies of electronic records in the same format or program). The public records officer may, but is not required to, provide copies of records in a different form or format (e.g., making .pdf electronic copies of paper records) if such copying is technically feasible using existing commission resources and does not result in the creation of a new public record.

(7) **Time to inspect or claim records.** The public records officer will notify the requester in writing when the requested public records are available for inspection and copying and that the requester should make arrangements to

inspect or claim any requested copies of those records. The requester must inspect the records or claim any copies within thirty days of the commission's notice. If the requester does not do so or does not make other arrangements within that thirty days, the commission may close the request.

(8) **Providing records in installments.** If a requester requests a large number of records, the public records officer may provide access to responsive records in installments. The public records officer will notify the requester in writing when each installment of the requested records is available for inspection and copying and that the requester should make arrangements to inspect or claim any requested copies of those records. The requester must inspect the records or claim any copies in each installment within thirty days of the commission's notice. If the requester does not do so or does not make other arrangements within that thirty days, the commission may stop searching for the remaining records and close the request.

(9) **Closing request.** The public records officer will close the request and notify the requester in writing of that closure under any one of the following circumstances:

(a) The commission has completed a reasonable search for the requested public records, and either:

(i) The commission has located no responsive documents; or

(ii) The commission has located responsive documents, the requester has inspected those records, and the commission has provided any requested copies of the records.

(b) The requester withdraws the request;

(c) The requester does not clarify an entirely unclear request within thirty days from the date of the public records officer's written request for clarification;

(d) The requester does not timely inspect or make arrangements to inspect or request copies of responsive records as provided in this section; or

(e) The requester does not timely submit any deposit, pay fees for an installment, or make a final payment the commission has assessed for requested copies of public records as required under WAC 480-04-100.

(10) **Subsequently discovered records.** The public records officer will promptly inform the requester if, after the commission has notified the requester that the commission has provided all available records, the commission becomes aware of additional responsive documents that existed at the time the requester made the request. The commission will make the additional documents available for inspection and copying on an expedited basis.

(11) **Log of requests**. The commission will maintain a log of the public records requests it receives, which will include:

(a) The identity of the requester if provided by the requester;

(b) The date the commission received the request;

(c) The text of the original request;

(d) A description of the responsive records that were redacted or withheld and the reasons therefor; and

(e) the date of the final disposition of the request.

AMENDATORY SECTION (Amending WSR 06-17-087, filed 8/14/06, effective 9/14/06)

WAC 480-04-100 Copying ((~~and service~~)) charges. The commission will charge to provide copies of public records ((~~upon request.~~

~~(1) The commission may charge a published fee for copying public records, if you request copies. The commission may, by order, within the requirements of RCW 42.17.300, establish and change prices and establish the maximum number of various kinds of copies that will be provided without charge~~)) as provided in this section.

(1) **Adoption of statutory copying charges.** The commission has not calculated the actual costs for copying its records because to do so would be unduly burdensome for the following reasons:

(a) The commission has insufficient resources to conduct a comprehensive study to determine the actual costs of copying its records;

(b) To conduct a study of the commission's actual copying costs would interfere with other essential agency functions; and

(c) The legislature has established reasonable fees and costs in RCW 42.56.120 after the public and requesters have commented on, and been informed of, such fees and costs.

To timely implement a fee schedule consistent with the Public Records Act, it is more cost efficient and expeditious and in the public interest for the commission to adopt the legislature's approved fees and costs for most of the commission's records, as authorized in RCW 42.56.120 and as published in the commission's fee schedule.

(2) ((~~The commission's~~)) **Fee schedule.** Persons may obtain the schedule of the commission's copying charges ((~~for copies, except as provided in WAC 480-07-145 (3)(b), is published in Administrative Policy 5.1c, which is available from the commission's web site or~~)) by contacting the commission's records center. ((~~Out-of-state customers and governmental agencies are not charged sales tax.~~

~~(3) WAC 480-07-145 (3)(b) fixes the charge for copies when a party to an adjudicative proceeding fails to file the number of copies required to meet the commission's internal distribution needs.~~)) The commission does not charge sales tax on copies it makes at its own facilities.

(3) **Cost estimates.** Upon request, the commission will provide a requester with a summary of the applicable charges before the commission makes copies of the requested records. The requester may revise the request to reduce the requested number of copies and correspondingly reduce the copying charges.

(4) **Deposits and prepayment.** Before beginning to make copies, the public records officer may require a requester to pay a deposit of up to ten percent of the estimated costs of copying all the requested records. The public records officer may also require the requester to pay the remainder of the copying costs before providing all the records, or to pay the costs of copying an installment before providing that installment.

(5) **Waiver or other fee arrangements.** The commission may waive copying charges. The commission also may enter into a contract, memorandum of understanding, or other agreement with a requester that provides an alternative fee

arrangement to the charges or in response to voluminous or frequently occurring requests.

(6) **Mailing and delivery costs.** The commission may charge the actual costs it incurs to mail or use a commercial carrier to deliver copies of the requested public records, including the cost of any digital storage medium or device on which the commission copies the records (such as a disc or flash drive), the shipping container or envelope, and the postage or delivery charge.

AMENDATORY SECTION (Amending WSR 03-24-028, filed 11/24/03, effective 1/1/04)

WAC 480-04-120 Review of denials of public records requests. (1) If the commission ((~~does not disclose~~)) denies a request for a public record ((~~that you have requested and you~~)) and the requester disagrees with the denial, ((~~you~~)) the requester may ask the public records officer, in writing, for a review of the denial. ((~~Your~~)) The written request for review must describe or enclose the public records officer's written statement that explains the reasons for the denial((~~, as provided in WAC 480-04-095(5)~~)).

(2) ((~~You~~)) The requester may hand deliver, or have a courier deliver, ((~~your~~)) the written request for review in person at the commission's administrative office or ((~~you~~)) the requester may send it by mail or ((~~electronic mail~~)) email.

(3) The ((~~public records officer~~)) commission will promptly ((~~review your~~)) consider the written request((~~. The public records officer may personally reconsider the denial decision, or may refer the request to the commission for review.~~

~~(4)~~)) for review. The public records officer's ((~~initial~~)) denial becomes final unless the commission modifies the decision within two business days after the commission receives ((~~your~~)) the request for review unless the requester and the commission agree to a longer commission review period. The commission, however, ((~~still~~)) may modify a denial decision at a later time. Once the public records officer's initial denial decision becomes final ((~~or is modified by the commission, you~~)), the requester may seek judicial review under RCW ((~~42.17.340~~)) 42.56.550, or the requester may request that the Washington attorney general review any claims of exemptions pursuant to RCW 42.56.530.

AMENDATORY SECTION (Amending WSR 03-24-028, filed 11/24/03, effective 1/1/04)

WAC 480-04-130 Protection of public records. (1) Only commission staff may copy public documents unless the public records officer decides that copying by others will not disrupt commission business operations or pose any risk to the integrity and safety of the documents.

(2) No person may take any public record from the area the public records officer designates for public inspection of public records unless expressly authorized to do so by the public records officer((~~.~~

~~(3) When a member of the public asks to examine an entire file or group of public records, as distinguished from specific public records that can be individually identified and made available, the commission may take a reasonable time to inspect the file or group of public records to remove any material designated as confidential and any information protected from disclosure by chapter 42.17 RCW, or other provision of law~~)). No person may disassemble or alter any document the commission allows that person to inspect.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 480-04-030	Organization of the Washington utilities and transportation commission.

WSR 18-20-015
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed September 21, 2018, 9:50 a.m., effective October 22, 2018]

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

Purpose: The department is amending sections in chapter 388-76 WAC to update the references to chapter 388-112 WAC contained throughout the chapter to the new chapter 388-112A WAC. Any references to chapter 388-112 WAC not addressed in this rule making that are contained in other sections of chapter 388-76 WAC currently open for rule making will be updated with the correct reference through those specific rule developments.

Citation of Rules Affected by this Order: Amending WAC 388-76-10035, 388-76-10063, 388-76-10064, 388-76-10129, 388-76-10130, 388-76-10135, 388-76-10140, 388-76-10145, 388-76-10146, 388-76-10198, 388-76-10200, 388-76-10415, and 388-76-10505.

Statutory Authority for Adoption: Chapter 70.128 RCW.

Adopted under notice filed as WSR 18-14-097 on July 3, 2018.

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 the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 13, 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 13, Repealed 0.

Date Adopted: September 20, 2018.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 12-01-004, filed 12/7/11, effective 1/7/12)

WAC 388-76-10035 License requirements—Multiple family home providers. The department will only consider an application for more than one home if the applicant has:

(1) Evidence of successful completion of the forty-eight hour residential care administrator's training to meet the applicable requirements of chapter ((~~388-112~~)) 388-112A WAC;

(2) The ability to operate more than one home;

(3) The following plans for each home the applicant intends to operate. Each of the following plans must be updated and maintained:

(a) A twenty-four hour a day, seven day a week staffing plan;

(b) A plan for managing the daily operations of each home; and

(c) A plan for emergencies, deliveries, staff and visitor parking.

(4) A demonstrated history of financial solvency related to the ability to provide care and services; and

(5) An entity representative or a resident manager at each home who is responsible for the care of each resident at all times.

AMENDATORY SECTION (Amending WSR 10-03-064, filed 1/15/10, effective 2/15/10)

WAC 388-76-10063 Application—General training requirements. An applicant must ensure that each person listed on the application has successfully completed the training if required under this chapter and chapter ((~~388-112~~)) 388-112A WAC.

AMENDATORY SECTION (Amending WSR 16-01-171, filed 12/22/15, effective 1/22/16)

WAC 388-76-10064 Adult family home administrator training requirements. (1) The applicant and the entity representative must successfully complete the department approved adult family home administration class as required in chapter ((~~388-112~~)) 388-112A WAC.

(2) An applicant and entity representative may not be required to take the adult family home administrator class if there is a change in ownership and the applicant and entity representative are already participants in the operation of a currently licensed home.

(3) An applicant and entity representative must take the adult family home administrator class when the application is for an additional licensed home and the class has not already been successfully taken.

(4) The class must be a minimum of forty-eight hours of classroom time and approved by the department.

(5) Under exceptional circumstances, the department may waive the administrator training class for up to four months if the application meets all the other requirements for licensure and all the components of WAC 388-76-10074.

AMENDATORY SECTION (Amending WSR 10-03-064, filed 1/15/10, effective 2/15/10)

WAC 388-76-10129 Qualifications—Adult family home personnel. The adult family home must ensure that the following are qualified and meet all of the applicable requirements of this chapter and chapter ((~~388-112~~)) 388-112A WAC:

(1) Any person employed or used by the adult family home, directly or by contract, by an adult family home; including but not limited to:

(a) The provider;

(b) Entity representative;

(c) Resident manager;

(d) Staff; and

((~~(f)~~ (e) Caregivers.

AMENDATORY SECTION (Amending WSR 15-03-037, filed 1/12/15, effective 2/12/15)

WAC 388-76-10130 Qualifications—Provider, entity representative and resident manager. The adult family home must ensure that the provider, entity representative and resident manager have the following minimum qualifications:

(1) Be twenty-one years of age or older;

(2) Have a United States high school diploma or high school equivalency certificate as provided in RCW 28B.50.536, or any English or translated government document of the following:

(a) Successful completion of government approved public or private school education in a foreign country that includes an annual average of one thousand hours of instruction a year for twelve years, or no less than twelve thousand hours of instruction;

(b) Graduation from a foreign college, foreign university, or United States community college with a two-year diploma, such as an associate's degree;

(c) Admission to, or completion of course work at a foreign or United States college or university for which credit was awarded;

(d) Graduation from a foreign or United States college or university, including award of a bachelor's degree;

(e) Admission to, or completion of postgraduate course work at, a United States college or university for which credits were awarded, including award of a master's degree; or

(f) Successful passage of the United States board examination for registered nursing, or any professional medical occupation for which college or university education was required.

(3) Completion of the training requirements that were in effect on the date they were hired or became licensed providers, including the requirements described in chapter ((~~388-112~~)) 388-112A WAC;

(4) Have good moral and responsible character and reputation;

(5) Be literate and able to communicate in the English language, and assure that a person is on staff and available at the home who is capable of understanding and speaking English well enough to be able to respond appropriately to

emergency situations and be able to read, understand and implement resident negotiated care plans.

(6) Assure that there is a mechanism to communicate with the resident in his or her primary language either through a qualified person on-site or readily available at all times, or other reasonable accommodations, such as a language line.

(7) Be able to carry out the management and administrative requirements of chapters 70.128, 70.129 and 74.34 RCW, this chapter and other applicable laws and regulations;

(8) Have completed at least one thousand hours of successful direct care experience in the previous sixty months obtained after age eighteen to vulnerable adults in a licensed or contracted setting before operating or managing a home. Individuals holding one of the following professional licenses are exempt from this requirement:

(a) Physician licensed under chapter 18.71 RCW;

(b) Osteopathic physician licensed under chapter 18.57 RCW;

(c) Osteopathic physician assistant licensed under chapter 18.57A RCW;

(d) Physician assistant licensed under chapter 18.71A RCW;

(e) Registered nurse, advanced registered nurse practitioner, or licensed practical nurse licensed under chapter 18.79 RCW.

(9) Have no disqualifying criminal convictions or pending criminal charges under chapter 388-113 WAC;

(10) Have none of the negative actions listed in WAC 388-76-10180;

(11) Obtain and keep valid cardiopulmonary resuscitation (CPR) and first-aid card or certificate as required in chapter ((~~388-112~~)) 388-112A WAC; and

(12) Have tuberculosis screening to establish tuberculosis status per this chapter.

AMENDATORY SECTION (Amending WSR 17-01-002, filed 12/7/16, effective 1/7/17)

WAC 388-76-10135 Qualifications—Caregiver. The adult family home must ensure each caregiver has the following minimum qualifications:

(1) Be eighteen years of age or older;

(2) Has a clear understanding of the caregiver job responsibilities and knowledge of each resident's negotiated care plan to provide care specific to the needs of each resident;

(3) Has basic communication skills to:

(a) Be able to communicate or make provisions to communicate with the resident in his or her primary language; and

(b) Understand and speak English well enough to:

(i) Respond appropriately to emergency situations; and

(ii) Read, understand, and implement resident negotiated care plans;

(4) Has completed the training requirements in effect on the date the caregiver was hired, including the requirements applicable to the caregiver under chapter ((~~388-112~~)) 388-112A WAC;

(5) Has no disqualifying criminal convictions or pending criminal charges under chapter 388-113 WAC;

(6) Has none of the negative actions listed in WAC 388-76-10180;

(7) Has a current valid ((~~first-aid~~)) first-aid card or certificate as required in chapter ((~~388-112~~)) 388-112A WAC, except nurses, who are exempt from this requirement;

(8) Has a valid cardiopulmonary resuscitation (CPR) card or certificate as required in chapter ((~~388-112~~)) 388-112A WAC; and

(9) Meets the tuberculosis screening requirements of this chapter.

AMENDATORY SECTION (Amending WSR 07-21-080, filed 10/16/07, effective 1/1/08)

WAC 388-76-10140 Qualifications—Students—Volunteers. The adult family home must ensure that students and volunteers meet the following minimum qualifications:

(1) Be eighteen years old or older;

(2) Meet the department's training requirements of chapter ((~~388-112~~)) 388-112A WAC;

(3) Have no criminal convictions listed in RCW 43.43.830 and 43.43.842 or state or federal findings of abandonment, abuse, neglect or financial exploitation; and

(4) Tuberculosis screening to establish tuberculosis status per this chapter.

AMENDATORY SECTION (Amending WSR 16-20-095, filed 10/4/16, effective 11/4/16)

WAC 388-76-10145 Qualifications—Licensed nurse as provider, entity representative, or resident manager. The adult family home must ensure that a licensed nurse who is a provider, entity representative, or resident manager:

(1) Meets all minimum qualifications for providers, entity representatives, or resident managers listed in WAC 388-76-10130; and

(2) Has a current valid cardiopulmonary resuscitation (CPR) card or certificate as required in chapter ((~~388-112~~)) 388-112A WAC.

AMENDATORY SECTION (Amending WSR 15-03-037, filed 1/12/15, effective 2/12/15)

WAC 388-76-10146 Qualifications—Training and home care aide certification. (1) The adult family home must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter ((~~388-112~~)) 388-112A WAC.

(2) The adult family home must ensure all adult family home caregivers, entity representatives, and resident managers hired on or after January 7, 2012, meet the long-term care worker training requirements of chapter ((~~388-112~~)) 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(b) Basic;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(3) All persons listed in subsection (2) of this section, must obtain the home-care aide certification if required by this section or chapters 246-980 or ((~~388-112~~)) 388-112A WAC.

(a) Until March 1, 2016, a provisional home-care aide certification may be issued by the department of health to a long-term care worker who is limited English proficient.

(4) Even if an adult family home applicant does not intend to provide direct personal care, the applicant must meet the long-term care worker training and home-care aide certification requirements under chapter ((~~388-112~~)) 388-112A WAC to the same extent that the requirements would apply if the applicant was a long-term care worker.

(5) Under RCW 18.88B.041 and chapter 246-980 WAC, certain individuals, including registered nurses, licensed practical nurses, certified nursing assistants or persons who are in an approved certified nursing assistant ((~~programs~~ program, are exempt from home-care aide certification and long-term care worker training requirements. This exemption does not apply to continuing education; these individuals must comply with continuing education requirements under chapter ((~~388-112~~)) 388-112A WAC.

(6) The adult family home must ensure that all staff receive the orientation and training necessary to perform their job duties.

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

AMENDATORY SECTION (Amending WSR 10-03-064, filed 1/15/10, effective 2/15/10)

WAC 388-76-10198 Adult family home—Personnel records. The adult family home must keep documents related to staff in a place readily accessible to authorized department staff. These documents must be available during the staff's employment, and for at least two years following employment. The documents must include but are not limited to:

(1) Staff information such as address and contact information.

(2) Staff orientation and training records pertinent to duties, including, but not limited to:

(a) Training required by chapter ((~~388-112~~)) 388-112A WAC, including as appropriate for each staff person, orientation, basic training or modified basic training, specialty training, nurse delegation core training, and continuing education;

(b) Cardiopulmonary resuscitation;

(c) First aid; and

(d) HIV/AIDS training.

(3) Tuberculosis testing results.

(4) Criminal history disclosure and background check results as required.

AMENDATORY SECTION (Amending WSR 12-16-087, filed 7/31/12, effective 8/31/12)

WAC 388-76-10200 Adult family home—Staff—Availability—Contact information. In addition to other licensing requirements for staff availability, the adult family home must:

(1) Ensure at least one qualified caregiver is present in the home whenever one or more residents are present in the home, except as provided in subsection (2). For purpose of this subsection, a qualified caregiver means someone who has completed orientation and basic training as required by chapter ((~~388-112~~)) 388-112A WAC;

(2) Ensure that before the adult family home leaves a resident unattended:

(a) That the adult family home determines that the resident can be left unattended safely, based upon an assessment that identifies the resident's strengths and needs;

(b) The resident knows what to do in an emergency and is able to successfully act on that knowledge; such as leaving the home or calling 911, when necessary;

(c) The adult family home individualizes each resident's negotiated care plan to the resident's identified strengths and needs and includes a limited and specific amount of time the resident is safe to be left unattended;

(d) The resident consents to the plan to be left unattended; and

(e) The resident is able to contact a responsible staff person at all times.

(3) Designate an experienced, staff member who is capable of responding on behalf of the adult family home by phone or pager at all times.

(4) Give residents the telephone or pager number for the contact required in subsection (2) of this section;

(5) Ensure the provider, entity representative or resident manager is readily available to:

(a) Each resident;

(b) Residents' representatives;

(c) Caregivers; and

(d) Authorized state staff.

AMENDATORY SECTION (Amending WSR 10-04-008, filed 1/22/10, effective 2/22/10)

WAC 388-76-10415 Food services. The adult family home must:

(1) Ensure that the safe food handling training requirements of chapter ((~~388-112~~)) 388-112A WAC are met; and

(2) Serve meals:

(a) In the home where each resident lives; and

(b) That accommodate each resident's:

(i) Preferences;

(ii) Food allergies and sensitivities;

(iii) Caloric needs;

(iv) Cultural and ethnic background; and

(v) Physical condition that may make food intake difficult such as being hard for the resident to chew or swallow.

AMENDATORY SECTION (Amending WSR 10-04-008, filed 1/22/10, effective 2/22/10)

WAC 388-76-10505 Specialty care—Admitting and retaining residents. The adult family home must not admit or keep a resident with specialty care needs, such as developmental disability, mental illness, or dementia as defined in WAC 388-76-10000, if the provider, entity representative, resident manager and staff have not completed the specialty

care training required by chapter ((~~388-112~~)) 388-112A WAC.

WSR 18-20-018
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed September 21, 2018, 10:27 a.m., effective October 22, 2018]

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

Purpose: The department is amending sections in chapter 388-78A WAC to update the references to chapter 388-112 WAC contained throughout the chapter to the new chapter 388-112A WAC. Any references to chapter 388-112 WAC not addressed in this rule making that are contained in other sections of chapter 388-78A WAC currently open for rule making will be updated with the correct reference through those specific rule developments.

Citation of Rules Affected by this Order: Amending WAC 388-78A-2450, 388-78A-2474, 388-78A-2490, 388-78A-2500, 388-78A-2510, 388-78A-2540, and 388-78A-2550.

Statutory Authority for Adoption: Chapter 18.20 RCW.

Adopted under notice filed as WSR 18-14-063 on June 29, 2018.

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 the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 7, 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: September 20, 2018.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2450 Staff. (1) Each assisted living facility must provide sufficient, trained staff persons to:

(a) Furnish the services and care needed by each resident consistent with his or her negotiated service agreement;

(b) Maintain the assisted living facility free of safety hazards; and

(c) Implement fire and disaster plans.

(2) The assisted living facility must:

(a) Develop and maintain written job descriptions for the administrator and each staff position and provide each staff person with a copy of his or her job description before or upon the start of employment;

(b) Verify staff persons' work references prior to hiring;

(c) Verify prior to hiring that staff persons have the required licenses, certification, registrations, or other credentials for the position, and that such licenses, certifications, registrations, and credentials are current and in good standing;

(d) Document and retain for twelve weeks, weekly staffing schedules, as planned and worked;

(e) Ensure all resident care and services are provided only by staff persons who have the training, credentials, experience and other qualifications necessary to provide the care and services;

(f) Ensure at least one caregiver, who is eighteen years of age or older and has current cardiopulmonary resuscitation and first-aid cards, is present and available to assist residents at all times:

(i) When one or more residents are present on the assisted living facility premises; and

(ii) During assisted living facility activities off of the assisted living facility premises.

(g) Ensure caregiver provides on-site supervision of any resident voluntarily providing services for the assisted living facility;

(h) Provide staff orientation and appropriate training for expected duties, including:

(i) Organization of the assisted living facility;

(ii) Physical assisted living facility layout;

(iii) Specific duties and responsibilities;

(iv) How to report resident abuse and neglect consistent with chapter 74.34 RCW and assisted living facility policies and procedures;

(v) Policies, procedures, and equipment necessary to perform duties;

(vi) Needs and service preferences identified in the negotiated service agreements of residents with whom the staff persons will be working; and

(vii) Resident rights, including without limitation, those specified in chapter 70.129 RCW.

(i) Develop and implement a process to ensure caregivers:

(i) Acquire the necessary information from the preadmission assessment, on-going assessment and negotiated service agreement relevant to providing services to each resident with whom the caregiver works;

(ii) Are informed of changes in the negotiated service agreement of each resident with whom the caregiver works; and

(iii) Are given an opportunity to provide information to responsible staff regarding the resident when assessments and negotiated service agreements are updated for each resident with whom the caregiver works.

(j) Ensure all caregivers have access to resident records relevant to effectively providing care and services to the resident.

(3) The assisted living facility must:

(a) Protect all residents by ensuring any staff person suspected or accused of abuse, neglect, financial exploitation, or abandonment does not have access to any resident until the assisted living facility investigates and takes action to ensure resident safety;

(b) Not interfere with the investigation of a complaint, coerce a resident or staff person regarding cooperating with a complaint investigation, or conceal or destroy evidence of alleged improprieties occurring within the assisted living facility;

(c) Prohibit staff persons from being directly employed by a resident or a resident's family during the hours the staff person is working for the assisted living facility;

(d) Maintain the following documentation on the assisted living facility premises, during employment, and at least two years following termination of employment:

(i) Staff orientation and training or certification pertinent to duties, including, but not limited to:

(A) Training required by chapter ((~~388-112~~)) 388-112A WAC;

(B) Home care aide certification as required by this chapter and chapter 246-980 WAC;

(C) Cardiopulmonary resuscitation;

(D) First aid; and

(E) HIV/AIDS training.

(ii) Disclosure statements and background checks as required in WAC 388-78A-2461 through 388-78A-2471; and

(iii) Documentation of contacting work references and professional licensing and certification boards as required by subsection (2) of this section.

(4) The assisted living facility is not required to keep on the assisted living facility premises, staff records that are unrelated to staff performance of duties. Such records include, but are not limited to, pay records, and health and insurance benefits for staff.

AMENDATORY SECTION (Amending WSR 14-05-035, filed 2/12/14, effective 3/15/14)

WAC 388-78A-2474 Training and home care aide certification requirements. (1) The assisted living facility must ensure staff persons hired before January 7, 2012 meet training requirements in effect on the date hired, including requirements in chapter ((~~388-112~~)) 388-112A WAC.

(2) The assisted living facility must ensure all assisted living facility administrators, or their designees, and caregivers hired on or after January 7, 2012 meet the long-term care worker training requirements of chapter ((~~388-112~~)) 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(b) Basic;

(c) Specialty for dementia, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(3) The assisted living facility must ensure that all staff receive appropriate training and orientation to perform their specific job duties and responsibilities.

(4) The assisted living facility must ensure all persons listed in subsection (2) of this section, obtain the home-care aide certification.

(5) Under RCW 18.88B.041 and chapter 246-980 WAC, certain individuals including registered nurses, licensed practical nurses, certified nursing assistants, or persons who are in an approved certified nursing assistant training program are exempt from long-term care worker basic training requirements. Continuing education requirements under chapter ((~~388-112~~)) 388-112A WAC still apply to these individuals, except for registered nurses and licensed practical nurses.

(6) For the purpose of this section, the term "caregiver" has the same meaning as the term "long-term care worker" as defined in RCW 74.39A.009.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2490 Specialized training for developmental disabilities. The assisted living facility must ensure completion of specialized training, consistent with chapter ((~~388-112~~)) 388-112A WAC, to serve residents with developmental disabilities, whenever at least one of the residents in the assisted living facility has a developmental disability as defined in WAC 388-823-0040, that is the resident's primary special need.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2500 Specialized training for mental illness. The assisted living facility must ensure completion of specialized training, consistent with chapter ((~~388-112~~)) 388-112A WAC, to serve residents with mental illness, whenever at least one of the residents in the assisted living facility has a mental illness that is the resident's primary special need and is a person who has been diagnosed with or treated for an Axis I or Axis II diagnosis, as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, and:

(1) Who has received the diagnosis or treatment within the previous two years; and

(2) Whose diagnosis was made by, or treatment provided by, one of the following:

(a) A licensed physician;

(b) A mental health professional;

(c) A psychiatric advanced registered nurse practitioner; or

(d) A licensed psychologist.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2510 Specialized training for dementia. The assisted living facility must ensure completion of specialized training, consistent with chapter ((~~388-112~~)) 388-112A WAC, to serve residents with dementia, whenever at least one of the residents in the assisted living facility has a dementia that is the resident's primary special need and has symptoms consistent with dementia as assessed per WAC 388-78A-2090(7).

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2540 Administrator requirements. The licensee must ensure the assisted living facility administrator:

(1) Meets the training requirements under chapter ((~~388-112~~)) 388-112A WAC; and

(2) Knows and understands how to apply Washington state statutes and administrative rules related to the operation of an assisted living facility; and

(3) Meets the administrator qualification requirements referenced in WAC 388-78A-2520 through 388-78A-2527.

AMENDATORY SECTION (Amending WSR 13-13-063, filed 6/18/13, effective 7/19/13)

WAC 388-78A-2550 Administrator training documentation. The assisted living facility must maintain for department review, documentation of the administrator completing:

(1) Training required by chapter ((~~388-112~~)) 388-112A WAC;

(2) Department training in an overview of Washington state statutes and administrative rules related to the operation of an assisted living facility;

(3) As applicable, certification from a department-recognized national accreditation health or personal care organization; and

(4) As applicable, the qualifying administrator-training program.

WSR 18-20-022
PERMANENT RULES
DEPARTMENT OF FISH AND WILDLIFE

[Order 18-255—Filed September 24, 2018, 7:56 a.m., effective October 25, 2018]

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

Purpose: Creating WAC 220-220-250 to define the license products available under the resident disabled veteran donation program, effective June 13, 2018.

Citation of Rules Affected by this Order: New WAC 220-220-250 Donation program for resident disabled veterans.

Statutory Authority for Adoption: RCW 77.32.590.

Adopted under notice filed as WSR 18-15-085 on July 18, 2018.

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 1, Amended 0, Repealed 0.

Number of Sections Adopted at the 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: September 20, 2018.

Kelly Susewind
Director

NEW SECTION

WAC 220-220-250 Donation program for resident disabled veterans. (1) The department is authorized to create a special donation program for resident disabled veterans who meet the eligibility criteria set forth in RCW 77.32.480 (1)(a) or (b).

(2) Funds donated by the public will be deposited into a disabled veterans donation fund account. On a first-come, first-served basis, qualifying resident disabled veteran will have the opportunity to purchase certain recreational hunting and fishing licenses at the prices set forth below using funds in the disabled veterans donation fund account, as available. Donation account funds may also be applied to dealer and transaction fees associated with each qualifying license purchase.

(3) Qualifying resident disabled veterans are eligible to purchase the following licenses using available funds from the disabled veterans donation fund account:

(a) **Hunting Licenses:**

(i) Deer;

(ii) Deer and elk;

(iii) Deer, elk, bear, cougar;

(iv) Elk;

(v) Small game;

(vi) Deer and elk with small game;

(vii) Deer with small game;

(viii) Deer, elk, bear, cougar with small game;

(ix) Elk with small game;

(x) Bear with small game;

(xi) Cougar with small game;

(xii) Bear;

(xiii) Cougar.

(b) **Fishing Licenses:**

(i) Annual combination fishing;

(ii) Three-day razor clam.

(4) Per RCW 77.32.480(1), qualifying resident disabled veterans will be issued hunting licenses at the reduced rate of a youth hunting license.

(5) Qualifying resident disabled veterans will be issued annual combination fishing licenses at the rate of eight dollars and fifty cents, which includes the reduced license rate of five dollars set forth in RCW 77.32.480(1) and the rockfish and biotoxin surcharges set forth in RCW 77.32.470 (2)(a) and 77.32.555(1).

(6) Qualifying resident disabled veterans will be issued three-day razor clam licenses at the rate of seven dollars, which includes the license rate of five dollars set forth in

RCW 77.32.520(5) and the biotoxin surcharge set forth in RCW 77.32.555(1).

WSR 18-20-023
PERMANENT RULES
SUPERINTENDENT OF PUBLIC INSTRUCTION

[Filed September 24, 2018, 9:33 a.m., effective October 25, 2018]

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

Purpose: This rule-making order revises the office of the superintendent of public instruction learning assistance program (LAP) carryover and recovery calculation to allow districts to carryover one hundred percent of unspent LAP high poverty funds from the 2017-18 school year to the 2018-19 school year only.

Citation of Rules Affected by this Order: Amending WAC 392-122-900.

Statutory Authority for Adoption: RCW 28A.150.290, 28A.710.220.

Adopted under notice filed as WSR 18-16-123 on August 1, 2018.

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 the 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: September 21, 2018.

Chris P. S. Reykdal
State Superintendent
of Public Instruction

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

WAC 392-122-900 General provision—Indirect cost limitations, carryover limitations and recoveries. Categorical apportionment moneys shall be expended for allowable categorical program costs. Indirect cost charges to categorical programs are limited as provided in this section. Categorical moneys may be carried over from one school district or charter school fiscal year to another only as provided in this section.

(1) The superintendent of public instruction shall recover categorical program allocations made pursuant to this chapter if not expended by the school district or charter school during the school year for allowable program costs.

(2) For the 2000-01 school year and thereafter, "allowable program costs" means direct program expenditures plus allowable indirect program charges.

(a) Direct program expenditures are expenditures directly traceable to the program for the school year reported consistent with the *Accounting Manual for Public School Districts in the State of Washington* and instructions provided by the superintendent of public instruction including the *Administrative Budgeting, and Financial Reporting Handbook*.

(b) For the purposes of this section, special education program expenditures shall be reduced (abated) by revenues to account 7121 special education revenues from other districts or charter schools.

(c) For special education, highly capable, and transitional bilingual, allowable indirect program charges equal direct program expenditures times the percentage calculated from the school district's or charter school's annual financial statements (Report F-196) for two school years prior as follows:

(i) Divide direct expenditures for program 97 ((~~districtwide~~)) district-wide support by;

(ii) Total general fund direct expenditures for all programs minus direct expenditures for program 97 ((~~districtwide~~)) district-wide support; and

(iii) Round to three decimal places.

(d) For the learning assistance program, allowable indirect program charges equal the direct program expenditures times the federal restricted indirect rate calculated by the superintendent of public instruction.

(e) For the institutional education program, allowable indirect program charges equal the state institutional education program allocation times the percentage allocated for indirect costs pursuant to the biennial operating appropriations act and the state funding formula.

(3) Commencing with the 1994-95 school year allocation, a school district or charter school may carry over from one school district fiscal year to the next up to ten percent of the state learning assistance program allocation. For the 2017-18 school year only, a school district or charter school may carry over all unspent learning assistance program high poverty allocations to the 2018-19 school year. Carryover moneys shall be expended solely for allowable learning assistance program costs.

(4) Commencing with the 1997-98 school year allocation, a district or charter school may carry over from one school fiscal year to the next up to ten percent of state special education program allocation. Carryover moneys shall be expended solely for allowable state special education program costs.

(5) Commencing with the 1998-99 school year allocation, a school district may carry over from one school district fiscal year to the next up to ten percent of the state institutional education program allocation. Carryover moneys shall be expended solely for allowable state institutional education program costs.

(6) The amount recovered pursuant to this section for special education, highly capable, bilingual, and learning assistance programs shall be determined as follows:

(a) Sum the state allocation for the categorical program for the school year and any carryover from the prior school year if applicable;

(b) Determine the district's or charter school's allowable program costs for the school year pursuant to this section;

(c) If the result of (a) of this subsection exceeds the result of (b) of this subsection, the difference less any allowable carryover shall be recovered.

(7) For the 2017-18 school year only, learning assistance program high poverty allocations are not subject to the recovery provisions outlined in WAC 392-122-900 (6)(a) through (c).

(8) The amount recovered pursuant to this section for the institutional education program shall be determined as follows:

(a) Sum the state allocation for the institutional education program for the school year excluding any amount provided for indirect costs, and any carryover from the prior school year if applicable;

(b) Determine the school district's direct expenditures for the institutional education program as reported on Report F-196 or such other document filed pursuant to instructions provided by the superintendent of public instruction;

(c) If the amount of (a) of this subsection exceeds the amount of (b) of this subsection, the difference less any allowable carryover shall be recovered.

(((~~(8)~~))) (9) This section applies to categorical program allocations to school districts, educational service districts and, in the case of institutional education programs, entities contracting to provide an institutional education program funded under this chapter.

WSR 18-20-025
PERMANENT RULES
WASHINGTON STATE UNIVERSITY

[Filed September 24, 2018, 9:58 a.m., effective October 25, 2018]

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

Purpose: The university is adding new chapter 504-49 WAC, regarding the administration of the state renewable energy system incentive program for citizens, businesses, and utilities.

In accordance with the renewable energy system incentive program law, ESSB 5939, signed into law on July 7, 2017, the state renewable energy system incentive program is to be administered by the Washington State University energy program. The new rules are needed to provide procedures and requirements for the administration of this program.

Citation of Rules Affected by this Order: New WAC 504-49-010, 504-49-100, 504-49-103, 504-49-105, 504-49-108, 504-49-110, 504-49-115, 504-49-120, 504-49-125, 504-49-130, 504-49-135, 504-49-140, 504-49-145, 504-49-150, 504-49-155, 504-49-160, 504-49-165, 504-49-170, 504-49-175, 504-49-180, 504-49-185, 504-49-190, 504-49-195, 504-49-200, 504-49-205, 504-49-210, 504-49-215, 504-49-220, 504-49-225, 504-49-230, 504-49-235, 504-49-240, 504-49-245, 504-49-250, 504-49-300, 504-49-305, 504-49-310, 504-49-400, 504-49-405, 504-49-500, 504-49-505, 504-49-510, 504-49-515, 504-49-520, 504-49-525, 504-49-600, 504-49-605, 504-49-610, 504-49-615, 504-49-700, 504-49-705, 504-49-710, and 504-49-715.

Statutory Authority for Adoption: RCW 28B.30.150.

Adopted under notice filed as WSR 18-15-087 on July 18, 2018.

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 53, Amended 0, Repealed 0.

Number of Sections Adopted at the 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 53, Amended 0, Repealed 0.

Date Adopted: September 21, 2018.

Deborah L. Bartlett, Director
Procedures, Records, and Forms
and University Rules Coordinator

Chapter 504-49 WAC

RENEWABLE ENERGY SYSTEM INCENTIVE PROGRAM

NEW SECTION

WAC 504-49-010 Introduction. (1) The rules in this chapter explain the renewable energy system incentive program, which is administered by the Washington State University energy program (hereinafter referred to as "energy program"). It is the legislature's intent to provide the incentives as described in RCW 82.16.130 in order to ensure the sustainable job growth and vitality of the state's renewable energy sector. The purpose of the incentive is to reduce the costs associated with installing and operating renewable energy systems by persons or entities receiving the incentive. This incentive program authorizes an incentive payment based on electricity generated by renewable energy systems located in Washington state. Qualified renewable energy systems include:

(a) Solar energy systems;

(b) Wind generators; and

(c) Certain types of anaerobic digesters that process manure from livestock into biogas and dried manure using microorganisms in a closed oxygen-free container, in which the biogas (such as methane) fuels a generator that generates electricity.

(2) The rules in this chapter are divided into seven parts based on subject matter, as follows:

(a) Part I: Definitions;

(b) Part II: Participation and application requirements, and incentive levels by project type;

(c) Part III: Calculation of incentives;

(d) Part IV: General topics;

(e) Part V: Manufactured in Washington state;

(f) Part VI: Application process for currently certified renewable energy systems in the cost recovery incentive program; and

(g) Part VII: Appeals rights.

PART I

DEFINITIONS

NEW SECTION

WAC 504-49-100 Overview. The definitions in Part I of this chapter (this section and WAC 504-49-103 through 504-49-195) apply throughout this chapter unless the context clearly requires otherwise.

NEW SECTION

WAC 504-49-103 Administrator. The term "administrator" has the following two meanings in this chapter:

(1) For purposes of a shared commercial solar project, the administrator is a utility or a business under contract with a utility which administers a shared commercial solar project that meets the eligibility requirements specified in this chapter. The administrator applies for certification on behalf of each of the project participants. In addition, the administrator performs administrative tasks on behalf of the owners as may be necessary, such as:

(a) Receiving the renewable energy incentive payments;

(b) Allocating and paying appropriate amounts of such payments to owners; and

(c) Communicating with the energy program about any changes in participants.

(2) For purposes of a community solar project as defined in WAC 504-49-120, the administrator is the utility, nonprofit, or local housing authority (as defined in RCW 35.82.020) that organizes and administers the community solar project. The administrator is responsible for applying for the renewable energy system incentive on behalf of the system's owners. In addition, the administrator performs administrative tasks on behalf of the owners as may be necessary, such as:

(a) Receiving the renewable energy incentive payments;

(b) Allocating and paying appropriate amounts of such payments to owners; and

(c) Communicating with the energy program about any changes in participants.

NEW SECTION

WAC 504-49-105 Caps and limits. "Caps and limits" are defined as follows:

(1) "Annual incentive limits" means the annual limits on total incentives paid per person, business, or household for a given fiscal year of electricity generation from the four project types described in chapter 36, Laws of 2017, 3rd sp. sess. (ESSB 5939). Each incentive recipient may qualify for payments up to the incentive cap within each project type. However, incentive recipients who have multiple projects within one project type are subject to the cap for the applicable project type. These caps are as follows:

(a) Residential-scale systems: Five thousand dollars;

(b) Commercial-scale systems: Twenty-five thousand dollars;

(c) Shared commercial solar projects: Up to thirty-five thousand dollars per year per project participant, as determined by the terms specified in chapter 36, Laws of 2017, 3rd sp. sess. (ESSB 5939); and

(d) Community solar projects: Five thousand dollars per project participant.

(2) "Utility credit cap" means that the maximum annual incentives paid by an electrical utility may not exceed one and one-half percent of the businesses' taxable power sales generated in calendar year 2014 and due under RCW 82.16.020 (1)(b) or two hundred fifty thousand dollars, whichever is greater, up to the utility's public utility tax liability.

(3) "Project type cap" has the following two meanings in this chapter:

(a) For commercial-scale systems, the project type cap is twenty-five percent of the remaining funds for credit available to a utility as of July 1, 2017; and

(b) For community solar and shared commercial solar projects combined, the project type cap is fifty percent of the remaining funds for credit available to a utility as of July 1, 2017.

(4) "Incentive rate limit" for shared commercial solar project participants means that the incentive rate must not exceed the difference between the levelized cost of energy output and the participant's retail rate.

(5) "Total program limit" means that the total incentive payments made under this program (in this chapter) may not exceed one hundred ten million dollars.

NEW SECTION

WAC 504-49-108 Certification. "Certification" means the authorization issued by the energy program establishing a system's eligibility and the eligibility of a person, business, or household to receive annual incentive payments from the serving utility for the incentive program term.

NEW SECTION

WAC 504-49-110 Commercial-scale system. "Commercial-scale system" means a renewable energy system or system other than a community solar project or a shared commercial solar project with a direct current combined nameplate capacity greater than twelve kilowatts that meets the applicable system eligibility requirements established in section 6, chapter 36, Laws of 2017, 3rd sp. sess. (ESSB 5939).

NEW SECTION

WAC 504-49-115 Community solar project. "Community solar project" means a solar energy system that:

(1) Has a nameplate generating capacity that is no larger than one thousand kilowatts direct current;

(2) Must have at least ten participants or one participant for every ten kilowatts direct current nameplate capacity, whichever is greater; and

(3) Meets the applicable eligibility requirements established in sections 6 and 7, chapter 36, Laws of 2017, 3rd sp. sess. (ESSB 5939).

NEW SECTION

WAC 504-49-120 Consumer-owned utility. "Consumer-owned utility" has the same meaning as in RCW 19.280.020.

NEW SECTION

WAC 504-49-125 Customer-owner. "Customer-owner" means the owner of a residential-scale or commercial-scale renewable energy system, where such owner:

(1) Is not a utility;

(2) Is the primary account holder of the utility account; and

(3) Either owns or occupies the premises where the renewable energy system is installed.

NEW SECTION

WAC 504-49-130 Direct current. "Direct current" means the unidirectional flow of electric charge.

NEW SECTION

WAC 504-49-135 Electric utility or utility. "Electric utility" or "utility" means a consumer-owned utility or investor-owned utility as those terms are defined in RCW 19.280.-020.

NEW SECTION

WAC 504-49-140 Fiscal year. "Fiscal year" means July 1st through June 30th of the following year for the purposes of this rule. For example, fiscal year 2018 goes from July 1, 2017, through June 30, 2018.

NEW SECTION

WAC 504-49-145 Nonprofit organization. "Nonprofit organization" means an organization exempt from taxation under 26 U.S.C. Sec. 501 (c)(3) of the federal Internal Revenue Code of 1986, as amended, as of January 1, 2009.

NEW SECTION

WAC 504-49-150 Person, business, and household. "Person, business, and household" means any individual, firm, partnership, corporation, company, association, agency, or any other legal entity that resides on a property or has a business located on a property within the service area of the utility where the renewable energy system is located.

(1) No person, business, or household is eligible to receive incentive payments provided under section 1, chapter 36, Laws of 2017, 3rd sp. sess. (ESSB 5939) of more than:

(a) Five thousand dollars per year for residential-scale systems or community solar projects;

(b) Twenty-five thousand dollars per year for commercial-scale systems; or

(c) Thirty-five thousand dollars per year for shared commercial solar projects.

(2) Example: Two or more individuals living together in one household, with one customer account with the participating utility, constitutes a household. Although they may each individually participate in this incentive program, these same individuals living together in one household receive incentives in accordance with this chapter.

NEW SECTION

WAC 504-49-155 Program term. "Program term" means eight years, or until cumulative incentive payments for electricity produced by the project reach fifty percent of the total system price, including applicable sales tax, whichever occurs first. Eight years is equivalent to ninety-six months of electricity generation from the time of certification.

NEW SECTION

WAC 504-49-160 Project participant. "Project participant" has the two following meanings:

(1) For purposes of community solar projects, a utility customer who participates in a community solar project in order to obtain a beneficial interest. Eligible participants of a community solar project that are business entities, such as a limited liability company or a corporation, are analyzed for participant eligibility and applicable incentive caps and limits by looking through the business entity to the members or stockholders that own the business entity.

(2) For purposes of shared commercial solar projects, a customer of a utility and located in the state of Washington.

NEW SECTION

WAC 504-49-165 Renewable energy system. "Renewable energy system" means a grid-connected:

(1) Solar energy system;

(2) Anaerobic digester as defined in RCW 82.08.900; or

(3) Wind generator.

NEW SECTION

WAC 504-49-170 Residential-scale system. "Residential-scale system" means a renewable energy system or systems located at a single situs with combined nameplate capacity of twelve kilowatts direct current or less that meets the applicable system eligibility requirements established in section 6, chapter 36, Laws of 2017, 3rd sp. sess. (ESSB 5939).

NEW SECTION

WAC 504-49-175 Shared commercial solar project. "Shared commercial solar project" means a solar energy system, owned or administered by an electric utility, which:

(1) Has a combined nameplate capacity of greater than one megawatt direct current and not more than five megawatts direct current;

(2) Has at least five participants; and

(3) Meets the applicable eligibility requirements established in sections 6 and 8, chapter 36, Laws of 2017, 3rd sp. sess. (ESSB 5939).

NEW SECTION

WAC 504-49-180 Solar energy system. "Solar energy system" means any device or combination of devices or elements that rely on direct sunlight as an energy source for use in the generation of electricity.

NEW SECTION

WAC 504-49-185 Solar inverter. "Solar inverter" means the device used to convert direct current to alternating current in a solar energy system.

NEW SECTION

WAC 504-49-190 Solar module. "Solar module" means the smallest nondivisible, self-contained physical structure housing interconnected photovoltaic cells and providing a single direct current electrical output.

NEW SECTION

WAC 504-49-195 Total system price. (1) "Total system price" includes only the renewable energy system components and fees that are integral and necessary for the generation of electricity. Components and fees include:

(a) Renewable energy system equipment (depends on system type):

(i) Solar energy system: Solar modules, inverter(s);

(ii) Wind generator: Turbine(s), tower(s), inverter(s);

(iii) Anaerobic digester: Digester/reactor, electrical generator.

(b) Balance of system (such as racking, wiring, switch gear, meter base);

(c) Nonhardware costs incurred up to the date of the final electrical inspection (such as fees associated with engineering, permitting, interconnection, application);

(d) Labor;

(e) Sales tax (as applicable).

(2) Total system price does not include structures and fixtures that are not integral and necessary to the generation of electricity, such as carports, roofing, and energy storage.

PART II

PARTICIPATION AND APPLICATION REQUIREMENTS, AND INCENTIVE LEVELS BY PROJECT TYPE

NEW SECTION

WAC 504-49-200 Participation by a utility in the renewable energy system incentive program is voluntary. (1) A utility electing to participate in the incentive program must notify the energy program of such election in writing.

(2) The utility may terminate its voluntary participation in the incentive program by providing notice in writing to the energy program to cease issuing new certifications for renewable energy systems that would be served by that utility.

(3) Such notice of termination of participation is effective after fifteen days, at which point the energy program may not accept new applications for certification of renewable energy systems that would be served by that utility.

(4) Upon receiving a utility's notice of termination of participation in the incentive program, the energy program must report on its web site that customers of that utility are no longer eligible to receive new certifications under the incentive program.

(5) A utility's termination of participation does not affect the utility's obligation to continue to make annual incentive payments for electricity generated by systems that were certified prior to the effective date of the notice. The energy program must continue to process and issue certifications for renewable energy systems that were received by the energy program before the effective date of the notice of termination.

(6) A utility that has terminated participation in the program may resume participation upon filing notice with the energy program.

NEW SECTION

WAC 504-49-205 Certification restrictions. No new certification may be issued under this chapter for a system which an applicant received notice of eligibility from the department of revenue under the cost recovery program (RCW 82.16.120), or for a renewable energy system served by a utility that has elected not to participate in the incentive program, as provided in WAC 504-49-200.

NEW SECTION

WAC 504-49-210 Renewable energy project requirements. Any person, business, or household, as defined in WAC 504-49-150, that participates in any of the four types of renewable energy projects defined in sections 5 through 8, chapter 36, Laws of 2017, 3rd sp. sess. (ESSB 5939), must meet the specified participation requirements and is subject to the system capacity limits, application requirements, and incentive limits, as follows:

(1) Residential-scale:

(a) Participation: The participant must be an owner of a residential-scale renewable energy system that is not a utility and:

(i) Is a customer of the utility that serves that location and has established an interconnection agreement with the utility for the renewable energy system; and

(ii) Either owns or occupies the premises where the renewable energy system is installed.

(b) Capacity: Twelve kilowatts direct current or less, combined:

(i) Example 1: A property with a six kilowatts direct current solar system on one structure and a five kilowatts direct current system on the same or separate structure qualifies for

the residential-scale incentive rate because the total capacity is less than twelve kilowatts direct current, combined.

(ii) Example 2: A property with a six kilowatts direct current solar system on one structure and a seven kilowatts direct current system on the same or separate structure does not qualify for the residential-scale incentive rate because the total capacity is greater than twelve kilowatts direct current, combined. This combined system instead qualifies for the commercial-scale incentive rate.

(iii) Example 3: A property with a twelve kilowatt direct current solar system, production metered and applying for the incentive, and any additional direct current system, production metered or not, and not applying for the incentive, on the same or separate structure, does not qualify for the residential-scale incentive rate because the combined capacity is greater than twelve kilowatts direct current. This combined system instead qualifies for the commercial-scale incentive rate.

(iv) In the case of multiple renewable energy systems on a structure such as a condominium or commercial building, each having a separate customer-owner and separate utility and production meters, each system, if under twelve kilowatts direct current, would qualify for the residential-scale rate.

(c) Application: The owner submits a completed application to the energy program for certification per requirements specified in WAC 504-49-220.

(d) Annual incentive limit: Five thousand dollars per person, business, or household.

(2) Commercial-scale:

(a) Participation: The participant must be an owner of a commercial-scale renewable energy system that is not a utility and:

(i) Is a customer of the utility that serves that location and has established an interconnection agreement with the utility for the renewable energy system; and

(ii) Either owns or occupies the premises where the renewable energy system is installed.

(b) Capacity: Greater than twelve kilowatts direct current, combined.

(i) Example 1: A property with a six kilowatts direct current solar system on one structure and a seven kilowatts direct current system on the same or separate structure qualifies for the commercial-scale incentive rate because the total capacity is greater than twelve kilowatts direct current, combined.

(ii) Example 2: A property with a six kilowatts direct current solar system on one structure and a five kilowatts direct current system on the same or separate structure qualifies for the residential-scale incentive rate because the total capacity is less than twelve kilowatts direct current, combined.

(c) Application: The owner submits a completed application to the energy program for certification per requirements specified in WAC 504-49-220.

(d) Annual incentive limit: Twenty-five thousand dollars per person, business, or household.

(3) Shared commercial solar:

(a) Administration: Administrators of this project type must be a utility or a business under contract with a utility;

(b) Participation: Projects must have at least five project participants, each of which is a customer of the utility and located in the state of Washington;

(c) Capacity: Combined nameplate capacity greater than one megawatt direct current and not more than five megawatts direct current;

(d) Application:

(i) Precertification. Prior to applying for certification, a shared commercial solar administrator must apply for precertification against the remaining funds available for incentive payments as of July 1, 2017. Precertification application requirements include, but are not limited to:

(A) The name of the utility serving the project location;

(B) Contact information for the project administrator and technical management personnel; and

(C) System information, including system component details and operation data such as global positioning system coordinates, tilt, estimated shading, and azimuth, as applicable;

(D) Additional information regarding deployment of projects in low- and moderate-income communities, as those terms are defined in RCW 43.63A.510, as requested.

(ii) Certification. The application for certification may not exceed the precertified system capacity. An application for certification must be completed by the shared commercial solar project administrator and approved by the energy program within one year of precertification issuance. Extensions past the three hundred sixty-five-day period are not granted. Projects that do not meet this deadline lose precertification status.

(e) Incentive rate: The incentive rate is set at the date of precertification approval;

(f) Annual incentive limit: Thirty-five thousand dollars per participant (person, business, household), consistent with their share of participation.

(4) Community solar project:

(a) Administration: A utility, nonprofit, or local housing authority that organizes or administers a solar project;

(b) Participation: The project must have at least ten participants, or one participant for every ten kilowatts direct current nameplate capacity, whichever is greater; and all participants must be customers of the participating utility;

(c) Capacity: Nameplate capacity that is no more than one thousand kilowatts direct current;

(d) There are no limitations on location unless stated in this section: Community solar project systems must be located in the state of Washington;

(e) Application:

(i) Precertification. Prior to applying for certification, a community solar project administrator must apply for precertification against the remaining funds available for incentive payments as of July 1, 2017. Precertification application requirements include, but are not limited to:

(A) The name of the utility serving the project location;

(B) Contact information for the project administrator and technical management personnel; and

(C) System information, including system component details and operation data such as global positioning system coordinates, tilt, estimated shading, and azimuth, as applicable.

(ii) Certification. The application for certification may not exceed the precertified system capacity. An application for certification must be completed by the community solar project administrator and approved by the energy program within one year of precertification issuance. Extensions past the three hundred sixty-five-day period are not granted. Projects that do not meet this deadline lose precertification status.

(f) Incentive rate: The incentive rate is set at the date of precertification approval;

(g) Annual incentive limit: Five thousand dollars per participant (person, business, household), consistent with their share of participation.

NEW SECTION

WAC 504-49-215 Department of revenue-certified renewable energy systems. To continue to be eligible to receive incentive payments under the renewable energy system cost recovery program (as described in WAC 458-20-273), the applicants (as defined in WAC 458-20-273) with the department of revenue certification must reapply with the energy program. This reapplication process is described in Part VI of this chapter and must be completed by April 30, 2018.

(1) Participation: Only applicants with renewable energy systems previously certified by the department of revenue may reapply for continued incentives.

(2) Application: Submit a completed reapplication to the energy program for certification in accordance with the requirements specified in Part VI of this chapter. For community solar projects, also submit a list of participants in the project.

(3) Annual incentive limit: Five thousand dollars per individual, household, business, or local governmental entity.

(4) Deadline: Reapplications must be submitted by April 30, 2018.

NEW SECTION

WAC 504-49-220 Requirements to apply for certification—Residential-scale and commercial-scale projects. The application must contain, but is not limited to, the following information; additional requirements are specified in WAC 504-49-210.

(1) The name and address of the customer-owner and location of the renewable energy system.

(2) System information, including system component details and operation data such as global positioning system coordinates, tilt, estimated shading, and azimuth, as applicable.

(3) An executed interconnection agreement with the serving utility.

(4) The date and supporting documentation verifying that the local jurisdiction issued its final electrical inspection of the renewable energy system.

(5) Documentation, including final sales invoice, and details of the total system price as defined in WAC 504-49-195.

(6) A signed statement that the applicant understands that this information is true, complete, and correct to the best of applicant's knowledge and belief under penalty of perjury.

(7) A signed statement that the applicant has not previously received a notice of eligibility from the department of revenue under RCW 82.16.120 entitling the applicant to receive annual incentive payments for electricity generated by the renewable energy system.

(8) A signed statement authorizing the energy program and the serving utility to share information related to issuing annual incentive payments, including application details and energy generation.

(9) Payment of the one hundred twenty-five dollar application fee.

(10) Provisional certification. The energy program may grant provisional certification prior to proof of final electrical inspection. Provisional certification expires one hundred eighty days after issuance, unless the applicant submits proof of the final electrical inspection from the applicable local jurisdiction, or the energy program extends the certification for a term or terms of thirty days due to extenuating circumstances.

NEW SECTION

WAC 504-49-225 Requirements to apply for certification—Shared commercial and community solar projects. The application must contain, but is not limited to, the information detailed below. Additional requirements are specified in WAC 504-49-210.

(1) The name and address of the project administrator and location of the renewable energy system.

(2) System information, including system component details and operation data such as global positioning system coordinates, tilt, estimated shading, and azimuth, as applicable.

(3) An executed interconnection agreement with the serving utility.

(4) The date and supporting documentation verifying that the local jurisdiction issued its final electrical inspection of the renewable energy system.

(5) Documentation, including final sales invoice, and details of total system price as defined in WAC 504-49-195.

(6) A signed statement that the administrator understands that this information is true, complete, and correct to the best of administrator's knowledge and belief under penalty of perjury.

(7) A signed statement that the administrator has not previously received a notice of eligibility from the department of revenue under RCW 82.16.120 entitling the community solar project participants to receive annual incentive payments for electricity generated by the solar energy system.

(8) A signed statement authorizing the energy program and the serving utility to share information related to issuing annual incentive payments, including application details and energy generation.

(9) Payment of the one hundred twenty-five dollar application fee.

(10) Additional information required for certification of shared commercial solar and community solar projects includes, but is not limited to:

(a) Shared commercial solar projects:

(i) Project design details;

(ii) Levelized cost of energy output of the system over its production life, and the calculations used to determine such cost;

(iii) A list of participants, including:

(A) Name;

(B) Address;

(C) Retail rate; and

(D) Utility account number;

(iv) Interconnection information; and

(v) Details regarding the majority of the installation work. If the majority of the installation of a shared commercial solar project is awarded to out-of-state contractors, the administrator must submit to the energy program:

(A) The reasons for using out-of-state contractors;

(B) The percentage of installation work performed by out-of-state contractors; and

(C) A cost comparison of the installation services performed by out-of-state contractors compared to the same services performed by Washington-based contractors.

(b) Community solar projects:

(i) System ownership information and business address;

(ii) Project design details;

(iii) Proof of registration with the utilities and transportation commission, as defined in commission rules;

(iv) A list of participants, including:

(A) Name;

(B) Address; and

(C) Utility account number.

(v) Subscription information, including:

(A) Rates;

(B) Fees;

(C) Terms and conditions.

(vi) Executed interconnection agreement if the project size is greater than five hundred kilowatts direct current; and

(vii) Updated information regarding deployment of projects in low- and moderate-income communities, as those terms are defined in RCW 43.63A.510, as requested.

NEW SECTION

WAC 504-49-230 Response from the energy program. Within thirty days of receipt of the application for precertification or certification, the energy program must notify the customer-owner or administrator, electronically or by mail, whether the renewable energy system qualifies for incentive payments. This notice must state the rate to be paid per kilowatt-hour of electricity generated by the renewable energy system, as provided in section 6(12), chapter 36, Laws of 2017, 3rd sp. sess. (ESSB 5939), subject to any applicable caps and limits on total annual payment as defined in this chapter.

NEW SECTION

WAC 504-49-235 Public disclosure. System certifications and the information contained therein are subject to public disclosure. In addition, all energy generation and incentive payment information associated with the certified system (as collected by the energy program) is subject to public disclosure.

NEW SECTION

WAC 504-49-240 Denial or revocation of system certification. The energy program may deny or revoke the approval of a system's certification and an appeal of this final determination may be initiated. The appeal provisions under Part VII of this chapter apply here.

NEW SECTION

WAC 504-49-245 Utility liability. A utility is not liable for incentive payments to a customer-owner if the utility has disconnected the customer due to a violation of a customer service agreement, such as nonpayment of the customer's bill or a violation of an interconnection agreement.

NEW SECTION

WAC 504-49-250 Modification to system. Modification details must be provided to the energy program. Examples are provided in WAC 504-49-305.

PART III

CALCULATION OF INCENTIVES

NEW SECTION

WAC 504-49-300 Incentive payment rate. The incentive payment rate is the sum of the base rate and the made-in-Washington bonus, if applicable. To determine the incentive payment, the incentive payment rate is then multiplied by the system's gross kilowatt-hours generated during the fiscal year to determine the incentive payment.

(1) Determining the base rate. The first step in computing the incentive payment is to determine the correct base rate to apply. This rate depends on the fiscal year in which the system was certified and the type of renewable energy project under consideration, as defined in the table in subsection (2) of this section.

(2) Made-in-Washington bonus. The bonus rate is determined by whether all applicable system components (solar modules, wind turbines or towers) are manufactured in Washington state. See additional manufacturing details in Part V of this chapter. Bonus rates vary depending on the fiscal year in which the system is certified, as provided in the table below.

Fiscal year of system certification	Base rate: Residential-scale	Base rate: Commercial-scale	Base rate: Community solar	Base rate: Shared commercial solar	Made-in-Washington bonus
2018	$0.16	$0.06	$0.16	$0.06	$0.05
2019	$0.14	$0.04	$0.14	$0.04	$0.04

Fiscal year of system certification	Base rate: Residential-scale	Base rate: Commercial-scale	Base rate: Community solar	Base rate: Shared commercial solar	Made-in-Washington bonus
2020	$0.12	$0.02	$0.12	$0.02	$0.03
2021	$0.10	$0.02	$0.10	$0.02	$0.02

(3) Examples: A renewable energy system certified in fiscal year 2019 and generate:

(a) Residential-scale system: Two thousand five hundred kilowatt-hours; commercial-scale system: Fourteen thousand kilowatt-hours.

(i) If a residential-scale or commercial-scale renewable energy system has only solar modules manufactured out-of-state, the computation is as follows:

(A) Residential-scale: 0.14 × 2,500 = $350.00;

(B) Commercial-scale: 0.04 × 14,000 = $560.00.

(ii) If a residential-scale or commercial-scale renewable energy system has all solar modules manufactured in Washington state, the computation is as follows:

(A) Residential-scale: (0.14 + 0.04) × 2,500 = $450.00;

(B) Commercial-scale: (0.04 + 0.04) × 14,000 = $1,120.00.

(iii) If a residential-scale or commercial-scale renewable energy system has a solar module manufactured in Washington state combined with additional solar modules manufactured out-of-state, the computation would be as follows:

(A) Residential-scale: 0.14 × 2,500 = $350.00;

(B) Commercial-scale: 0.04 × 14,000 = $560.00.

(iv) If residential-scale or commercial-scale wind generator equipment has an out-of-state turbine combined with a tower manufactured in Washington state, the computation is as follows:

(A) Residential-scale: (0.14 + 0.04) × 2,500 = $450.00;

(B) Commercial-scale: (0.04 + 0.04) × 14,000 = $1,120.00.

(v) If residential-scale wind generator equipment has both an out-of-state turbine and tower, the computation is as follows:

(A) Residential-scale: 0.14 × 2,500 = $350.00;

(B) Commercial-scale: 0.04 × 14,000 = $560.00.

(b) Shared commercial solar project system: Four million kilowatt-hours.

(i) If a shared commercial system has out-of-state solar modules, the computation is as follows: 0.04 × 4,000,000 = $160,000.00. The solar project administrator distributes the incentive payments consistent with share of participation. If a participant is involved at five percent of the project, their incentive payment is $160,000.00 × 0.05 = $8,000.00 (contingent on the rates, fees, terms or conditions of the project).

(ii) If a shared commercial system has all solar modules manufactured in Washington state, the computation is as follows: (0.04 + 0.04) × 4,000,000 = $320,000.00. The solar project administrator distributes the incentive payments consistent with share of participation. If a participant is involved at five percent of the project, their incentive payment is $320,000.00 × 0.05 = $16,000.00 (contingent on the rates, fees, terms or conditions of the project).

(c) Community solar project system: Fifty thousand kilowatt-hours.

(i) If a community solar energy system has all solar modules manufactured in Washington state combined with an out-of-state inverter, the computation is as follows: (0.14 + 0.04) × 50,000 = $9,000.00. The solar project administrator distributes the incentive payments consistent with share of participation. If a participant is involved at five percent of the project, their incentive payment is $9,000.00 × 0.05 = $450.00 (contingent on the rates, fees, terms or conditions of the project).

(ii) If a community solar energy system has some solar modules manufactured in Washington state combined with additional solar modules manufactured out-of-state, the computation is as follows: 0.14 × 50,000 = $7,000.00. The solar project administrator distributes the incentive payments consistent with share of participation. If a participant is involved at five percent of the project, their incentive payment is $7,000.00 × 0.05 = $350.00 (contingent on the rates, fees, terms or conditions of the project).

NEW SECTION

WAC 504-49-305 Additions or changes to existing certified systems. (1) All additions or changes to existing certified systems may be subject to existing utility standards and policies.

(2) If a residential-scale or commercial-scale customer-owner makes investments that result in an expansion of capacity, the applicant must provide this information to the energy program. The energy program may:

(a) Issue a new certification for an additional system installed with a previously certified system, as long as the new system meets the program requirements and its production can be measured separately from the previously certified system. These systems may be subject to additional annual reporting requirements including, but not limited to, production meter readings from each system.

(b) Issue a recertification if the additional capacity is not measured separately. Such recertification expires on the same day as the original certification for the residential-scale or commercial-scale system, and applies the incentive rates and program rules that are in effect as of the date of the recertification.

(3) The following examples illustrate how increases in system capacity may affect incentive payments:

(a) A five kilowatts direct current residential-scale system is certified in February 2019 and is eligible for the fourteen cents incentive rate. Two kilowatts direct current of capacity is added in February 2021 without a separate production meter and the system is recertified in the same fiscal year. The incentive rate of ten cents per kilowatt-hour applies to all future incentive payments of the entire seven kilowatts direct current system. Incentive payments end in 2027 or when cumulative incentive payments reach fifty percent of the total system price plus the expansion price, including applicable sales tax, whichever comes first;

(b) A five kilowatts direct current residential-scale system is certified in February 2019 and is eligible for the four-

teen cents incentive rate. If two kilowatts direct current of capacity is added in February 2021 with its own production meter, the addition may be certified separately and the ten cent rate applies only to the production from this separate system and ends in 2029. The originally certified five kilowatts direct current system continues to be certified at the fourteen cents rate, with those payments ending in 2027. Cumulative incentive payments of fifty percent of the total system price, including applicable sales tax, apply separately to the five kilowatts direct current and two kilowatts direct current installations;

(c) An increase in nameplate capacity, production metered or not, results in the total capacity being greater than twelve kilowatts direct current. Recertification is required and the applicable commercial-scale incentive rate will apply.

NEW SECTION

WAC 504-49-310 Cumulative limit on incentive payments. Incentive payments continue for eight years or until cumulative incentive payments for electricity produced by the project reach fifty percent of the total system price, including applicable sales tax, whichever occurs first.

PART IV

MANUFACTURED IN WASHINGTON STATE

NEW SECTION

WAC 504-49-400 What constitutes manufactured in Washington? The energy program must, in consultation with the department of commerce, establish a list of equipment that is eligible for the bonus rates described in this chapter.

(1) In order for a solar module, or a wind turbine or tower, to qualify as manufactured in Washington state, the manufactured component must meet the following definitions:

(a) "Solar module" means the smallest nondivisible, self-contained physical structure housing interconnected photovoltaic cells and providing a single direct current electrical output. The lamination of the modules must occur in Washington state;

(b) "Wind turbine" refers to a device that converts the wind's kinetic energy into electrical energy and "tower" refers to the supporting structure.

(2) Is combining products considered to be manufacturing? When determining whether a solar module, or a wind turbine or tower, are manufactured in Washington, the energy program considers various factors to determine if a manufacturer combining various items into a single package is engaged in a manufacturing activity. Any one of the following factors is not considered conclusive evidence of a manufacturing activity:

(a) The ingredients are purchased from various suppliers;

(b) The manufacturer combining the ingredients attaches his or her own label to the resulting product;

(c) The ingredients are purchased in bulk and broken down to smaller sizes;

(d) The combined product is marketed at a substantially different value from the selling price of the individual components; and

(e) The manufacturer combining the items does not sell the individual items except within the package.

NEW SECTION

WAC 504-49-405 What is the process for a manufacturer to get its product qualified as made in Washington? The manufacturer must request certification from the energy program that its product, such as a module, or wind turbine or tower, qualifies as made in Washington.

(1) Manufacturer's statement. The manufacturer must supply the energy program with a statement specifying what processes were carried out in Washington state to qualify the product.

(2) Penalty of perjury. The manufacturer's statement must be made under penalty of perjury.

(3) Field visit to view manufacturing process. The energy program performs a field visit to view the manufacturing process for the product, which may also include, but is not limited to:

(a) An inspection of the process by an engineer or other technical expert;

(b) Testing and evaluation of a product pulled off the production line;

(c) Review of purchase invoices to verify the vendor sources for the parts used in the manufacturing of the product;

(d) Inspection of the production line; and

(e) Requests for clarification concerning questions, if any, discovered during the inspection.

(4) Approval or disapproval of manufacturer's certification. Within thirty days of the field visit, the energy program issues a written decision to the manufacturer on its product's qualification as made in Washington state. The energy program makes the decision available to the public.

(5) Change in manufacturing process. The manufacturer must notify the energy program of any change in the manufacturing process for previously certified products within ten days of such a change.

(6) Inspection of previously certified product's manufacturing process. The energy program reserves the right to perform an inspection of the manufacturing processes for each product, such as a solar module, or a wind tower or turbine, that has been previously certified as manufactured in Washington state. The inspection is conducted to verify that the product continues to qualify as manufactured in Washington state.

(7) Denial or revocation of approval of certification. The energy program may revoke the approval of certification that a product, such as a module, or a wind turbine or tower, is made in Washington state when it finds that the product does not qualify for certification as manufactured in Washington state.

(8) The appeal provisions under Part VII of this chapter apply here.

(9) Document retention. The manufacturer must retain the documentation of the made in Washington certification process for five years after the application period for the related incentive program closes.

PART V

GENERAL TOPICS

NEW SECTION

WAC 504-49-500 Is there a time limit on when incentive payment may be made for a system's generated electricity? Yes. Incentive payments may only be made for kilowatt-hours generated on or after July 1, 2017, and for the following eight years, or until cumulative incentive payments for electricity generated by the project reach fifty percent of the total system price, including applicable sales tax, whichever occurs first.

(1) Authorization of incentive payments. No incentive payments may be authorized or accrued until the final electrical inspection and executed interconnection agreement are submitted to the energy program.

(2) Certification is valid for the incentive program term. This certification entitles the person, business, or household to receive incentive payments for electricity generated from the date the renewable energy system commences operation, or the date the system is certified, whichever date is later.

(3) Changes to incentive rates. Incentive rates determined by certification date may not be retroactively changed except to correct errors that were made during the original application or certification process and that are discovered later.

(4) Incentive schedule. Incentives are issued based on the gross kilowatt-hours generated during the fiscal year beginning on July 1st and ending on June 30th. For the last year of incentive payments, the payment is the balance of the last year of generation less the first year of generation. A negative balance for the last year results in nonpayment.

(5) Certification date. Certification date is determined by the date when the energy program completes its review of a submitted application. However, due to the timing of this program, the following administrative processes apply:

(a) For applications submitted from July 1, 2017, to December 31, 2017:

(i) For purposes of systems that commenced operation on or after July 1, 2017: The certification date is assigned based on the date that the local jurisdiction issued its final approval of the electrical inspection of the renewable energy system.

(ii) For purposes of systems that commenced operation before July 1, 2017: The certification date is assigned as July 1, 2017.

(b) For applications submitted on or after January 1, 2018: The certification date is assigned on the date when the energy program completes its review of a submitted application. The energy program encourages customer-owners to submit all applications on the date the local jurisdiction issues its final approval of the electrical inspection of the renewable energy system. In instances where the certification date might follow the final electrical inspection by more than thirty days, the customer-owner or the serving utility must provide additional information to ascertain the correct initial electrical generation amount to use in calculating the first year of incentive payments.

NEW SECTION

WAC 504-49-505 Must the customer-owner or administrator keep records regarding incentive payments? (1) Customer-owners or administrators receiving incentive payments must keep and preserve, for a period of five years after the receipt of the last incentive payment from the utility, suitable records as may be necessary to determine the amount of incentive received.

(2) Examination of records. Such records must be open for examination at any time upon notice by the energy program.

NEW SECTION

WAC 504-49-510 How to determine if community solar or shared commercial solar projects located on the same property are one combined system or separate systems for determining the applicable limit? In determining if a community solar or shared commercial solar project is within the applicable limit when more than one community solar or shared commercial solar project is located on one property, the energy program treats each project's system as separate from the other projects if there are separate production meters and separate certification applications have been submitted to the energy program.

NEW SECTION

WAC 504-49-515 Are the renewable energy system's environmental attributes transferred when ownership of the renewable energy system changes? The nonpower attributes of the renewable energy system belong to the utility customer who owns or hosts the system or, in the case of a community solar project or a shared commercial solar project, the participant. The attributes may be kept, sold, or transferred at the utility customer's discretion unless, in the case of a utility-owned community solar or shared commercial solar project, a contract between the customer and the utility clearly specifies that the utility retains the attributes.

NEW SECTION

WAC 504-49-520 What do I have to do if I purchase property that has an existing renewable energy system? If a person, business, or household purchases a property that has a renewable energy system certified in the renewable energy system incentive program, the new customer-owner must (at a minimum) notify the energy program of the transfer of ownership and provide an executed interconnection agreement with the utility serving the premises.

NEW SECTION

WAC 504-49-525 What if I sell my share in a community solar or shared commercial solar project? The administrator of a community solar project or shared commercial solar project must provide notice to the energy program of any changes or transfers in project participation.

PART VI

APPLICATION PROCESS FOR CURRENTLY CERTIFIED RENEWABLE ENERGY SYSTEMS IN THE COST RECOVERY INCENTIVE PROGRAM

NEW SECTION

WAC 504-49-600 Requirements to reapply for certification. The reapplication for continued incentive payments through June 30, 2020, must be submitted to the energy program by April 30, 2018. This reapplication must contain, but is not limited to, the following information as specified in the applicant and eligibility requirements in WAC 458-20-273:

(1) The name and address of the applicant and location of the renewable energy system;

(2) The applicant's tax registration number;

(3) The utility name and utility account number;

(4) System information, including system component details and operation data such as global positioning system coordinates, tilt, estimated shading, and azimuth, as applicable;

(5) A signed statement that the applicant understands that this information is true, complete, and correct to the best of their knowledge and belief under penalty of perjury; and

(6) A signed statement authorizing the energy program and the serving utility to share information related to issuing annual incentive payments, including application details and energy generation.

NEW SECTION

WAC 504-49-605 May a renewable energy system that has already been certified by the department of revenue be certified in the new program for incentive payments beyond June 30, 2020? No. If the applicant's renewable energy system has already been certified by the department of revenue for cost recovery incentives, that system is ineligible for the new incentive program.

NEW SECTION

WAC 504-49-610 May I increase the capacity of a department of revenue-certified system? The person, business, or household may not increase the capacity of a department of revenue-certified system to receive additional cost recovery program incentive payments.

NEW SECTION

WAC 504-49-615 Is there a fee to reapply? No. There is no fee for reapplication for a department of revenue-certified renewable energy system.

PART VII

APPEALS RIGHTS

NEW SECTION

WAC 504-49-700 What are the appeal rights under the renewable energy system incentive payment program? (1) The energy program may take four different types of actions that may result in a right to an appeal:

(a) Denying a system's precertification or certification;

(b) Revoking a system's precertification or certification;

(c) Denying a manufacturer's statement of a product as qualifying as made in Washington state; and

(d) Revoking a previously approved certification of a product qualifying as made in Washington.

(2) The same appeal procedures apply to all four types of action. All appeals involving the renewable energy system incentive program in this chapter are conducted as formal adjudicative proceedings under RCW 34.05.413 through 34.05.476 and chapter 10-08 WAC.

(3) The notice issued by the energy program provides an explanation of the reasons for the denial or revocation, and advises the recipient about how to appeal the decision if the recipient disagrees.

(4) The energy program's action is final unless the recipient files an appeal petition with the energy program within thirty days of service (receipt) of the notice of the energy program's action. RCW 34.05.010(19) defines "service" and includes service by postal mail, electronic mail, and personal service.

NEW SECTION

WAC 504-49-705 Presiding officer—Final order—Review. For both a denial of an application for certification and a notice of intent to revoke a previously approved certification, the presiding officer of a formal adjudicative proceeding is the Washington state office of administrative hearings. The presiding officer makes the final decision and enters a final order as provided in RCW 34.05.461 (1)(b).

NEW SECTION

WAC 504-49-710 Petitions for reconsideration. RCW 34.05.470 governs petitions for reconsideration. Petitions for reconsideration must be addressed to or delivered to the presiding officer at the address provided in the final order. The petition for reconsideration must be filed and served as required by WAC 10-08-110.

NEW SECTION

WAC 504-49-715 Judicial review. Judicial review of the final order of the presiding officer is governed by RCW 34.05.510 through 34.05.598.

WSR 18-20-040
PERMANENT RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed September 25, 2018, 2:31 p.m., effective October 26, 2018]

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

Purpose: The department is amending sections in chapter 388-107 WAC to update the references to chapter 388-112 WAC contained throughout the chapter to the new chapter 388-112A WAC.

Citation of Rules Affected by this Order: Amending WAC 388-107-0001, 388-107-0250, 388-107-0630, 388-107-0650, 388-107-0690, and 388-107-1180.

Statutory Authority for Adoption: Chapter 70.97 RCW.

Adopted under notice filed as WSR 18-14-064 on June 29, 2018.

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 the 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: September 25, 2018.

Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 16-14-078, filed 7/1/16, effective 8/1/16)

WAC 388-107-0001 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

"Abuse" means the willful action or inaction that inflicts injury, unreasonable confinement, intimidation, or punishment on a resident. In instances of abuse of a resident who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is presumed to cause physical harm, pain, or mental anguish. Abuse is also defined in RCW 74.34.020. Abuse includes sexual abuse, mental abuse, physical abuse, and exploitation of a resident, which have the following meanings:

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

(2) **"Physical abuse"** means the willful action of inflicting bodily injury or physical mistreatment. Physical abuse includes, but is not limited to, striking with or without an object, slapping, pinching, choking, kicking, shoving, prodding, or the use of chemical restraints or physical restraints except as described in section 388-107-0420;

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

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

"Activities of daily living" means the following tasks related to basic personal care: Bathing; toileting; dressing; personal hygiene; mobility; transferring; and eating.

"Administrative hearing" is a formal hearing proceeding before a state administrative law judge that gives:

(1) A licensee an opportunity to be heard in disputes about licensing actions, including the imposition of remedies, taken by the department; or

(2) An individual an opportunity to appeal a finding of abandonment, abuse, neglect, financial exploitation of a resident, or misappropriation of a resident's funds.

"Administrator" means an enhanced services facility administrator who must be in active administrative charge of the enhanced services facility as required in this chapter. Unless exempt under RCW 18.88B.041, the administrator must complete long-term care worker training and home care aide certification.

"Advance directive," as used in this chapter, means any document indicating a resident's choice with regard to a specific service, treatment, medication or medical procedure option that may be implemented in the future such as power of attorney health care directive, limited or restricted treatment cardiopulmonary resuscitation (CPR), do not resuscitate (DNR), and organ tissue donation.

"Aggressive behavior" means actions by the individual that constitute a threat to the individual's health and safety or the health and safety of others in the environment.

"Antipsychotic medications" means that class of medications primarily used to treat serious manifestations of mental illness associated with thought disorders, which includes but is not limited to atypical antipsychotic medications.

"Applicant" means the individual or entity, as defined in this section that has submitted, or is in the process of submitting, an application for an enhanced services facility license.

"Capacity" means the maximum amount an enhanced services facility can serve is sixteen residents.

"Caregiver" means the same as "long-term care worker" as defined in RCW 74.39A.009, as follows: "Long-term care workers" include all persons who provide paid, hands-on personal care services for the elderly or persons with disabilities, including but not limited to individual providers of home care services, direct care workers employed by home care agencies, providers of home care agencies to persons with developmental disabilities under Title 71A RCW, all direct care workers in state-licensed enhanced services facilities, assisted living facilities, and adult family homes, respite care providers, direct care workers employed by community residential service businesses, and any other direct care worker providing home or community-based services to the elderly or persons with functional disabilities or developmental disabilities.

"Challenging behavior" means a persistent pattern of behaviors that inhibit the individual's functioning in public places, in the facility and integration within the community, or uncontrolled symptoms of a physical or mental condition. These behaviors may have been present for long periods of time or have manifested as an acute onset.

"Chemical dependency" means alcoholism, medication addiction, or dependence on alcohol and one or more other psychoactive chemicals, as the context requires and as those terms are defined in chapter 70.96A RCW.

"Chemical dependency professional" means a person certified as a chemical dependency professional by the department of health under chapter 18.205 RCW.

"Deficiency" means an enhanced services facility's practice, action, or inaction that violates any or all of the requirements of chapter 70.97 RCW or this chapter.

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

"Direct supervision" means oversight by a person on behalf of the enhanced services facility who has met training requirements, demonstrated competency in core areas, or has been fully exempted from the training requirements, is on the premises, and is quickly and easily available to the caregiver.

"Enhanced services facility" or **"ESF"** means a facility licensed under chapter 70.97 RCW that provides treatment and services to persons for whom acute inpatient treatment is not medically necessary and who have been determined by the department to be inappropriate for placement in other licensed facilities due to the complex needs that result in behavioral and security issues. For the purposes of this chapter, an enhanced services facility is not an evaluation and treatment facility certified under chapter 71.05 RCW.

"Facility" means an enhanced services facility.

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

"Holding technique" means using the least amount of force necessary to manually hold all or part of a person's body in a way that restricts the person's free movement; also includes any approved controlling maneuvers identified in the person-centered service plan. Examples include holds taught in approved training for deescalation techniques and control of self-harm or aggressive behavior. This definition does not apply to briefly holding, without force, a person in order to calm the person, or holding a person's hand to escort the person safely from one area to another.

"Infectious" means capable of causing infection or disease by entrance of organisms into the body, which grow and multiply there, including, but not limited to, bacteria, viruses, protozoans, and fungi.

"Inspection" means the process by which department staff evaluates the enhanced services facility licensee's compliance with applicable statutes and regulations.

"License suspension" is an action taken by the department to temporarily revoke an enhanced services facility license in accordance with RCW 70.97.120 and this chapter.

"Licensee" means the individual or entity, as defined in this chapter, to whom the department issues the enhanced services facility license.

"Licensed physician" means a person licensed to practice medicine or osteopathic medicine and surgery in the state of Washington.

"Likelihood of serious harm" means a substantial risk that:

(1) Physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself;

(2) Physical harm will be inflicted by an individual upon another, as evidenced by behavior that has caused such harm or that places another person or persons in reasonable fear of sustaining such harm; or

(3) Physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior that has caused substantial loss or damage to the property of others.

"Long-term care worker" as defined in RCW 74.39A.009, has the same meaning as the term "caregiver."

"Management agreement" means a written, executed agreement between the licensee and the manager regarding the provision of certain services on behalf of the licensee.

"Mandated reporter":

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

(2) For the purpose of the definition of mandated reporter, "facility" means a residence licensed or required to be licensed under chapter 18.20 RCW, Assisted living facility; chapter 18.51 RCW, Nursing homes; chapter 70.128 RCW, Adult family homes; chapter 72.36 RCW, Soldiers' homes; chapter 71A.20 RCW, Residential habilitation centers; chapter 70.97 RCW, Enhanced services facility or any other facility licensed by the department.

"Medically fragile" means a chronic and complex physical condition which results in prolonged dependency on specialized medical care that requires frequent daily skilled

nursing interventions. If these medically necessary interventions are interrupted or denied, the resident may experience irreversible damage or death. Examples of specialized medical care and treatment for medically fragile residents include but are not limited to: IV therapies requiring monitoring of vital signs and dose titration dependent on lab values; wound care requiring external vacuum or other mechanical devices for debridement; complicated wound care requiring other specialized or extensive interventions and treatment; ventilator or other respiratory device dependence and monitoring; dependence on licensed staff for complex respiratory support; and peritoneal or hemodialysis (on-site).

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

"**Medication service**" means any service provided either directly or indirectly by an enhanced services facility related to medication administration medication assistance, or resident self-administration of medication.

"Mental disorder" means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions.

"Mental health professional" means a psychiatrist, psychologist, psychiatric nurse, licensed mental health counselor, licensed mental health counselor-associate, licensed marriage and family therapist, licensed marriage and family therapist-associate, licensed independent clinical social worker, licensed independent clinical social worker-associate, licensed advanced social worker, or licensed advanced social worker-associate and such other mental health professionals as may be defined by rules adopted by the secretary under the authority of chapter 71.05 RCW.

"Misappropriation of resident property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money.

"Neglect" means:

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

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

"Permanent restraining order" means a restraining order or order of protection issued either following a hearing, or by stipulation of the parties. A "permanent" order may be in force for a specific time period (e.g. 5 years), after which it expires.

"Prescriber" means a health care practitioner authorized by Washington state law to prescribe medications.

"Professional person" means a mental health professional and also means a physician, registered nurse, and such others as may be defined in rules adopted by the secretary pursuant to the provisions of this chapter.

"**Psychopharmacologic medications**" means a class of prescription medications that affect the mind, emotions, and behavior, including but not limited to antipsychotics, antianxiety medication, and antidepressants.

"Reasonable accommodation" and "reasonably accommodate" have the meaning given in federal and state antidiscrimination laws and regulations which include, but are not limited to, the following:

(1) Reasonable accommodation means that the enhanced services facility must:

(a) Not impose an admission criterion that excludes individuals unless the criterion is necessary for the provision of enhanced services facility services;

(b) Make reasonable modification to its policies, practices or procedures if the modifications are necessary to accommodate the needs of the resident;

(c) Provide additional aids and services to the resident.

(2) Reasonable accommodations are not required if:

(a) The resident or individual applying for admission presents a significant risk to the health or safety of others that cannot be eliminated by the reasonable accommodation;

(b) The reasonable accommodations would fundamentally alter the nature of the services provided by the enhanced services facility; or

(c) The reasonable accommodations would cause an undue burden, meaning a significant financial or administrative burden.

"RCW" means Revised Code of Washington.

"Records" means:

(1) **"Active records"** means the current, relevant documentation regarding residents necessary to provide care and services to residents; or

(2) **"Inactive records"** means historical documentation regarding the provision of care and services to residents that is no longer relevant to the current delivery of services and has been thinned from the active record.

"Registration records" include all the records of the department, regional support networks, treatment facilities, and other persons providing services to the department, county departments, or facilities which identify individuals who are receiving or who at any time have received services for mental illness.

"Resident" means a person admitted to an enhanced services facility.

"Resident's representative" means:

(1) The legal representative who is the person or persons identified in RCW 7.70.065 and who may act on behalf of the resident pursuant to the scope of their legal authority. The legal representative shall not be affiliated with the licensee, enhanced services facility, or management company, unless the affiliated person is a family member of the resident; or

(2) If there is no legal representative, a person designated voluntarily by a competent resident in writing, to act in the resident's behalf concerning the care and services provided by the enhanced services facility and to receive information from the enhanced services facility if there is no legal representative. The resident's representative may not be affiliated with the licensee, enhanced services facility, or management company, unless the affiliated person is a family member of the resident. The resident's representative under this subsection shall not have authority to act on behalf of the resident once the resident is no longer competent. The resident's com-

petence shall be determined using the criteria in RCW 11.88.010 (1)(e).

"Secretary" means the secretary of the department or the secretary's designee.

"Significant change" means:

(1) A deterioration in a resident's physical, mental, or psychosocial condition that has caused or is likely to cause clinical complications or life-threatening conditions; or

(2) An improvement in the resident's physical, mental, or psychosocial condition that may make the resident eligible for discharge or for treatment in a less intensive or less secure setting.

"Significant medication error" includes any failure to administer or receive a medication according to an authorized health care provider's order, or according to the manufacturer's directions for nonprescription medications, that results in an error involving the wrong medication, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration.

"Social worker" means a person with a master's or further advanced degree from a social work educational program accredited and approved as provided in RCW 18.320.010.

"Staff" or "staff person" means any person who:

(1) Is employed or used by an enhanced services facility, directly or by contract, to provide care and services to any resident.

(2) Staff must meet all of the requirements of chapter ((~~388-112~~)) 388-112A WAC.

"Stop placement" or "stop placement order" is an action taken by the department prohibiting enhanced services facility admissions, readmissions, and transfers of patients into the enhanced services facility from the outside.

"Temporary restraining order" means restraining order or order of protection that expired without a hearing, was terminated following an initial hearing, or was terminated by stipulation of the parties in lieu of an initial hearing.

"Treatment" means the broad range of emergency, detoxification, residential, inpatient, and outpatient services and care, including diagnostic evaluation, mental health or chemical dependency education and counseling, medical, physical therapy, restorative nursing, psychiatric, psychological, and social service care, vocational rehabilitation, and career counseling.

"Violation" means the same as "deficiency" as defined in this section.

"Volunteer" means an individual who interacts with residents without reimbursement.

"Vulnerable adult" includes a person:

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

(2) Found incapacitated under chapter 11.88 RCW; or

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

(4) Admitted to any facility, including any enhanced services facility; or

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

(6) Receiving services from an individual provider.

(7) Who self-directs his or her own care and receives services from a personal aide under chapter 74.39 RCW.

(8) For the purposes of requesting and receiving background checks pursuant to RCW 43.43.832, it shall also include adults of any age who lack the functional, mental, or physical ability to care for themselves.

"WAC" means Washington Administrative Code.

AMENDATORY SECTION (Amending WSR 14-19-071, filed 9/12/14, effective 10/13/14)

WAC 388-107-0250 Staffing credentials and qualifications. (1) The enhanced services facility must ensure the staffing ratios are met with the following credentialed staff, who are in good professional standing:

(a) Registered nurse;

(b) Licensed practical nurse;

(c) Nursing assistant certified or certified home care aide; and

(d) Mental health professional.

(2) The enhanced services facility must ensure that any caregiver, excluding professional licensed nursing staff:

(a) Must be at least 18 years of age;

(b) Has successfully completed a department-approved certified nursing assistant training program; or

(c) Meets the long-term worker training and certification requirements as described in chapter ((~~388-112~~)) 388-112A WAC.

AMENDATORY SECTION (Amending WSR 14-19-071, filed 9/12/14, effective 10/13/14)

WAC 388-107-0630 Training and home care aide certification requirements. (1) Under RCW 18.88B.041 and chapter 246-980 WAC, certain individuals including registered nurses, licensed practical nurses, certified nursing assistants, or persons who are in an approved certified nursing assistant program are exempt from long-term care worker training requirements.

(2) Continuing education requirements are outlined in chapter ((~~388-112~~)) 388-112A WAC; registered nurses and licensed practical nurses are exempt from the long-term care worker continuing education requirement.

(3) The enhanced services facility must ensure staff persons meet training requirements in effect on the date hired, including requirements described in chapter ((~~388-112~~)) 388-112A WAC, unless exempt under RCW 18.88B.041.

(4) The enhanced services facility must ensure all enhanced services facility administrators, or their designees, and caregivers who are not exempt under subsection (1) of this section meet the long-term care worker training requirements of chapter ((~~388-112~~)) 388-112A WAC, including but not limited to:

(a) Orientation and safety;

(b) Basic training;

(c) Specialty for dementia and, mental illness and/or developmental disabilities when serving residents with any of those primary special needs;

(d) Cardiopulmonary resuscitation and first aid; and

(e) Continuing education.

(5) The enhanced services facility must ensure that all staff receives appropriate training and orientation to perform their specific job duties and responsibilities.

(6) The enhanced services facility must ensure the following staff obtains home care aide certification, unless exempt under WAC 246-980-070:

(a) All long-term care workers, within two hundred days of hire;

(b) All enhanced services facility applicants, before licensure;

(c) All enhanced services facility administrators within two hundred days of hire, and

(d) Any other staff who will provide direct care and services to residents.

AMENDATORY SECTION (Amending WSR 14-19-071, filed 9/12/14, effective 10/13/14)

WAC 388-107-0650 Specialized training. (1) The enhanced services facility must ensure all staff who have any interaction with the residents successfully complete the mental health and dementia specialized trainings, consistent with chapter ((~~388-112~~)) 388-112A WAC, prior to working in the enhanced services facility.

(2) The facility must ensure all staff who have interaction with the residents complete any other specialty trainings to meet the needs of the residents being served, such as developmental disabilities.

AMENDATORY SECTION (Amending WSR 14-19-071, filed 9/12/14, effective 10/13/14)

WAC 388-107-0690 Facility-based trainers. If the enhanced services facility provides continuing education, in-service education or quarterly staff education, the educators must be approved by the department prior to educational intervention, in accordance with chapter ((~~388-112~~)) 388-112A WAC.

AMENDATORY SECTION (Amending WSR 14-19-071, filed 9/12/14, effective 10/13/14)

WAC 388-107-1180 Administrator qualifications—General. The licensee must appoint an administrator who:

(1) Is at least twenty-one years old;

(2) Has a bachelor's degree in social sciences, social services, human services, behavioral sciences, or an allied medical field;

(3) Meets the training requirements under chapter ((~~388-112~~)) 388-112A WAC and has specialized training in the provision of the care and services required for vulnerable adults with dementia, mental health and behavioral issues;

(4) Has at least one year of full-time experience working with vulnerable populations with complex personal care and behavioral needs;

(5) Knows and understands how to apply Washington state statutes and administrative rules related to the operation of a long-term care facility; and

(6) Is qualified to perform the administrator's responsibilities specified in WAC 388-107-1190.

WSR 18-20-044
PERMANENT RULES
SECRETARY OF STATE

[Filed September 26, 2018, 9:33 a.m., effective October 27, 2018]

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

Purpose: Amend WAC 434-750-290 to change process for redirected donations.

Citation of Rules Affected by this Order: Amending WAC 434-750-290.

Statutory Authority for Adoption: RCW 41.04.033.

Adopted under notice filed as WSR 18-17-021 on August 3, 2018.

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 the 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: September 26, 2018.

Mark Neary
Assistant Secretary of State

AMENDATORY SECTION (Amending WSR 17-12-089, filed 6/6/17, effective 7/7/17)

WAC 434-750-290 Decertified contributions. The CFD must work directly with its donors to determine where to direct donations originally pledged to a participating organization or federation that has been deemed noneligible or decertified. The CFD must provide the donor with options to disburse the pledged and collected donations to other participating organizations or federations or provide a refund of collected donations for the open quarter. If a donor does not respond to the CFD regarding redirecting donations, the CFD ((~~must issue a refund of all donations collected for the open quarter and cancel the donation. If the CFD determines it is not feasible to return such funds to donors, it~~)) must determine the appropriate disposition of the funds.

WSR 18-20-047
PERMANENT RULES
HEALTH CARE AUTHORITY

[Filed September 26, 2018, 12:15 p.m., effective January 1, 2019]

Effective Date of Rule: January 1, 2019.

Purpose: HB [SHB] 2651 amends RCW 74.09.340 to increase the personal needs allowance for people in residential and institutional care settings. The agency is amending

WAC 182-513-1105 to reflect the changes in HB [SHB] 2651.

Citation of Rules Affected by this Order: Amending WAC 182-513-1105.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160, HB [SHB] 2651, 65th legislature, 2018 regular session; ESSB 6032, sections 204 (2)(p) and 207(13), 2018 supplemental operating budget.

Adopted under notice filed as WSR 18-17-046 on August 8, 2018.

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 the 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: September 26, 2018.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 17-23-039, filed 11/8/17, effective 1/1/18)

WAC 182-513-1105 Personal needs allowance (PNA) and room and board standards in a medical institution and alternate living facility (ALF). (1) This section describes the personal needs allowance (PNA), which is an amount set aside from a client's income that is intended for personal needs, and the room and board standard.

(2) The PNA in a state veteran's nursing facility:

(a) Is $70 for a veteran without a spouse or dependent children receiving a needs-based veteran's pension in excess of $90;

(b) Is $70 for a veteran's surviving spouse with no dependent children receiving a needs-based veteran's pension in excess of $90; or

(c) Is $160 for a client who does not receive a needs-based veteran's pension.

(3) The PNA in a medical institution for clients receiving aged, blind, or disabled (ABD) cash assistance or temporary assistance for needy families (TANF) cash assistance is the client's personal and incidental (CPI) cash payment based on residing in a medical institution, which is $41.62.

(4) The PNA in an alternate living facility (ALF) for clients receiving ABD cash assistance or TANF cash assistance is the CPI based on residing in an ALF that is not an adult family home, which is $38.84.

(5) The PNA for clients not described in subsections (2), (3), and (4) of this section((~~:~~

~~(a) Is $57.28 for clients~~)), who reside in a medical institution((~~:~~)) or

(((~~(b) Is $62.79 for clients who reside~~)) in an ALF, is $70.

(6) Effective January 1, 2018, and each year thereafter, the amount of the PNA in subsection (5) of this section may be adjusted by the percentage of the cost-of-living adjustment (COLA) for old-age, survivors, and disability social security benefits as published by the federal Social Security Administration. This adjustment is subject to state legislative funding.

(7) The room and board standard in an ALF used by home and community services (HCS) and the developmental disabilities administration (DDA) is based on the federal benefit rate (FBR) minus the current PNA as described under subsection (5)(b) of this section.

(8) The current PNA and room and board standards used in long-term services and supports are published under the institutional standards on the Washington apple health (medicaid) income and resource standards chart located at www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

WSR 18-20-072
PERMANENT RULES
DEPARTMENT OF HEALTH

[Filed September 28, 2018, 10:36 a.m., effective October 29, 2018]

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

Purpose: Chapter 246-980 WAC, Home care aides, the rules were amended as part of the five-year rule review process under RCW 43.70.041 and to clarify ambiguities reported by stakeholders, consolidate the current rules by subject matter, and create standards of professional conduct for the profession.

Citation of Rules Affected by this Order: New WAC 246-980-025, 246-980-115, 246-980-150 and 246-980-160; repealing WAC 246-980-050, 246-980-060, 246-980-070, 246-980-080 and 246-980-090; and amending WAC 246-980-010, 246-980-020, 246-980-030, 246-980-040, 246-980-100, 246-980-120, 246-980-130, and 246-980-140.

Statutory Authority for Adoption: RCW 18.88B.021.

Adopted under notice filed as WSR 18-07-099 on March 20, 2018.

Changes Other than Editing from Proposed to Adopted Version: In WAC 246-980-040 (1)(d), reference to repealed WAC 388-112-0053 was changed to current WAC 388-112A-0310.

A final cost-benefit analysis is available by contacting Stacey Saunders, P.O. Box 47852, Olympia, WA 98504, phone 360-236-2813, fax 360-236-2901, TTY 360-833-6388 or 711, email stacey.saunders@doh.wa.gov, web site www.doh.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 the 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 3, Amended 8, Repealed 5.

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 4, Amended 8, Repealed 5.

Date Adopted: September 26, 2018.

John Wiesman, DrPH, MPH
Secretary

AMENDATORY SECTION (Amending WSR 13-19-087, filed 9/18/13, effective 10/19/13)

WAC 246-980-010 Definitions. The definitions in this section and in RCW 74.39A.009 apply throughout this chapter unless the context clearly requires otherwise.

(1) "Activities of daily living" means self-care abilities related to personal care such as bathing, body care, bed mobility, eating, locomotion, medication assistance, use of the toilet, personal hygiene, dressing, and transfer. ((~~Activities of daily living include instrumental activities of daily living.~~))

(2) "Date of hire" means:

(a) The date of service authorization for individual providers hired by the department of social and health services((~~.~~)); or

(b) The date the long-term care worker ((~~is hired by an~~)) provides direct care for pay from any employer, other than the department of social and health services;

(c) The date of hire is specific to each long-term care worker, not to the employer, and does not change if a long-term care worker changes employers. If a long-term care worker is or has been employed by more than one employer, the earliest date of hire will be the date of hire for that worker.

(3) "Department" means the department of health.

(4) "Direct care worker" means a paid caregiver who provides hands-on personal care services to individuals with disabilities or the elderly requiring long-term care.

(5) "Instrumental activities of daily living" means routine activities performed in the home or the community such as meal preparation, shopping, house cleaning, laundry, maintaining employment, travel to medical services, use of the telephone, and management of personal finances.

(6) "Medication assistance" has the same meaning as chapter 246-888 WAC.

(7) "Secretary" means the secretary of the department of health.

AMENDATORY SECTION (Amending WSR 13-19-087, filed 9/18/13, effective 10/19/13)

WAC 246-980-020 ((~~Who must be certified as a home care aide?~~)) Long-term care workers and home care aide certification. (((~~(1)~~))) Any person who is hired on or after January 7, 2012, as a long-term care worker for the elderly or persons with disabilities, regardless of the employment title, must obtain certification as a home care aide, unless exempt under WAC 246-980-025. This includes, but is not limited to:

(((~~(a)~~))) (1) An individual provider of home care services who is reimbursed by the state;

(((~~(b)~~))) (2) A direct care employee of a home care agency;

(((~~(c)~~))) (3) A provider of home care services to persons with developmental disabilities under Title 71A RCW;

(((~~(d)~~))) (4) A direct care worker in a state licensed assisted living facility;

(((~~(e)~~))) (5) A direct care worker in a state licensed adult family home;

(((~~(f)~~))) (6) A respite care provider who is reimbursed by the state or employed by a private agency or facility licensed by the state to provide personal care services; and

(((~~(g)~~))) (7) Any other direct care workers providing home or community-based services to the elderly or persons with developmental disabilities.

((~~(2) A long-term care worker who meets the requirements in subsection (1) of this section but is exempted under WAC 246-980-070 is not required to obtain certification.~~))

NEW SECTION

WAC 246-980-025 Individuals exempt from obtaining a home care aide certification. (1) The following individuals are not required to obtain certification as a home care aide. If they choose to voluntarily become certified, they must successfully pass the entry level training required by RCW 74.39A.074 and meet the requirements of WAC 246-980-040 (1)(b) and (c).

(a) An individual provider caring only for a biological, step, or adoptive child or parent.

(b) An individual provider who provides twenty hours or less of care for one person in any calendar month.

(c) An individual employed by a community residential service business.

(d) An individual employed by a residential habilitation center licensed under chapter 71A.20 RCW or a facility certified under 42 C.F.R. Part 483.

(e) A direct care worker who is not paid by the state or by a private agency or facility licensed by the state to provide personal care services.

(f) A person working as an individual provider who only provides respite services and works less than three hundred hours in any calendar year.

(g) Any direct care worker exempt under RCW 18.88B.041(1).

(2) The following long-term care workers are not required to obtain certification as a home care aide. If they choose to voluntarily become certified, they must meet the requirements of WAC 246-980-040 (1)(b) and (c). The training requirements under RCW 74.39A.074(1) are not required.

(a) An individual who holds an active credential by the department as a:

(i) Registered nurse, a licensed practical nurse, or advanced registered nurse practitioner under chapter 18.79 RCW; or

(ii) Nursing assistant-certified under chapter 18.88A RCW.

(b) A home health aide who was employed by a medicare certified home health agency within the year before being hired as a long-term care worker and has met the requirements of 42 C.F.R. Part 484.36.

(c) A person who is in an approved training program for certified nursing assistant under chapter 18.88A RCW, provided that the training program is completed within one hundred twenty calendar days of the date of hire and that the nursing assistant-certified credential has been issued within two hundred calendar days of the date of hire.

(d) An individual with special education training and an endorsement granted by the superintendent of public instruction under RCW 28A.300.010 and is approved by the secretary.

(e) An individual employed as a long-term care worker on January 6, 2012, or who was employed as a long-term care worker between January 1, 2011, and January 6, 2012, and who completed all of the training requirements in effect as of the date of hire. This exemption expires if the long-term care worker has not provided care for three consecutive years.

(i) The department may require the exempt long-term care worker who was employed as a long-term care worker between January 1, 2011, and January 6, 2012, to provide proof of that employment. Proof may include a letter or similar documentation from the employer that hired the long-term care worker between January 1, 2011, and January 6, 2012, indicating the first and last day of employment, the job title, a job description, and proof of completing training requirements. Proof of training will also be accepted directly from the approved instructor or training program, if applicable.

(ii) For an individual provider reimbursed by the department of social and health services, the department will accept verification from the department of social and health services or the training partnership.

AMENDATORY SECTION (Amending WSR 13-19-087, filed 9/18/13, effective 10/19/13)

WAC 246-980-030 ((~~Can a nonexempt long-term care worker work before~~)) Working while obtaining certification as a home care aide((~~?~~)). (1) A ((~~nonexempt~~)) long-term care worker may provide care before receiving certification as a home care aide if all the following conditions are met:

(a) Before providing care, the long-term care worker must complete the training required by RCW 74.39A.074 (1)(d)(i)(A) and (B).

(b) The long-term care worker must submit an application for home care aide certification to the department within fourteen calendar days of hire. An application is considered to be submitted on the date it is post-marked or, for applications submitted in person or online, the date it is accepted by the department.

(2) ((~~The long-term care worker may not work for more than two hundred calendar days from their date of hire without obtaining certification.~~)) A long-term care worker is no longer eligible to provide care without a credential under the following circumstances:

(a) The long-term care worker does not successfully complete all of the training required by RCW 74.39A.074(1) within one hundred twenty calendar days from their date of hire;

(b) The long-term care worker has not obtained their certification within two hundred calendar days from their date of hire, or two hundred sixty calendar days if granted a provisional certificate under RCW 18.88B.041.

(3) This section does not apply to long-term care workers exempt from certification under WAC 246-980-025.

AMENDATORY SECTION (Amending WSR 13-19-087, filed 9/18/13, effective 10/19/13)

WAC 246-980-040 ((~~What must a nonexempt long-term care worker do to be eligible for a home care aide certification and what documentation is required?~~)) Certification requirements. (1) To qualify for certification as a home care aide, the applicant must:

(a) Successfully complete ((~~the entry level training required by RCW 74.39A.074(1) before taking the examination;~~)) all training required by RCW 74.39A.074(1) within one hundred twenty calendar days of the date of hire as a long-term care worker;

(b) Successfully pass the home care aide certification examination, after completing training;

(c) Become certified within two hundred days of date of hire, or two hundred sixty days if granted a provisional certificate under RCW 18.88B.041; and

(((~~(c)~~))) (d) Complete four clock hours of AIDS education as required in chapter 246-12 WAC, Part 8. This is included in the basic training requirements in WAC 388-71-0906 and ((~~388-112-0053~~)) 388-112A-0310.

(2) ((~~An applicant must submit directly to the examination contractor:~~

~~(a) A completed application for examination provided by the examination contractor; and~~

~~(b) The fee required by the examination contractor.~~

~~(3)~~)) An applicant for certification as a home care aide must submit to the department:

(a) A completed application for both certification and the examination on forms provided by the department;

(b) The exam fee set by the examination vendor and required fees under WAC 246-980-990; and

(c) A certificate of completion from an approved training program indicating that the applicant has successfully completed the entry level training required by RCW 74.39A.074. The certificate of completion or other official verification may also be submitted directly from the approved instructor or training program.

(((~~(4)~~))) (3) An applicant must submit to a state and federal background check as required by RCW 74.39A.056.

(4) An applicant exempt from certification under WAC 246-980-025(2) who voluntarily chooses to be certified must provide documentation of qualification for the exemption. The applicant is not required to take the training required in subsection (1)(a) of this section or provide proof of training completion to the department.

GENERAL REQUIREMENTS ((~~FOR THE APPLICATION~~)) FOR HOME CARE AIDE CERTIFICATION ((~~BY BOTH REQUIRED AND VOLUNTARY HOME CARE AIDES~~))

AMENDATORY SECTION (Amending WSR 13-19-087, filed 9/18/13, effective 10/19/13)

WAC 246-980-100 Examination and reexamination for home care aide certification. (1) The certification examination will consist of both a written knowledge test and a skills demonstration.

(2) The certification examination will test the core competencies, including but not limited to((~~,~~)):

(a) Communication skills((~~,~~));

(b) Worker self-care((~~,~~));

(c) Problem solving((~~,~~));

(d) Maintaining dignity((~~,~~));

(e) Consumer directed care((~~,~~));

(f) Cultural sensitivity((~~,~~));

(g) Body mechanics((~~,~~));

(h) Fall prevention((~~,~~));

(i) Skin and body care((~~,~~));

(j) Home care aide roles and boundaries((~~,~~));

(k) Supporting activities of daily living((~~,~~)); and

(l) Food preparation and handling.

(3) An applicant must apply ((~~directly to the examination contractor~~)) to take the examination by completing the application for both certification and the examination and returning it to the department. The department will notify the examination contractor once an applicant meets all requirements to take the certification examination.

(4) The examination contractor will notify an applicant of the date, time, and place of the examination.

(5) The examination contractor will notify both the department and an applicant of the examination results.

(a) An applicant who does not successfully pass any portion of the examination can follow the examination contractor's procedures for review and appeal.

(b) An applicant who does not successfully pass any portion of the examination may retake that portion of the examination two times.

(i) To retake the examination, an applicant must submit an application for reexamination, along with the required reexamination fee directly to the examination contractor.

(ii) An application for reexamination may be submitted any time after an applicant receives notice of not successfully completing any portion of the certification examination.

(c) An applicant who does not successfully pass both portions of the certification examination within two years of successfully completing the required training or who does not successfully pass both portions of the certification examination after completing the certification examination three consecutive times:

(i) Must retake and successfully complete the core competencies portion of the entry-level training as required by RCW 74.39A.074 before retaking both portions of the certification examination; and

(ii) Cannot continue to provide care as a long-term care worker until the certification has been issued.

NEW SECTION

WAC 246-980-115 Renew or reinstate an expired certification. (1) To renew a home care aide certification the practitioner must:

(a) Renew the certification every year by the home care aide's birthday as provided in chapter 246-12 WAC, Part 2;

(b) Submit a completed application as provided by the department; and

(c) Provide verification of twelve hours of continuing education as required by RCW 74.39A.341 and WAC 246-980-110 with the renewal application.

(2) To reinstate an expired certification:

(a) If the certification has been expired for less than three years, the practitioner must submit proof of twelve continuing education hours as required by RCW 74.39A.341 and WAC 246-980-110 for each year it has been expired, and meet the requirements of chapter 246-12 WAC, Part 2.

(b) If the certification has been expired for three years or more, the practitioner must successfully repeat the training and examination requirements in WAC 246-980-040 and meet the requirements of chapter 246-12 WAC, Part 2.

(c) A practitioner previously exempt from certification by WAC 246-980-025(2) who voluntarily chooses to be certified is not required to complete training to reinstate a certification expired over three years so long as they continue to be exempt under WAC 246-980-025(2) at the time of reapplying.

AMENDATORY SECTION (Amending WSR 13-19-087, filed 9/18/13, effective 10/19/13)

WAC 246-980-120 Home care aide—Application—Conviction data—Criteria for denial or conditional license. (1) An applicant who has any criminal history may be denied certification or may be granted certification with conditions pursuant to RCW 18.130.055.

(2) In determining whether to deny certification or grant certification with conditions due to an applicant's criminal history, the department may consider, but is not limited to, the following factors:

(a) The severity of the crime as classified under law;

(b) The number of convictions and whether the applicant has exhibited a pattern of criminal conduct;

(c) The amount of time elapsed since the date of conviction or the date of offense;

(d) The amount of time the applicant has spent in the community after release from custody;

(e) Whether any conviction is listed by the department of social and health services as a disqualifying crime, including those offenses listed in RCW 43.43.830 (((~~(5), (6), or~~)) (7), (8), or (9);

(f) Whether the applicant has complied with court-ordered conditions such as treatment, restitution, or other remedial or rehabilitative measures;

(g) Other remediation or rehabilitation by the applicant subsequent to the conviction date;

(h) Whether the applicant disclosed the conviction on the certification application; and

(i) Any other factor relating to the applicant's ability to practice as a home care aide with reasonable skill and safety.

(3) A long-term care worker disqualified from working with vulnerable persons under chapter 74.39A RCW may not be certified as a home care aide.

AMENDATORY SECTION (Amending WSR 13-19-087, filed 9/18/13, effective 10/19/13)

WAC 246-980-130 Provision for delegation of certain tasks to a home care aide. (1) A home care aide-certified may perform tasks delegated by a registered nurse for patients in community-based care settings or in-home care settings each as defined in RCW 18.79.260 (3)(e).

(2) Before performing any delegated task a home care aide-certified must show the certificate of completion of the core delegation training from the department of social and health services to the registered nurse delegator.

(3) A home care aide-certified who is performing nurse delegation tasks must comply with all applicable requirements of the nursing care quality assurance commission in WAC 246-840-910 through 246-840-970.

(4) A home care aide-certified, who may be performing insulin injections must show a certificate of completion of diabetic training from the department of social and health services to the registered nurse delegator.

(5) A home care aide-certified must meet any additional training requirements identified by the department of social and health services.

(6) For the purposes of this section, delegated nursing care tasks must be performed:

(a) Only for the specific patient for whom those tasks are delegated;

(b) Only with the patient's consent; and

(c) In compliance with all applicable requirements in WAC 246-840-910 through 246-840-970.

(7) A home care aide-certified may consent or refuse to consent to perform a delegated nursing care task. The home care aide-certified is responsible for his or her own actions with the decision to consent or refuse to consent and the performance of the delegated nursing care task.

(8) A home care aide-certified must not accept delegation of, or perform, the following nursing care tasks:

(a) Administration of medication by injection, with the exception of insulin injections;

(b) Sterile procedures;

(c) Central line maintenance;

(d) Acts that require nursing judgment.

(9) A person who is working as a long-term care worker but has not received a home care aide certification must have either ((~~a~~)) an active nursing assistant-certified or an active nursing assistant-registered credential issued by the department and comply with WAC 246-841-405 to perform delegated tasks.

AMENDATORY SECTION (Amending WSR 16-17-100, filed 8/18/16, effective 9/18/16)

WAC 246-980-140 Scope of practice for long-term care workers. (1) A long-term care worker performs activities of daily living or activities of daily living and instrumental activities of daily living. A person performing only instrumental activities of daily living is not acting under the long-term care worker scope of practice.

(a) "Activities of daily living" means self-care abilities related to personal care such as bathing, eating, medication assistance, using the toilet, dressing, and transfer. This may include fall prevention, skin and body care.

(b) "Instrumental activities of daily living" means activities in the home and community including cooking, shopping, house cleaning, doing laundry, working, and managing personal finances.

(2) A long-term care worker documents observations and tasks completed, as well as communicates observations ((~~on the day they were performed to clients, family, supervisors, and, if appropriate, health care providers~~)).

(3) A long-term care worker may perform medication assistance as described in chapter 246-888 WAC.

(4) A long-term care worker may perform nurse delegated tasks, to include medication administration, if he or she meets and follows the requirements in WAC 246-980-130.

(5) A long-term care worker may provide skills acquisition training on instrumental activities of daily living and the following activities of daily living tasks: Dressing, application of deodorant, washing hands and face, hair washing, hair combing and styling, application of makeup, menses care, shaving with an electric razor, tooth brushing or denture care, and bathing tasks excluding any transfers in or out of the bathing area.

(6) This section applies to all long-term care workers, whether required to be certified or exempt.

NEW SECTION

WAC 246-980-150 Standards of practice. (1) A long-term care worker must demonstrate behavior which maintains and respects client or resident rights and safety. This includes, but is not limited to, the following:

(a) A long-term care worker may not solicit, accept or borrow money, material or property from a client or resident. This subsection does not apply to a long-term care worker who is in an established personal relationship with the client, preexisting the provision of services, where there is no evidence of exploiting the client.

(b) A long-term care worker may not accept from a client or resident gifts of value greater than twice the current hourly minimum wage in Washington state. Gifts are limited to customary gift-giving times, such as birthdays or major holidays. This subsection does not apply to a long-term care worker who is in an established personal relationship with the client, preexisting the provision of services, where there is no evidence of exploiting the client.

(c) A long-term care worker may not accept, borrow, or take alcohol or drugs (prescription or nonprescription), including marijuana, from a client or resident.

(d) A long-term care worker may not ingest, inject, inhale, or consume in any manner any substance, including prescribed medicine, that impairs their ability to perform their job duties during the time in which they are paid to provide care.

(e) A long-term care worker may not solicit or accept a role that gives them power over a client's or resident's

finances, legal matters, property, or health care decisions. This includes, but is not limited to, acting as power of attorney, legal guardian, payee, insurance beneficiary, or executor or beneficiary of a will. This subsection does not apply to a long-term care worker who is in an established personal relationship with the client, preexisting the provision of services, where there is no evidence of exploiting the client.

(f) A long-term care worker may not be the landlord for a client or resident they provide care to. This does not apply to adult family homes licensed by the department of social and health services so long as the adult family home license is active and in good standing. This section does not apply to a long-term care worker who is in an established personal relationship with the client, preexisting the provision of services, where there is no evidence of exploiting the client.

(g) A long-term care worker shall respect a client's or resident's privacy and shall not take or disseminate photos or videos of a client or resident that do not respect the client's or resident's dignity and rights. This includes, but is not limited to, social media. A long-term care worker must obtain the written permission of the client or resident, or their legal guardian, prior to taking or disseminating any photo or video of the client or resident, unless the long-term care worker is in an established personal relationship with the client, preexisting the provision of services, where there is no evidence of exploiting the client.

(2) For the purposes of this section, "landlord" means having a formal, written lease agreement between the lessor and lessee. It does not apply to situations in which cohabitants voluntarily contribute financially to household expenses without a lease agreement.

NEW SECTION

WAC 246-980-160 Sexual misconduct. A long-term care worker shall not engage in sexual misconduct as defined in WAC 246-16-100.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-980-050	How long does a nonexempt long-term care worker have to complete the home care aide training and certification requirements?
WAC 246-980-060	How does a nonexempt home care aide renew a certification or reinstate an expired certification?
WAC 246-980-070	Who is exempt from obtaining a home care aide certification?
WAC 246-980-080	How does an exempt individual apply for certification as a home care aide?
WAC 246-980-090	How does an exempt home care aide renew a home care aide certification or reinstate an expired home care aide certification?

WSR 18-20-081
PERMANENT RULES
DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES

[Filed October 1, 2018, 8:39 a.m., effective November 1, 2018]

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

Purpose: The department of children, youth, and families (DCYF) adopts these rules to establish, implement, and enforcement [enforce] requirements to protect the health and safety of children who are cared for by license-exempt family, friends, and neighbors (FFN) participating in working connections child care. Adoption of these rules complies with a requirement imposed by the federal child care development fund governed by 42 U.S.C. 9858 et seq. The rules establish preservice and training requirements for FFN care providers, health and safety activities and practices during care, and the consequences of noncompliance.

Citation of Rules Affected by this Order: New WAC 110-16-0001 Purpose and authority, 110-16-0005 Definitions, 110-16-0010 Provider approval, 110-16-0015 Provider responsibilities, 110-16-0025 Health and safety training, 110-16-0030 Health and safety activities, 110-16-0035 Health and safety practices, and 110-16-0040 Compliance.

Statutory Authority for Adoption: RCW 43.216.055 and 43.216.065; chapter 43.216 RCW.

Other Authority: 42 U.S.C. 9858 et seq.

Adopted under notice filed as WSR 18-15-095 on July 18, 2018.

Changes Other than Editing from Proposed to Adopted Version: WAC 110-16-0005, inserted definition for "subsidy payment begin date."

WAC 110-16-0010 (1)[(b)](ii), inserted clarification that a variety of documents could be used to prove legal employment eligibility.

WAC 110-16-0025, training completion date changed to "within ninety calendar days of the subsidy payment begin date." Removed current child development associate credential and an associates' degree of applied science or higher with an early child education major from accepted training equivalencies.

WAC 110-16-0030 (3)(c), inserted clarification that (1) written information and local resources about child development and (2) regional contact information for FFN child care services and resources will be provided during technical assistance visits.

WAC 110-16-0030(4), removed parent's requirement to ensure provider has necessary training to administer medication and respond to allergic reactions.

WAC 110-16-0035, removed details of health and safety practices and inserted clarification that health and safety practices covered in required training must be followed. Removed requirement to keep dangerous substances apart from food and food prep areas.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 8, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the 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: September 28, 2018.

Brenda Villarreal
Rules Coordinator

Chapter 110-16 WAC

LICENSE-EXEMPT CARE—FAMILY, FRIENDS, AND NEIGHBORS (FFN) IN-HOME/RELATIVE CHILD CARE PROVIDERS

PART I

INTRODUCTION

NEW SECTION

WAC 110-16-0001 Purpose and authority. (1) The purpose of this chapter is to establish rules for the administration of child care subsidy funds through the working connections child care (WCCC) program for family, friends, and neighbors (FFN) in-home/relative child care providers. The department of children, youth, and families (DCYF) is the lead agency for the federal Child Care Development Fund (CCDF) program, governed by 42 U.S.C. 9858 et. seq., (CCDF authorization and implementation statutes) and 45 C.F.R. Part 98 (CCDF regulations). This chapter addresses CCDF health and safety requirements and WCCC program requirements for family, friends, and neighbors (FFN) in-home/relative child care providers.

(2) In addition to the requirements contained in this chapter, FFN providers must comply with applicable provisions of chapter 43.216 RCW (department of children, youth, and families), chapter 110-06 WAC (background check rules), and chapter 110-15 WAC (WCCC) subsidy program rules.

(3) The requirements contained in this chapter are consistent with and support the department's commitment to promoting the health, safety, and well-being of children, expanding access to quality early learning opportunities to improve outcomes in young children and promoting school readiness.

(4) The department recognizes that a child's parents and family are the child's first and most important teachers and decision makers. The department is committed to working alongside parents to promote the overall well-being of their children, providing technical assistance and resource referral at the request of parents or providers, and using a variety of methods to communicate with parents and providers about program changes and relevant resources and information.

NEW SECTION

WAC 110-16-0005 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) **"Benefit"** means a regular payment made by a government agency on behalf of a person eligible to receive it.

(2) **"Child"** or **"children,"** except when otherwise specified, means a child or children eligible for WCCC benefits under chapter 110-15 WAC.

(3) **"Days"** means calendar days unless otherwise specified.

(4) **"Department"** or **"DCYF"** means the department of children, youth, and families.

(5) **"In-home/relative provider"** or **"family, friends, and neighbors (FFN) provider"** means an individual who is exempt from child care licensing requirements and is approved for WCCC payments under WAC 110-15-0125. Reference in this chapter to the term "provider" means an in-home/relative or FFN provider, except when otherwise specified.

(6) **"In loco parentis"** means the adult caring for a child eligible for WCCC in the absence of the biological adoptive, or step-parents, and who is not a relative, court-ordered guardian, or custodian, and who is responsible for exercising day-to-day care and control of the child.

(7) **"Infant"** is a child birth through eleven months of age.

(8) **"Lockdown"** means to remain inside the home when police or an official emergency response agency notifies a provider that it is unsafe to leave or be outdoors during an emergency situation.

(9) **"Parent"** means, for the purposes of this chapter, the "in loco parentis" or the biological, adoptive, or step-parent, court-ordered guardian, or custodian eligible for WCCC benefits under this chapter.

(10) **"Subsidy payment begin date"** means the first day the provider is authorized to start billing for care provided to eligible children.

(11) **"Supervise"** or **"supervision"** means a provider must be able to see or hear the children they are responsible for at all times. Providers must use their knowledge of each child's development and behavior to anticipate what may occur to prevent unsafe or unhealthy events or conduct, or to intervene in such circumstances as soon as possible. Providers must also reposition themselves or the children to be aware of where children are and what they are doing during care. Providers must reassess and adjust their supervision each time child care activities change.

(12) **"Swimming pool"** means a pool that has a water depth greater than two feet.

(13) **"Technical assistance"** means the provision of customized supports to develop or strengthen processes, knowledge application, or implementation of services by providers.

(14) **"Toddler"** means a child twelve months through twenty-nine months of age.

(15) **"Wading pool"** means a pool that has a water depth of less than two feet. A portable wading pool is one that is formed of molded plastic or inflatable parts and can be removed after use.

(16) **"Water activities"** refers to the activities in which children in care swim or play in a body of water that poses a risk of drowning for children.

(17) **"WCCC"** means the working connections child care program, a child care subsidy program available to eligible families to help pay for child care.

PART II

PROVIDER APPROVAL AND RESPONSIBILITIES

NEW SECTION

WAC 110-16-0010 Provider approval. (1) To be approved as a family, friend, and neighbor (FFN) in-home/ relative provider for the WCCC program, the individual must:

(a) Be eighteen years of age or older;

(b) Complete the approval process that will include, but not be limited to, providing:

(i) Legal name, current street address, telephone number, and email address;

(ii) Documents required to establish that the individual meets legal employment eligibility requirements that may include, but are not limited to:

(A) A legible copy of the individual's valid Social Security card; and

(B) A legible copy of the individual's valid government issued photo identification, such as a current driver's license, Washington state identification, or passport.

(c) Meet all applicable WCCC subsidy and background check requirements of chapters 110-15 and 110-06 WAC.

(2) An individual will not be approved to receive WCCC subsidy payment as a provider for an eligible child in his or her care if the individual is:

(a) The child's biological or adoptive parent, step-parent, or the parent's live-in partner;

(b) The child's legal guardian or the guardian's spouse or live-in partner;

(c) An adult acting in loco parentis or that adult's spouse or live-in partner;

(d) An individual with a revoked child care license; or

(e) Receiving temporary assistance for needy families (TANF) benefits on behalf of the eligible child.

(3) Providers are not eligible to receive WCCC benefits for their own children for the same hours for which they receive payment for child care they provide for other WCCC-eligible children.

NEW SECTION

WAC 110-16-0015 Provider responsibilities. (1) The provider must:

(a) Agree to provide care, supervision, and daily activities based on the child's developmental needs, including health, safety, physical, nutritional, emotional, cognitive, and social needs;

(b) Report any legal name, address, or telephone number changes to DCYF within ten days;

(c) Comply with the requirements contained in this chapter and the applicable requirements in chapters 110-06 and 110-15 WAC;

(d) Allow parents access to their own children at all times while in care; and

(e) Have access to a telephone with 911 emergency calling services and capability for both incoming and outgoing calls during all times children are in care.

(2) The provider must not submit an invoice for more than six children for the same hours of care.

(3) Care must be provided in the following locations:

(a) Providers related to the child by marriage, blood relationship, or court decree and who are grandparents, great-grandparents, siblings (if living in a separate residence), aunts, or uncles, must choose to be approved to provide care in either the provider's home or the child's home, with the exception that providers residing with a person disqualified under chapter 110-06 WAC must provide care in the child's home.

(b) Providers related to the child by marriage, blood, or court decree, but not listed in (a) of this subsection, must choose to be approved to provide care in either the provider's home or the child's home, with the exception that providers residing with a person disqualified under chapter 110-06 WAC must provide care in the child's home.

(c) Providers not related to the child, such as friends or neighbors must provide care in the child's home.

(4) Providers must comply with health and safety activities as follows:

(a) Providers related to the child as described in subsection (3)(b) of this section, must participate in a technical assistance phone call with the department within ninety days of the subsidy payment begin date and annually thereafter;

(b) Providers not related to the child, as described in subsection (3)(c) of this section:

(i) Must complete the department-approved training required in WAC 110-16-0025; and

(ii) Must have an annual technical assistance visit in the child's home.

PART III

HEALTH AND SAFETY REQUIREMENTS

NEW SECTION

WAC 110-16-0025 Health and safety training. (1) A provider not related to the child, as described in WAC 110-16-0015 (3)(c) must complete the following training within ninety calendar days of the subsidy payment begin date:

(a) Infant, child, and adult first aid and cardiopulmonary resuscitation (CPR):

(i) This training must be taken in person and the provider must demonstrate learned skills to the instructor.

(ii) The instructor must be certified by the American Red Cross, American Heart Association, American Safety and Health Institute, or other nationally recognized certification program.

(b) Prevention of sudden infant death syndrome and safe sleep practices when caring for infants; and

(c) Department-approved health and safety training which includes the following topic areas:

(i) Prevention and control of infectious diseases;

(ii) Administration of medication;

(iii) Prevention of, and response to, emergencies due to food and allergic reactions;

(iv) Building and physical premises safety, including identification of and protection from hazards, bodies of water, and vehicular traffic;

(v) Prevention of shaken baby syndrome, abuse head trauma, and child maltreatment;

(vi) Emergency preparedness and response planning for natural disaster and human-caused events;

(vii) Handling and storage of hazardous materials and the appropriate disposal of bio contaminants;

(viii) Appropriate precautions in transporting children;

(ix) Recognition and reporting of child abuse and neglect, including the prevention of child abuse and neglect as defined in RCW 26.44.020 and mandatory reporting requirements under RCW 26.44.030; and

(x) Other topic areas as determined by the department.

(2) A provider not related to the child, as described in WAC 110-16-0015 (3)(c) can meet the health and safety training in subsection (1)(c) of this section if the department verifies that the provider has completed any of the following either prior to or within ninety calendar days of the subsidy payment begin date:

(a) Child care basics, a department-approved thirty-hour health and safety training.

(b) Washington state early childhood education initial certificate (twelve credits) that includes early childhood education and development 105 health, safety, and nutrition.

(3) A provider not related to the child, as described in WAC 110-16-0015 (3)(c), who, on October 1, 2018, has an existing WCCC subsidy authorization with an end date on or before December 30, 2018, does not need to complete the training required under subsections (1) or (2) of this section. If the provider is reauthorized for payment beginning January 1, 2019, or later, the provider must complete the training required under subsections (1) and (2) of this section unless exempt from training under subsection (2)(b) of this section.

(4) A provider not related to the child, as described in WAC 110-16-0015 (3)(c), must annually renew portions of the training required in subsection (1)(c) of this section, as determined by state or federal requirements.

NEW SECTION

WAC 110-16-0030 Health and safety activities. (1) Providers not related to the child as described in WAC 110-16-0015 (3)(c), must comply with the following health and safety activity requirements:

(a) Complete the Parent and FFN Provider Health and Safety Agreement; and

(b) Participate in an annual, scheduled visit in the child's home. If necessary, as determined by the department, follow-up visits may occur on a more frequent basis.

(2) The Parent and FFN Provider Health and Safety Agreement must:

(a) Be signed by the provider and parent(s) and verify that the parent(s) and provider discussed and reviewed all of the topics and subject matter items contained in the agreement. The subject matter items include, but are not limited to, emergency contacts, fire and emergency prevention, knowledge and treatment of children's illnesses and allergies, developmental and special needs, medication administration, safe transportation, child immunizations, and safe evacuation; and

(b) Be received by the department within forty-five days of completion of the training requirements in WAC 110-16-0025 (2)(a) or verification of the training exemption in WAC 110-16-0025 (2)(b).

(3) The purpose of the annual, scheduled visit in the child's home is to:

(a) Provide technical assistance to the provider regarding the health and safety requirements described in this chapter;

(b) Observe the provider's interactions with the child, and discuss health and safety practices;

(c) Provide written information and local resources about child development to include the major domains of cognitive, social, emotional, physical development, and approaches to learning; and

(d) Provide regional contact information for FFN child care services and resources.

(4) If the department is not able to successfully complete a scheduled visit with the provider in the child's home after three attempts, the provider will be deemed not in compliance with the requirements of this chapter.

(5) At the annual, scheduled visit, the provider must show:

(a) Proof of identity;

(b) Proof of current certification for first aid and cardiopulmonary resuscitation (CPR) in the form of a card, certificate, or instructor letter;

(c) Proof of vaccination against or acquired immunity for vaccine-preventable diseases for all children in care, if the provider's children are on-site at any time with the eligible children. Proof can include:

(i) A current and complete department of health certificate of immunization status (CIS) or certificate of exemption (COE) or other department of health approved form; or

(ii) A current immunization record from the Washington state immunization information system (WA IIS).

(d) Written permission from the parent to:

(i) Allow children to use a swimming pool;

(ii) Administer medication for treatment of illnesses and allergies of the children in care;

(iii) Provide for and accommodate developmental and special needs; and

(iv) Provide transportation for care, activities, and school when applicable.

(e) The written home evacuation plan required in WAC 110-16-0035 (4)(c).

NEW SECTION

WAC 110-16-0035 Health and safety practices. (1) Providers not related to the child, as described in WAC 110-16-0015 (3)(c), must comply with the following health and safety activity practices according to the required health and safety training:

(a) Prevention and control of infectious diseases;

(b) Prevention of sudden infant death syndrome and safe sleep practices, including sudden infant death syndrome/sudden unexpected infant death syndrome risk reduction; and

(c) Recognition and reporting of child abuse and neglect as defined in RCW 26.44.020 and mandatory reporting requirements under RCW 26.44.030.

(2) **Medication administration.** Providers not related to the child, as described in WAC 110-16-0015 (3)(c), must comply with the following medication administration requirements:

(a) A child's parent, or an appointed designee, must provide training to the provider for special medical procedures that the provider may have to administer to the child. This training must be documented and signed by the provider and parent;

(b) The provider must not give medication to any child without written and signed consent from that child's parent or health care provider. The medication must be given according to the directions on the medication label using appropriately cleaned and sanitized medication measuring devices;

(c) The provider must not give or allow others to give any medication to a child for the purpose of sedating the child unless the medication has been prescribed for a specific child for that particular purpose by a health care professional; and

(d) Medication must be stored and maintained as directed on the packaging or prescription label, including applicable refrigeration requirements.

(3) **Indoor building and physical premises safety.** Providers not related to the child, as described in WAC 110-16-0015 (3)(c), must comply with the following indoor building and physical premises safety requirements:

(a) The provider must visually scan indoor areas to identify potential child safety hazards and discuss removal or reduction of identified hazards with the parent. If it is not possible for the provider to immediately correct or make a hazard completely inaccessible to a child, the provider must supervise the child to avoid injury from such identified hazard. Child safety hazards include, but are not limited to:

(i) Tobacco and cannabis products and containers holding tobacco and cannabis products or ashes;

(ii) Firearms, guns, weapons, and ammunition;

(iii) Any equipment, material, or objects that may pose a risk of choking, aspiration, or ingestion. For purposes of this section, equipment, material, or objects with a diameter or overall dimension of one and three-quarter inch or less are considered items that may pose a risk of choking, aspiration, or ingestion;

(iv) Straps, strings, cords, wires, or similar items capable of forming a loop around a child's neck that are not being used for a supervised activity;

(v) Poisons, chemicals, toxins, dangerous substances or any product labeled "Keep out of reach of children," including, but not limited to, fuel, lighter fluid, solvents, fertilizer, ice melt product, pool chemicals, pesticides, or insecticides, cleansers and detergents, air freshener or aerosols, sanitizing products, and disinfectants;

(vi) Personal grooming, cosmetics, and hygiene products including, but not limited to, nail polish remover, lotions, creams, toothpaste, powder, shampoo, conditioners, hair gels or hair sprays, bubble bath, or bath additives;

(vii) Alcohol, including closed and open containers;

(viii) Plastic bags and other suffocation hazards;

(ix) Equipment, materials, or products that may be hot enough to injure a child;

(x) Freezers, refrigerators, washers, dryers, compost bins, and other entrapment dangers;

(xi) Uneven walkways, damaged flooring or carpeting, or other tripping hazards;

(xii) Large objects capable of tipping or falling over, such as televisions, dressers, bookshelves, wall cabinets, sideboards or hutches, and wall units;

(xiii) Indoor temperatures less than sixty-eight degrees Fahrenheit or greater than eighty-two degrees Fahrenheit;

(xiv) Water accessible to children that may be hotter than one hundred twenty degrees Fahrenheit (the provider should always feel hot water before using on or for a child);

(xv) Windows and stairs accessible to children; and

(xvi) Electrical outlets, power strips, exposed wires, and electrical/extension cords.

(b) During care hours, providers must not themselves, and must not allow others who may be in the presence of the children to:

(i) Possess or use illegal drugs;

(ii) Consume or use alcohol or cannabis products in any form;

(iii) Be under the influence of alcohol, cannabis products in any form, illegal drugs, or misused prescription drugs; and

(iv) Smoke or vape in the home, vehicle, or in close proximity to a child.

(4) **Outdoor building and physical premises safety.** The provider must visually scan outdoor play areas to identify potential child safety hazards and discuss removal or reduction of identified hazards with the parent. If it is not possible for the provider to immediately correct or make a hazard completely inaccessible to a child, the provider must supervise the child to avoid injury. Outdoor hazards include, but are not limited to:

(a) Outdoor play area or equipment that is not clean, not in good condition, or not maintained or safe for a child of a certain age to use;

(b) Bouncing equipment including, but not limited to, trampolines, rebounders and inflatable equipment. This requirement does not apply to bounce balls designed to be used by individual children;

(c) Toxic plants or plants with poisonous leaves such as foxglove, morning glory, tomato, potato, rhubarb, or poison ivy;

(d) Extreme weather conditions such as:

(i) Heat in excess of one hundred degrees Fahrenheit;

(ii) Cold below twenty degrees Fahrenheit;

(iii) Lightning storm, tornado, hurricane or flooding; and

(iv) Air quality warnings by public health or other authorities.

(e) Bodies of water such as:

(i) Swimming pools when not being used, portable wading pools, hot tubs, spas, and jet tubs;

(ii) Ponds, lakes, storm retention ponds, ditches, fountains, fish ponds, landscape pools, or similar bodies of water; and

(iii) Uncovered wells, septic tanks, below grade storage tanks, farm manure ponds, or other similar hazards.

(f) Streets, alleyways, parking lots or garages.

(5) **Emergency preparedness and response planning.** Providers not related to the child, as described in WAC 110-16-0015 (3)(c), must comply with the following emergency preparedness and response planning requirements:

(a) The provider must visually scan indoor and outdoor areas to identify potential fire or burn hazards and discuss the removal or reduction of identified hazards with the parent. If it is not possible for the provider to immediately correct or make identified hazards completely inaccessible to a child, the provider must supervise the child to avoid injury from such identified hazards. Fire or burn hazards include, but are not limited to:

(i) Appliances and any heating device that has a hot surface when in use or still hot after use;

(ii) Open flame devices, candles, matches, and lighters. Open flame devices, candles, matches, and lighters must not be used during care hours; and

(iii) The lack of, or nonworking smoke detectors, fire extinguishers, or other fire prevention equipment.

(b) If there is a fire in the home during care hours, the provider's first responsibility is to evacuate the children in care to a safe gathering spot outside the home and then call 911;

(c) The provider and parent must have an agreed upon written home evacuation plan in the event of fire or an emergency or other disaster. The plan must be updated as needed and include, at a minimum:

(i) A floor plan that shows emergency exit pathways, doors, and windows;

(ii) A description for how the provider will evacuate all of the children, especially those who cannot walk;

(iii) A description for how the provider will account for all of the children in the home;

(iv) A designated, safe gathering spot or alternative short-term location for the children and provider pending arrival of the fire department, emergency response, or the parent;

(v) A description of what to take, such as a first aid kit, medications, water, and food; and

(vi) A description for how parents will be contacted after the emergency is over and arrange for pick-up of children, if needed.

(d) To be properly prepared for a home evacuation or lockdown, the provider must be able to easily access emergency items including, but not limited to:

(i) A first aid kit;

(ii) A working flashlight available for use as an emergency light source and extra batteries if the flashlight is powered by batteries;

(iii) A working telephone; and

(iv) Food, water, and a three-day supply of medication required by individual children.

(e) The provider must practice emergency and home evacuation drills with the children as follows:

(i) Earthquake and home evacuation drills once every six calendar months; and

(ii) A lockdown drill annually.

(6) **Child transportation.** Providers not related to the child, as described in WAC 110-16-0015 (3)(c), must comply with the following child transportation requirements: When transporting children, the provider must:

(a) Comply with RCW 46.61.687 and other applicable laws that pertain to child restraints and car seats appropriate for the size and age of each child in care;

(b) Drive only with a valid driver's license;

(c) Have in effect a current motor vehicle insurance policy that provides coverage for the driver, the vehicle, and all other occupants;

(d) Ensure that children are accounted for when entering and exiting a vehicle for transport to and from any destination; and

(e) Never leave the children by themselves.

(7) **Supervision of children.** Providers not related to the child, as described in WAC 110-16-0015 (3)(c), must comply with the following supervision requirements:

(a) The provider must supervise children during care hours. Supervising children requires the provider to engage in specific actions including, but not limited to:

(i) Scanning the environment, looking and listening for both verbal and nonverbal cues to anticipate problems and planning accordingly;

(ii) Positioning oneself to supervise areas accessible to children; and

(iii) Considering the following when deciding whether increased supervision is needed:

(A) Ages of children;

(B) Individual differences and abilities of children;

(C) Layout of the home and play areas; and

(D) Risks associated with the activities children are engaged in.

(b) The provider must provide increased supervision when the children:

(i) Interact with pets or animals;

(ii) Engage in water or sand play;

(iii) Play in an area in close proximity to a body of water;

(iv) Use a route to access an outdoor play area when the area is not next to the home;

(v) Engage in activities in the kitchen;

(vi) Ride on public transportation;

(vii) Engage in outdoor play; and

(viii) Participate in field trips.

(c) The provider must ensure no infant or child is left unattended during:

(i) Diapering;

(ii) Bottle feeding; or

(iii) Tummy time.

(d) The provider must not allow any person other than a child's parent or authorized individual to have unsupervised access to a child during care hours. For the purpose of this

section, individuals authorized to have unsupervised access include:

(i) A government representative including emergency responders who have specific and verifiable authority for access; and

(ii) A person, such as a family member, family friend, or the child's therapist or health care provider, authorized in writing or over the telephone by a child's parent.

PART IV

COMPLIANCE

NEW SECTION

WAC 110-16-0040 Compliance. (1) If the department determines a provider has failed to comply with a requirement described in this chapter, the department may do one or more of the following:

(a) Offer and provide technical assistance for the purpose of correcting noncompliance issues that arise from WAC 110-16-0015, 110-16-0025, 110-16-0030, or 110-16-0035;

(b) Require an in-home compliance agreement (ICA) for the purpose of correcting noncompliance issues;

(c) Take steps to initiate termination of the provider's participation in the WCCC subsidy programs; and

(d) Take steps to initiate a determination of child care subsidy payment discrepancies pursuant to WAC 110-15-0266 that may have resulted from noncompliance issues.

(2) An in-home compliance agreement (ICA) must contain the following:

(a) A description of the noncompliance issues and the regulations or statutes violated;

(b) A statement from the provider describing the provider's proposed plan to comply with the regulations or statutes;

(c) The date by which the noncompliance issues must be corrected;

(d) A statement of other corrective action that may be required if compliance does not occur by the specified date;

(e) The signatures of the provider and the department representative agreeing to the terms of the ICA; and

(f) A statement from the department indicating whether the corrective action requirements were satisfactorily met.

(3) The length of time the department may allow for the provider to make the corrections necessary to be in compliance will be determined by the department with consideration given to:

(a) The seriousness of the noncompliance; and

(b) The threat to the health, safety, and well-being of the children in care.

WSR 18-20-085
PERMANENT RULES
DEPARTMENT OF HEALTH
(Podiatric Medical Board)

[Filed October 1, 2018, 10:28 a.m., effective November 1, 2018]

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

Purpose: Chapter 246-922 WAC, Podiatric physicians and surgeons, the podiatric medical board (board) has adopted new sections, amendments, and repeal of existing rule establishing requirements and standards for prescribing opioid medications by podiatric physicians. The adopted rules provide a necessary framework and structure for safe, consistent opioid prescribing practice that comply with the directed [direction] of ESHB 1427.

Citation of Rules Affected by this Order: New WAC 246-922-675, 246-922-680, 246-922-685, 246-922-690, 246-922-695, 246-922-700, 246-922-705, 246-922-710, 246-922-715, 246-922-720, 246-922-725, 246-922-730, 246-922-735, 246-922-740, 246-922-745, 246-922-750, 246-922-755, 246-922-760, 246-922-765, 246-922-770, 246-922-775, 246-922-780, 246-922-785 and 246-922-790; repealing WAC 246-922-663, 246-922-664, 246-922-665, 246-922-666, 246-922-667, 246-922-668, 246-922-669, 246-922-670, 246-922-671, 246-922-672 and 246-922-673; and amending WAC 246-922-660, 246-922-661, and 246-922-662.

Statutory Authority for Adoption: RCW 18.22.005, 18.22.015, and 18.22.800.

Other Authority: ESHB 1427 (chapter 297, Laws of 2017), codified in part as RCW 18.22.800.

Adopted under notice filed as WSR 18-15-064 on July 16, 2018.

Changes Other than Editing from Proposed to Adopted Version: There were four instances throughout the rules where "practitioner" was changed to "podiatric physician" - WAC 246-922-662(6) renumbered as (7), 246-922-720(3), 246-922-725(1), and in the title to 246-922-760.

Under WAC 246-922-661, the board amended subsection (4) to clarify what constitutes an inpatient patient.

Under WAC 246-922-662, the board made the following amendments:

* Deleted "or other health care practitioner" from subsection (1) as it was redundant.
* Revised the definition of "biological specimen test" or "biological specimen testing" in subsection (3) to clarify that it means testing of bodily fluids or other biological samples including, but not limited to, urine or hair for the presence of various drugs and metabolites.
* Added a new subsection (4) for "cancer-related pain" to clarify when pain falls under the exclusion in WAC 246-922-661 and the pain that falls under the chronic pain definition.
* The remaining subsections were renumbered.
* Changed the tense in former subsection (5), now (6), from singular to plural as that is how the term is used in the rules.
* Included "opioid induced" to former subsection (8), now (9), to clarify the type of risk to morbidity and mortality.
* Deleted former subsection (13) for "multidisciplinary pain clinic" and much of the verbiage was inserted into the definition for "pain management clinic," then all references throughout the rules were updated to a single term.
* Amended subsection (17) as meaning "a facility that provides comprehensive pain management and may include care provided by multiple available disciplines, practitioners, or treatment modalities."

* Deleted "that is authorized to be dispensed when the patient has exhausted their current supply" from subsection (21) as being redundant.

Under WAC 246-922-680, the board changed "acute, subacute, or perioperative pain" to "the treatment of pain" for simplification and clarification.

Under WAC 246-922-685(1), the board removed "licensed to prescribe opioids" as superfluous.

Under WAC 246-922-695(2), the board restored the sentence "A three day supply or less will often be sufficient; more than a seven day supply will rarely be needed." This change eliminates the perception that a seven day supply would be the standard for all patients.

Under WAC 246-922-700(2), the board restored the sentences "A three day supply or less will often be sufficient; more than a fourteen day supply will rarely be needed for perioperative pain." and "For more specific best practices, the podiatric physician may refer to clinical practice guidelines including, but not limited to, those produced by the Agency Medical Directors' Group, the Centers for Disease Control and Prevention, or the Bree Collaborative."

Under WAC 246-922-705, the board made the following amendments:

* Changed subsection (2)(b) from "The observed documented improvement" to "The observed or reported improvement" for clarity.
* Changed subsection (2)(i) to clarify when a risk-benefit analysis should be conducted.

Under WAC 246-922-735, the board made the following amendments:

* Added "per day" in subsection (2) to MED.
* Clarified in subsection (2)(b) a consultation can be "telephone, electronic, or in-person."
* Deleted "licensed health care" from "practitioner" as redundant from subsection (2)(c).

Under WAC 246-922-745, the board amended the two references to pain clinics to the single uniform term "pain management clinic."

Under WAC 246-922-750, the board will now refer to the WAC sections of the other professions' rules describing pain management specialist qualifications rather than list out the requirements for other practitioners in the podiatric physician rules. The change ensures that if changes are made to other professions' pain management specialist requirements, the podiatric physician rules will remain accurate.

Under WAC 246-922-755, the board changed the title from "Tapering requirements" to "Evaluation of, or change in, treatment plan" to better describe the section's subject.

Under WAC 246-922-760 (2)(a), the board changed the title to indicate podiatric physician rather than practitioner and added "per day" to MED.

Under WAC 246-922-775 (1)(e), the board changed "Sleeping medications" to "Nonbenzodiazepine hypnotics."

Under WAC 246-922-790, the board made the following amendments:

* In subsection (2), authorized designee was clarified as being "in accordance with WAC 246-470-050."
* In subsections (4)(b) and (c), verbiage was added to clarify that moderate-risk and low risk patients are determined using the risk assessment tool described in WAC 246-922-715.
* In subsection (8), "sedative hypnotics" was change[d] to "co-prescribed medications listed in WAC 246-922-775(1)" to clarify that PMP checks with an integrated EMR are required for medications when coprescribed, not for when any sedative hypnotic is prescribed.

A final cost-benefit analysis is available by contacting Susan Gragg, P.O. Box 47852, Olympia, WA 98504-7852, phone 360-236-4941, fax 360-236-2901, TTY 360-833-6388 or 711, email susan.gragg@doh.wa.gov, web site www.doh.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 24, Amended 3, Repealed 11.

Number of Sections Adopted at the 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 24, Amended 3, Repealed 11.

Date Adopted: September 6, 2018.

Randy Anderson, DPM
Chair

((~~PAIN MANAGEMENT~~)) OPIOID PRESCRIBING—GENERAL PROVISIONS

AMENDATORY SECTION (Amending WSR 11-10-063, filed 5/2/11, effective 7/1/11)

WAC 246-922-660 ((~~Pain management—~~))Intent and scope. ((~~These rules~~)) WAC 246-922-660 through 246-922-790 govern the ((~~use~~)) prescribing of opioids in the treatment of ((~~patients for chronic noncancer~~)) pain.

AMENDATORY SECTION (Amending WSR 11-10-063, filed 5/2/11, effective 7/1/11)

WAC 246-922-661 Exclusions. ((~~The rules adopted under~~)) WAC 246-922-660 through ((~~246-922-673~~)) 246-922-790 do not apply to:

(1) The treatment of patients with cancer-related pain;

(2) The provision of palliative, hospice, or other end-of-life care; ((~~or~~

~~(2) The management of acute pain caused by an injury or surgical procedure.~~))

(3) The provision of procedural premedications; or

(4) The treatment of admitted inpatient and observation hospital patients.

AMENDATORY SECTION (Amending WSR 11-10-063, filed 5/2/11, effective 7/1/11)

WAC 246-922-662 Definitions. The definitions in this section apply ((~~in~~)) to WAC ((~~246-922-600 through 246-922-673~~)) 246-922-660 through 246-922-790 unless the context clearly requires otherwise.

(1) "Aberrant behavior" means behavior that indicates misuse, diversion, unauthorized use of alcohol or other controlled substances, or active opioid use disorder. This includes, but is not limited to: Multiple early refills or renewals or obtaining prescriptions for the same or similar drugs from more than one practitioner.

(2) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. ((~~It is generally time-limited, often less than three months in duration, and usually less than six months.~~

~~(2) "Addiction" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include:~~

~~(a) Impaired control over drug use;~~

~~(b) Craving;~~

~~(c) Compulsive use; or~~

~~(d) Continued use despite harm.~~)) Acute pain is considered to be six weeks or less in duration.

(3) "Biological specimen test" or "biological specimen testing" means testing of bodily fluids or other biological samples including, but not limited to, urine or hair for the presence of various drugs and metabolites.

(4) "Cancer-related pain" means pain resulting from cancer in a patient who is less than two years post-completion of curative anticancer treatment with current evidence of disease.

(5) "Chronic ((~~noncancer~~)) pain" means a state in which ((~~noncancer~~)) pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain ((~~over months or years~~)) more than twelve weeks in duration. Chronic pain includes pain resulting from cancer or treatment of cancer in a patient who is two years post-completion of curative anticancer treatment with no current evidence of disease.

(((~~(4) "Comorbidity~~)) (6) "Comorbidities" means a preexisting or coexisting physical or psychiatric disease or condition.

(((~~(5)~~))) (7) "Episodic care" means medical care provided by a ((~~provider~~)) podiatric physician other than the designated primary ((~~provider~~)) practitioner in the acute care setting, for example, urgent care or emergency department.

(((~~(6)~~))) (8) "High dose" means ninety milligrams morphine equivalent dose, or more, per day.

(9) "High-risk" is a category of patient at increased risk of opioid induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, history of substance use disorder or abuse, aberrant behavior, high dose opioid prescription, or the use of any central nervous system depressant.

(10) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less((~~. Hospice involves an interdisciplinary approach to provide health care, pain management, and emotional and spiritual support. The emphasis is on comfort, quality of life and patient and family support. Hospice can be provided in the patient's home as well as freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities~~)).

(((~~(7)~~))) (11) "Hospital" means any institution, place, building, or agency licensed under chapter 70.41 or 71.12 RCW, or designated under chapter 72.23 RCW to provide accommodations, facilities, and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care of two or more individuals not related to the operator who are suffering from illness, injury, deformity, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis.

(12) "Medication assisted treatment" or "MAT" means the use of pharmacologic therapy, often in combination with counseling and behavioral therapies, for the treatment of substance use disorders.

(13) "Morphine equivalent dose" or "MED" means a conversion of various opioids to a morphine equivalent dose by the use of accepted conversion tables.

(((~~(8) "Multidisciplinary pain clinic" means a clinic or office that provides comprehensive pain management and includes care provided by multiple available disciplines or treatment modalities; for example, physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, advanced registered nurse practitioners, physician therapy, occupational therapy, or other complementary therapies.~~

~~(9)~~))) (14) "Opioid analgesic" or "opioid" means a drug that is either an opiate derived from the opium poppy or opiate-like that is a semisynthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, tramadol, buprenorphine, and methadone.

(15) "Palliative care" means care that maintains or improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness((~~. With palliative care particular attention is given to the prevention, assessment, and treatment of pain and other symptoms, and to the provision of psychological, spiritual, and emotional support~~)).

(16) "Pain" means an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(17) "Pain management clinic" means a facility that provides comprehensive pain management and may include care provided by multiple available disciplines, practitioners, or treatment modalities.

(18) "Perioperative pain" means acute pain that occurs surrounding the performance of surgery.

(19) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW.

(20) "Practitioner" means an advanced registered nurse practitioner licensed under chapter 18.79 RCW, a dentist

licensed under chapter 18.32 RCW, a physician licensed under chapter 18.71 or 18.57 RCW, a physician assistant licensed under chapter 18.71A or 18.57A RCW, or a podiatric physician licensed under chapter 18.22 RCW.

(21) "Refill" or "renewal" means a second or subsequent filling of a previously issued prescription. For the purposes of WAC 246-922-660 through 246-922-790, refills or renewals are subject to the same limitations and requirements as initial prescriptions.

(22) "Subacute pain" means a continuation of pain, of six weeks to twelve weeks in duration.

(23) "Substance use disorder" means a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Substance use disorder is not the same as physical dependence or tolerance that are normal physiological consequences of extended opioid therapy for pain. It is characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

NEW SECTION

WAC 246-922-675 Patient notification, secure storage, and disposal. (1) The podiatric physician shall provide information to the patient educating them of risks associated with the use of opioids as appropriate to the medical condition, the type of patient, and the phase of treatment. The podiatric physician shall document such notification in the patient record.

(2) Patient notification must occur, at a minimum, at the following points of treatment:

(a) The first issuance of a prescription for an opioid; and

(b) The transition between phases of treatment, as follows:

(i) Acute nonoperative pain or acute perioperative pain to subacute pain; and

(ii) Subacute pain to chronic pain.

(3) Patient notification must include information regarding:

(a) The safe and secure storage of opioid prescriptions; and

(b) The proper disposal of unused opioid medications including, but not limited to, the availability of recognized drug take-back programs.

(4) The patient notification requirements in this section shall be deemed fulfilled by providing board-approved patient education information.

NEW SECTION

WAC 246-922-680 Use of alternative modalities for pain treatment. Podiatric physicians shall exercise professional judgment in selecting appropriate treatment modalities for the treatment of pain, including the use of nonopioid multimodal pharmacologic and nonpharmacologic therapy as an alternative to opioids whenever reasonable, clinically appropriate, evidence-based alternatives exist. Nonopioid pain management modalities may include, but are not limited to, antidepressants, anticonvulsants, anti-inflammatory medications, acetaminophen, interventional procedures, or any nonpharmacological pain treatments, or any combination of the above modalities.

NEW SECTION

WAC 246-922-685 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, a podiatric physician shall complete a one-time continuing education regarding best practices in the prescribing of opioids and the rules in this chapter on opioid prescribing. The continuing education must be at least one hour in length.

(2) The podiatric physician shall complete the one-time continuing education described in subsection (1) of this section by the end of the podiatric physician's first full continuing education reporting period after January 1, 2019, or during the first full continuing education reporting period after initial licensure, whichever is later.

(3) The continuing education required under this section counts toward meeting any applicable Category 1 continuing education requirements.

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

NEW SECTION

WAC 246-922-690 Patient evaluation and patient record. Prior to prescribing opioids for acute nonoperative pain or acute perioperative pain, the podiatric physician shall:

(1) Conduct and document an appropriate history and physical examination, including screening for risk factors for overdose and severe postoperative pain;

(2) Evaluate the nature and intensity of the pain or anticipated pain following surgery; and

(3) Inquire about any other medications the patient is prescribed or is taking, including type, dosage, and quantity prescribed.

NEW SECTION

WAC 246-922-695 Acute nonoperative pain. The podiatric physician shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record:

(1) The podiatric physician, or his or her authorized designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-922-790 and document their review and any concerns in the patient record.

(2) If the podiatric physician prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids. A three-day supply or less will often be sufficient; more than a seven-day supply will rarely be needed. The podiatric physician shall not prescribe beyond a seven day supply without clinical documentation in the patient record to justify the need for such a quantity.

(3) The podiatric physician shall reevaluate the patient who does not follow the expected course of recovery. If documented improvement in function or pain control has not

occurred, the podiatric physician shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

(4) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This may include:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations to investigate causes of continued acute nonoperative pain or other treatments.

(5) Long-acting or extended release opioids are not typically indicated for acute nonoperative pain. Should a podiatric physician need to use a long-acting or extended release opioid for acute pain, the podiatric physician shall document the reason in the patient record.

(6) A podiatric physician shall not discontinue medication assisted treatment medications when treating acute pain, except when consistent with the provisions of WAC 246-922-780.

(7) If the podiatric physician elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the podiatric physician shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain in WAC 246-922-705 and 246-922-710 shall apply.

NEW SECTION

WAC 246-922-700 Acute perioperative pain. The podiatric physician shall comply with the requirements in this section when prescribing opioid analgesics for perioperative pain and shall document completion of these requirements in the patient record:

(1) The podiatric physician, or his or her authorized designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-922-790 and document their review and any concerns in the patient record.

(2) If the podiatric physician prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids. A three-day supply or less will often be sufficient; more than a seven-day supply will rarely be needed. The podiatric physician shall not prescribe beyond a fourteen-day supply from the time of discharge without clinical documentation in the patient record to justify the need for such a quantity. For more specific best practices, the podiatric physician may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group, the Centers for Disease Control and Prevention, or the Bree Collaborative.

(3) The podiatric physician shall reevaluate the patient who does not follow the expected course of recovery. If documented improvement in function or pain control has not occurred, the podiatric physician shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

(4) Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This may include:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations or other treatments.

(5) If the podiatric physician elects to prescribe a combination of opioids with a Schedule II-V medication listed in WAC 246-922-775 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-922-775 from another practitioner, such prescribing must be in accordance with WAC 246-922-775.

(6) If the podiatric physician elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the podiatric physician shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain in WAC 246-922-705 and 246-922-710 shall apply unless there is documented improvement in function or pain control and there is a documented plan and timing for discontinuation of all opioid medications.

OPIOID PRESCRIBING FOR SUBACUTE PAIN

NEW SECTION

WAC 246-922-705 Patient evaluation and patient record. The podiatric physician shall comply with the requirements in this section when prescribing opioid analgesics for subacute pain and shall document completion of these requirements in the patient record:

(1) Prior to prescribing an opioid for subacute pain, the podiatric physician shall:

(a) Conduct an appropriate history and physical examination or review and update the patient's existing history and examination taken during the acute nonoperative or acute perioperative phase;

(b) Evaluate the nature and intensity of the pain;

(c) Inquire about other medications the patient is prescribed or is taking, including type, dosage, and quantity prescribed;

(d) Conduct, or cause his or her authorized designee to conduct, a query of the PMP in accordance with provisions of WAC 246-922-790 and document the review and any concerns in the patient record;

(e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the podiatric physician determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone;

(f) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating;

(g) Screen or refer the patient for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety.

(2) The podiatric physician treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following are documented in the patient record:

(a) The presence of one or more recognized diagnoses or indications for the use of opioid pain medication;

(b) The observed or reported improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;

(c) The result of any queries of the PMP and any concerns the podiatric physician may have;

(d) All medications the patient is known to be prescribed or taking;

(e) An appropriate pain treatment plan, including the consideration of, or attempts to use, nonpharmacological modalities and nonopioid therapy;

(f) Results of any aberrant biological specimen testing results and the risk-benefit analysis if opioids are to be continued;

(g) Results of screening or referral for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety;

(h) Results of screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy;

(i) The risk-benefit analysis conducted if opioids and any of the medications listed in WAC 246-922-775(1) are prescribed concurrently; and

(j) All other required components of the patient record, as established in statute or rule.

(3) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This may include:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations or other treatments.

NEW SECTION

WAC 246-922-710 Subacute pain. (1) The podiatric physician shall recognize the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase and take into consideration the risks and benefits of continued opioid prescribing for the patient.

(2) If tapering has not begun prior to the six- to twelve-week subacute phase, the podiatric physician shall reevaluate the patient who does not follow the expected course of recovery. If documented improvement in function or pain control has not occurred, the podiatric physician shall reconsider the continued use of opioids or whether tapering or discontinuing the use of opioids is clinically indicated. The podiatric physician shall make reasonable attempts to discontinue the use of opioids prescribed for the acute pain event by no later than the twelve-week conclusion of the subacute phase.

(3) If the podiatric physician prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. During the subacute phase, the podiatric physician shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity.

(4) If the podiatric physician elects to prescribe a combination of opioids with a medication listed in WAC 246-922-775 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-922-775 from another practitioner, the podiatric physician shall prescribe in accordance with WAC 246-922-775.

(5) If the podiatric physician elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the podiatric physician shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain in WAC 246-922-715 through 246-922-760 shall apply.

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

NEW SECTION

WAC 246-922-715 Patient evaluation and patient record. (1) For the purpose of this section, "risk assessment tool" means validated tools or questionnaires appropriate for identifying a patient's level of risk for substance abuse or misuse.

(2) The podiatric physician shall evaluate and document the patient's health history and physical examination in the patient record prior to treating for chronic pain.

(a) History. The patient's health history must include:

(i) The nature and intensity of the pain;

(ii) The effect of pain on physical and psychosocial function;

(iii) Current and past treatments for pain, including medications and their efficacy;

(iv) Review of any significant comorbidities;

(v) Any current or historical substance use disorder;

(vi) Current medications and, as related to treatment of the pain, the efficacy of medications tried; and

(vii) Medication allergies.

(b) Evaluation. The patient evaluation prior to opioid prescribing must include:

(i) Appropriate physical examination;

(ii) Consideration of the risks and benefits of chronic pain treatment for the patient;

(iii) Medications the patient is taking including indication(s), type, dosage, quantity prescribed, and, as related to treatment of pain, efficacy of medications tried;

(iv) Review of the PMP in accordance with the provisions of WAC 246-922-790;

(v) Any available diagnostic, therapeutic, and laboratory results;

(vi) Use of a risk assessment tool and assignment of the patient to a high-, moderate-, or low-risk category. The podiatric physician should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk;

(vii) Any available consultations, particularly as related to the patient's pain;

(viii) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;

(ix) Treatment plan and objectives including:

(A) Documentation of any medication prescribed;

(B) Biologic specimen testing ordered; and

(C) Any labs or imaging ordered.

(x) Written agreements, also known as a "pain contract," for treatment between the patient and the practitioner; and

(xi) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.

(c) The health record must be maintained in an accessible manner, readily available for review, and contain documentation of requirements in this subsection, as well as all other required components of the patient record, as established in statute or rule.

NEW SECTION

WAC 246-922-720 Treatment plan. (1) When the patient enters the chronic pain phase, the podiatric physician shall reevaluate the patient by treating the situation as a new disease.

(2) The chronic pain treatment plan must state the objectives that will be used to determine treatment success and must include:

(a) Any change in pain relief;

(b) Any change in physical and psychosocial function; and

(c) Additional diagnostic evaluations or other planned treatments.

(3) After treatment begins, the podiatric physician shall adjust drug therapy to the individual health needs of the patient.

(4) The podiatric physician shall complete patient notification in accordance with the provisions of WAC 246-922-675.

NEW SECTION

WAC 246-922-725 Written agreement for treatment. The podiatric physician shall use a written agreement for treatment with the patient who requires long-term opioid therapy for chronic pain. The written agreement shall outline the patient's responsibilities and must include:

(1) The patient's agreement to provide biological samples for biological specimen testing when requested by the podiatric physician;

(2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills;

(3) Reasons for which opioid therapy may be discontinued, such as violation of a written agreement;

(4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, a single clinic, or a multidisciplinary pain clinic;

(5) The requirement that all chronic opioid prescriptions are to be dispensed by a single pharmacy or pharmacy system whenever possible;

(6) The patient's agreement to not abuse substances that can put the patient at risk for adverse outcomes;

(7) A written authorization for:

(a) The podiatric physician to release the agreement for treatment to:

(i) Local emergency departments;

(ii) Urgent care facilities;

(iii) Other practitioners caring for the patient who might prescribe pain medications; and

(iv) Pharmacies.

(b) The podiatric physician to report known violations of the agreement to the practitioner treating the patient's chronic pain and to the PMP.

(8) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

(9) Acknowledgment that if the patient violates the terms of the agreement, the violation and the podiatric physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

NEW SECTION

WAC 246-922-730 Periodic review. (1) The podiatric physician shall periodically review the course of treatment for chronic pain. The frequency of visits, biological testing, and PMP queries in accordance with the provisions of WAC 246-922-790 must be determined based on the patient's risk category:

(a) For a high-risk patient, at least quarterly;

(b) For a moderate-risk patient, at least semiannually;

(c) For a low-risk patient, at least annually;

(d) Immediately upon indication of concerning aberrant behavior; and

(e) More frequently at the podiatric physician's discretion.

(2) During the periodic review, the podiatric physician shall determine:

(a) The patient's compliance with any medication treatment plan;

(b) If pain, function, or quality of life have improved, diminished, or are maintained using objective evidence; and

(c) If continuation or modification of medications for pain management treatment is necessary based on the podiatric physician's evaluation of progress toward treatment objectives.

(3) Periodic patient evaluations must also include:

(a) History and physical examination related to the pain;

(b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and

(c) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient at a frequency determined by the patient's risk category, and otherwise in accordance with the provisions of WAC 246-922-790 and subsection (1) of this section.

(4) The podiatric physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with the current treatment plan is unsatisfactory. The podiatric physician shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-922-755.

NEW SECTION

WAC 246-922-735 Consultation—Recommendations and requirements. (1) The podiatric physician shall consider referring the chronic pain patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients. The management of chronic pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold is one hundred twenty milligrams MED per day. Unless the consultation is exempt under WAC 246-922-740 or 246-922-745, a podiatric physician who prescribes a dosage amount at or above the mandatory consultation threshold must comply with the pain management specialist consultation requirements described in WAC 246-922-750. The mandatory consultation must consist of at least one of the following:

(a) An office visit with the patient and the pain management specialist;

(b) A telephone, electronic, or in-person consultation between the pain management specialist and the podiatric physician;

(c) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the podiatric physician or with a practitioner designated by the podiatric physician or the pain management specialist; or

(d) Other chronic pain evaluation services as approved by the board.

(3) The podiatric physician shall document each consultation with the pain management specialist. Any written record of the consultation by the pain management specialist shall be maintained as a patient record by the specialist. If the pain management specialist provides a written record of the consultation to the podiatric physician, the podiatric physician shall maintain it as part of the patient record.

(4) The podiatric physician shall use great caution when prescribing opioids to children and adolescents with chronic pain; appropriate referral to a specialist is encouraged.

NEW SECTION

WAC 246-922-740 Consultation—Exemptions for exigent and special circumstances. A podiatric physician is not required to consult with a pain management specialist as defined in WAC 246-922-750 when they have documented adherence to all standards of practice as defined in WAC 246-922-715 through 246-922-760 and when one or more of the following conditions are met:

(1) The patient is following a tapering schedule;

(2) The patient requires treatment for acute pain, which may or may not include hospitalization, requiring a temporary escalation in opioid dosage with expected return to their baseline dosage level or below;

(3) The podiatric physician documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing at or above one hundred twenty MED per day without first obtaining a consultation; or

(4) The podiatric physician documents the patient's pain and function is stable and the patient is on a nonescalating dosage of opioids.

NEW SECTION

WAC 246-922-745 Consultation—Exemptions for the podiatric physician. A podiatric physician is not required to consult with a pain management specialist as defined in WAC 246-922-735 if one or more of the following qualifications are met:

(1) The podiatric physician is a pain management specialist under WAC 246-922-750;

(2) The podiatric physician has successfully completed, every four years, a minimum of twelve continuing education hours on chronic pain management in accordance with WAC 246-922-310. At least two of these hours must be in substance use disorders;

(3) The podiatric physician is a pain management practitioner working in a pain management clinic or a multidisciplinary academic research facility; or

(4) The podiatric physician has a minimum of three years of clinical experience in a pain management clinic, and at least thirty percent of their current practice is the direct provision of pain management care.

NEW SECTION

WAC 246-922-750 Pain management specialist. A pain management specialist shall meet one or more of the following qualifications:

(1) If a podiatric physician, the podiatric physician must:

(a) Be board certified or board eligible by a specialty that includes a focus on pain management by the American Board of Foot and Ankle Surgery or its predecessor, the American Board of Podiatric Medicine, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or other accredited certifying board as approved by the Washington state podiatric medical board; or

(b) Have a minimum of three years of clinical experience in a chronic pain management care clinic;

(c) Be credentialed in pain management by a Washington state podiatric medical board-approved national professional association, pain association, or other credentialing entity;

(d) Have successfully completed a minimum of at least eighteen continuing education hours in pain management during the past two years; and

(e) At least thirty percent of the podiatric physician's current practice is the direct provision of pain management care.

(2) If an allopathic physician, in accordance with WAC 246-919-945;

(3) If an allopathic physician assistant, in accordance with WAC 246-918-885;

(4) If an osteopathic physician, in accordance with WAC 246-853-750;

(5) If an osteopathic physician assistant, in accordance with WAC 246-854-330;

(6) If a dentist, in accordance with WAC 246-817-965; or

(7) If an advanced registered nurse practitioner, in accordance with WAC 246-840-493.

NEW SECTION

WAC 246-922-755 Evaluation of, or change in, treatment plan. (1) The podiatric physician shall assess and document the appropriateness of continued use of the current treatment plan if the patient's response to or compliance with the current treatment plan is unsatisfactory.

(2) The podiatric physician shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

(a) The patient requests tapering, changing, discontinuing treatment, or referral for a substance use disorder;

(b) The patient experiences a deterioration in function or pain;

(c) The patient is noncompliant with the written agreement;

(d) Other treatment modalities are indicated;

(e) There is evidence of misuse, abuse, substance use disorder, or diversion;

(f) The patient experiences a severe adverse event or overdose;

(g) There is unauthorized escalation of doses; or

(h) When the patient is receiving an escalation in opioid dosage with no improvement in pain, function, or quality of life.

NEW SECTION

WAC 246-922-760 Patients with chronic pain, including those on high doses—Establishing a relationship with a new podiatric physician. (1) When a patient receiving chronic opioid pain medications changes to a new podiatric physician, it is normally appropriate for the podiatric physician to initially maintain the patient's current opioid doses. Over time, the podiatric physician may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) A podiatric physician's treatment of a new high-dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-922-735 and the tapering requirements of WAC 246-922-755 for the first three months of newly established care if:

(a) The patient was previously being treated with a dosage of opioids at or above one hundred twenty milligrams MED per day for chronic pain under an established written agreement for treatment of the same chronic condition or conditions;

(b) The patient's dose is stable and nonescalating;

(c) The patient has a demonstrated history in their record of compliance with treatment plans and written agreements as documented by medical records and PMP queries; and

(d) The patient has documented functional stability, pain control, or improvements in function or pain control, at the presenting dose.

OPIOID PRESCRIBING—SPECIAL POPULATIONS

NEW SECTION

WAC 246-922-765 Special populations—Patients twenty-five years of age or under, pregnant patients, and aging populations. (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the podiatric physician shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.

(2) Pregnant patients. Use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient shall not be discontinued without oversight by the MAT prescribing practitioner. The podiatric physician shall weigh carefully the risks and benefits of opioid detoxification during pregnancy.

(3) Aging populations. As people age, their tolerance and metabolizing of opioids may change. The podiatric physician shall treat pain in a manner commensurate with the distinctive needs of patients who are sixty-five years of age or older and who have been on chronic opioid therapy or who are initiating opioid treatment.

NEW SECTION

WAC 246-922-770 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the podiatric physician knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the podiatric physician shall review the PMP and document the review and any concerns in the patient record.

(2) A podiatric physician providing episodic care to a patient who the podiatric physician knows is being treated with opioids for chronic pain should provide additional opioids equal to the severity of the acute pain. If opioids are provided, the podiatric physician shall limit the use of opioids to the minimum amount necessary to control the acute nonoperative pain, acute perioperative pain, or similar acute exacerbation of pain until the patient can receive care from the practitioner who is managing the patient's chronic pain treatment.

(3) The episodic care podiatric physician shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment.

(4) The episodic care podiatric physician shall coordinate care with the patient's chronic pain treatment practitioner if that person is known to the episodic care podiatric physician, when practicable.

OPIOID PRESCRIBING—COPRESCRIBING

NEW SECTION

WAC 246-922-775 Coprescribing of opioids with certain medications. (1) The podiatric physician shall not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation of clinical judgment:

(a) Benzodiazepines;

(b) Barbiturates;

(c) Sedatives;

(d) Carisoprodol; or

(e) Nonbenzodiazepine hypnotics, also known as Z drugs.

(2) If a patient receiving an opioid prescription is known to be concurrently prescribed one or more of the medications listed in subsection (1) of this section, the podiatric physician prescribing opioids shall consult, or make a reasonable effort to consult, with the other prescriber(s) to establish a patient care plan for the use of the medications concurrently or consider whether one of the medications should be tapered.

NEW SECTION

WAC 246-922-780 Coprescribing of opioids for patients receiving medication assistant treatment. (1) Where practicable, the podiatric physician providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving MAT shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or a pain specialist.

(2) The podiatric physician shall not discontinue MAT medications when treating acute nonoperative pain or acute perioperative pain without documentation of the reason for doing so, nor shall these medications be used to deny necessary operative intervention.

NEW SECTION

WAC 246-922-785 Coprescribing of naloxone. (1) The podiatric physician shall confirm or provide a current prescription for naloxone when high-dose opioids are prescribed to a high-risk patient.

(2) The podiatric physician should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

NEW SECTION

WAC 246-922-790 Prescription monitoring program—Required registration, queries, and documentation. (1) The podiatric physician shall register to access the PMP or demonstrate proof of having registered to access the PMP if the podiatric physician prescribes opioids in Washington state.

(2) The podiatric physician is permitted to delegate performance of a required PMP query to an authorized designee in accordance with WAC 246-470-050.

(3) At a minimum, the podiatric physician shall ensure a PMP query is performed prior to the prescription of an opioid at the following times:

(a) Upon the second refill or renewal of an opioid prescription for acute nonoperative pain or acute perioperative pain;

(b) The time of transition from acute to subacute pain; and

(c) The time of transition from subacute to chronic pain.

(4) For chronic pain management, the podiatric physician shall ensure a PMP query is performed at a minimum frequency determined by the patient's risk assessment, as follows:

(a) For a high-risk patient, a PMP query shall be completed at least quarterly.

(b) For a moderate-risk patient as determined using the risk assessment tool described in WAC 246-922-715, a PMP query shall be completed at least semiannually.

(c) For a low-risk patient as determined using the risk assessment tool described in WAC 246-922-715, a PMP query shall be completed at least annually.

(5) The podiatric physician shall ensure a PMP query is performed for any chronic pain patient immediately upon identification of aberrant behavior.

(6) The podiatric physician shall ensure a PMP query is performed when providing episodic care to a patient who the podiatric physician knows to be receiving opioids for chronic pain, in accordance with WAC 246-922-770.

(7) For the purposes of this section, the requirement to consult the PMP does not apply when the PMP or the electronic medical record (EMR) cannot be accessed by the podiatric physician due to a temporary technological or electrical failure.

(8) If the podiatric physician is working in a practice, group, or institution that integrates access to the PMP into the workflow of the EMR, the podiatric physician shall ensure a PMP query is performed for all prescriptions of opioids and coprescribed medications listed in WAC 246-922-755(1) for acute pain.

(9) Pertinent concerns discovered in the PMP must be documented in the patient record.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-922-663	Patient evaluation.
WAC 246-922-664	Treatment plan.
WAC 246-922-665	Informed consent.
WAC 246-922-666	Written agreement for treatment.
WAC 246-922-667	Periodic review.
WAC 246-922-668	Long-acting opioids, including methadone.
WAC 246-922-669	Episodic care.
WAC 246-922-670	Consultation—Recommendations and requirements.
WAC 246-922-671	Consultation—Exemptions for exigent and special circumstances.
WAC 246-922-672	Consultations—Exemptions for the podiatric physician.
WAC 246-922-673	Pain management specialist.

WSR 18-20-086
PERMANENT RULES
DEPARTMENT OF HEALTH
(Nursing Care Quality Assurance Commission)

[Filed October 1, 2018, 10:32 a.m., effective November 1, 2018]

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

Purpose: Chapter 246-840 WAC, the nursing care quality assurance commission (commission) has adopted new sections and changes to existing rule that establish requirements and standards for prescribing opioid drugs by advanced registered nurse practitioners (ARNP). The adopted rules provide a necessary framework and structure for safe, consistent opioid prescribing practice consistent with the directives of ESHB 1427.

Citation of Rules Affected by this Order: New WAC 246-840-4651, 246-840-4653, 246-840-4655, 246-840-4657, 246-840-4659, 246-840-4661, 246-840-4663, 246-840-4665, 246-840-4667, 246-840-4935, 246-840-4940, 246-840-4950, 246-840-4955, 246-840-4960, 246-840-4970, 246-840-4980 and 246-840-4990; repealing WAC 246-840-473, 246-840-480 and 246-840-483; and amending WAC 246-840-460, 246-840-463, 246-840-465, 246-840-467, 246-840-470, 246-840-475, 246-840-477, 246-840-485, 246-840-487, 246-840-490, and 246-840-493.

Statutory Authority for Adoption: RCW 18.79.800.

Other Authority: ESHB 1427 (chapter 297, Laws of 2017), codified as part of RCW 18.79.800.

Adopted under notice filed as WSR 18-14-086 on July 2, 2018.

Changes Other than Editing from Proposed to Adopted Version: Five nonsubstantive changes were adopted by the commission following the hearing. The proposed definition of "multimodal management of pain" was deleted from WAC 246-840-465 because the term is not used in the adopted rule language. WAC 246-840-467 (2)(i) was moved to subsection (2)(k) of the adopted rule to eliminate the confusing juxtaposition of the ninth letter of the alphabet (i) and the small Roman numeral one (i) in rule language ordering. The phrase "approved by the profession's accrediting organization" in WAC 246-840-490(2) was changed to "approved by a continuing education accrediting organization" to clarify the commission's intent that ARNPs may complete continuing education from both medical and nursing organizations. "An advanced registered nurse practitioner" was added to the introductory sentence of WAC 246-840-493 to clarify that the pain management specialist qualification requirements listed refers only to the requirements specific to an ARNP. The title of WAC 246-840-4935 was changed from "Tapering requirements" to "Assessment of treatment plan" to better reflect the content of the rule and clarify that the rule includes more than the consideration of tapering.

A final cost-benefit analysis is available by contacting Amber Zawislak, P.O. Box 47864, Olympia, WA 98504-7864, phone 360-236-4785, fax 360-236-4738, TTY 360-833-6388 or 711, email amber.zawislak@doh.wa.gov, web site doh.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 17, Amended 11, Repealed 3.

Number of Sections Adopted at the 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 17, Amended 11, Repealed 3.

Date Adopted: August 10, 2018.

Paula R. Meyer, MSN, RN, FRE
Executive Director

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-460 Pain management—Intent. ((~~These rules~~)) WAC 246-840-460 through 246-840-4990 govern the use of opioids in the treatment of ((~~patients for chronic noncancer~~)) pain in the acute, perioperative, subacute, and chronic phases. Treatment modalities including opioid use can serve to improve the quality of life for those patients who suffer from pain, as well as reduce the morbidity and costs associated with undertreatment or inappropriate treatment of pain. For the purpose of these rules, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments. In addition to these rules, the nursing commission recommends practitioners adhere to applicable state agency medical directors' group (AMDG) and federal Centers for Disease Control and Prevention (CDC) guidelines for the treatment of pain in all phases.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-463 Exclusions. ((~~The rules adopted under~~)) WAC 246-840-460 through ((~~246-840-493~~)) 246-840-4990 do not apply to:

(1) The treatment of patients with cancer-related pain;

(2) The provision of palliative, hospice, or other end-of-life care; ((~~or~~

~~(2) The management of acute pain caused by an injury or surgical procedure.~~))

(3) The treatment of inpatient hospital patients; or

(4) Procedural premedications.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-465 Definitions. The following definitions ((~~in this section~~)) apply in WAC 246-840-460 through ((~~246-840-493~~)) 246-840-4990, unless the context clearly requires otherwise.

(1) "Aberrant behavior" means behavior that indicates misuse, diversion, or substance use disorder. This includes,

but is not limited to, multiple early refills or renewals, or obtaining prescriptions for the same or similar drugs from more than one practitioner or other health care provider.

(2) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus, and typically is associated with invasive procedures, trauma, and disease. ((~~It is generally time-limited, often less than three months in duration, and usually less than six months.~~

~~(2) "Addiction" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include:~~

~~(a) Impaired control over drug use;~~

~~(b) Craving;~~

~~(c) Compulsive use; or~~

~~(d) Continued use despite harm.~~

~~(3)~~)) Acute pain is considered to be six weeks or less in duration.

(3) "Biological specimen test" or "biological specimen testing" means testing of bodily fluids or other biological samples including, but not limited to, urine or hair for the presence of various drugs and metabolites.

(4) "Chronic ((~~noncancer~~)) pain" means a state in which ((~~noncancer~~)) pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process, that causes continuous or intermittent pain ((~~over months or years~~)) more than twelve weeks in duration, lasting months or years. Chronic pain includes pain resulting from cancer or treatment in a patient who is two years post completion of curative anti-cancer treatment with no current evidence of disease.

(((~~(4) "Comorbidity"~~)) (5) "Comorbidities" means a ((~~pre-existing~~)) preexisting or coexisting physical or psychiatric disease or condition.

(((~~(5)~~)) (6) "Episodic care" means medical care provided by ((~~a provider~~)) an advanced registered nurse practitioner other than the designated primary ((~~provider~~)) care practitioner in the acute care setting, for example, urgent care or emergency department.

(((~~(6)~~)) (7) "High dose" means ninety milligram morphine equivalent dose (MED), or more, per day.

(8) "High-risk" means a category of patient at increased risk of morbidity or mortality, such as from comorbidities, polypharmacy, history of substance use disorder or abuse, aberrant behavior, high dose opioid prescription, or the use of any central nervous system depressant.

(9) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less. ((~~Hospice involves an interdisciplinary approach to provide health care, pain management, and emotional and spiritual support. The emphasis is on comfort, quality of life and patient and family support. Hospice can be provided in the patient's home as well as freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities.~~

~~(7)~~))

(10) "Hospital" means any institution, place, building, or agency licensed by the department under chapter 70.41 or 71.12 RCW or designated as a state hospital under chapter 72.23 RCW, to provide accommodations, facilities, and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care of two or more individuals not related to the operator who are suffering from illness, injury, deformity, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis.

(11) "Inpatient" means a person who has been admitted to a hospital for more than twenty-four hours.

(12) "Medication assisted treatment (MAT)" means the use of pharmacologic therapy, often in combination with counseling and behavioral therapies, for the treatment of substance use disorders.

(13) "Morphine equivalent dose (MED)" means a conversion of various opioids to a morphine equivalent dose by the use of accepted conversion tables or calculators.

(((~~(8)~~)) (14) "Multidisciplinary pain clinic" means a ((~~clinic or office~~)) facility that provides comprehensive pain management and ((~~may~~)) includes care provided by multiple available disciplines, ((~~for example, physicians, osteopathic physicians, physician assistants, advanced registered nurse practitioners, physical therapists, occupational therapists, and other complementary therapies.~~

~~(9)~~)) practitioners, or treatment modalities.

(15) "Nonoperative pain" means pain which does not occur as a result of surgery.

(16) "Opioid analgesic" or "opioid" means a drug that is either an opiate derived from the opium poppy, or opiate-like semi-synthetic or synthetic drugs. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, and methadone.

(17) "Palliative care" means care that maintains or improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness. With palliative care, particular attention is given to the prevention, assessment, and treatment of pain and other symptoms, and to the provision of psychological, spiritual, and emotional support.

(18) "Pain" means an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(19) "Pain management clinic" means a publicly or privately owned facility for which a majority of patients are receiving chronic pain treatment.

(20) "Perioperative pain" means acute pain that occurs as the result of surgery.

(21) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW.

(22) "Practitioner" means an advanced registered nurse practitioner licensed under chapter 18.79 RCW, a dentist licensed under chapter 18.32 RCW, a physician licensed under chapter 18.71 or 18.57 RCW, a physician assistant licensed under chapter 18.71A or 18.57A RCW, or a podiatric physician licensed under chapter 18.22 RCW.

(23) "Risk assessment tools" means validated tools or questionnaires appropriate for identifying a patient's level of risk for substance use or misuse.

(24) "Subacute pain" means a continuation of pain, of six to twelve weeks in duration.

(25) "Substance use disorder" means a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Substance use disorder is not the same as physical dependence or tolerance that are normal physiological consequences of extended opioid therapy for pain. It is characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

NEW SECTION

WAC 246-840-4651 Patient notification, secure storage, and disposal. (1) The practitioner shall provide information to the patient educating them of:

(a) Risks associated with the use of opioids as appropriate to the medical condition, the type of patient, and the phase of treatment;

(b) The safe and secure storage of opioid prescriptions; and

(c) The proper disposal of unused opioid medications including, but not limited to, the availability of recognized drug take-back programs.

(2) The practitioner shall document such notification in the patient record.

(3) Patient notification must occur, at a minimum, at the following points of treatment:

(a) The first issuance of a prescription for an opioid; and

(b) The transition between phases of treatment, as follows:

(i) Acute nonoperative pain or acute perioperative pain to subacute pain; and

(ii) Subacute pain to chronic pain.

NEW SECTION

WAC 246-840-4653 Use of alternative modalities for pain treatment. The practitioner shall consider multimodal pharmacologic and nonpharmacologic therapy for pain rather than defaulting to the use of opioid therapy alone whenever reasonable as evidence-based, clinically appropriate alternatives exist. A practitioner may combine opioids with other medications and treatments including, but not limited to, acetaminophen, acupuncture, chiropractic, cognitive behavior therapy, nonsteroidal anti-inflammatory drugs (NSAIDs), osteopathic manipulative treatment, physical therapy, massage, or sleep hygiene.

NEW SECTION

WAC 246-840-4655 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, an advanced registered nurse practitioner licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids. Additionally, a chronic pain management specialist must meet the continuing education requirements in WAC 246-840-493. The continuing education must be at least four hours in length.

(2) The advanced registered nurse practitioner shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the advanced registered nurse practitioner's first full continuing education reporting period after January 1, 2019, or during the first full continuing education reporting period after initial licensure, whichever is later. The four hour course may count toward any NCQAC required continuing education.

NEW SECTION

WAC 246-840-4657 Diagnosis identified on prescriptions. The advanced registered nurse practitioner shall include the diagnosis or the International Classification of Diseases (ICD) code on all opioid prescriptions.

NEW SECTION

WAC 246-840-4659 Patient evaluation and patient record—Acute. Prior to prescribing an opioid for acute nonoperative pain or acute perioperative pain, the advanced registered nurse practitioner shall:

(1) Conduct and document an appropriate history and physical examination including screening for risk factors for overdose and severe postoperative pain;

(2) Evaluate the nature and intensity of the pain or anticipated pain following surgery; and

(3) Inquire about any other medications the patient is prescribed or is taking including type, dosage, and quantity prescribed.

NEW SECTION

WAC 246-840-4661 Treatment plan—Acute nonoperative pain. The advanced registered nurse practitioner shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record.

(1) The advanced registered nurse practitioner shall consider recommending or prescribing nonopioid analgesics as the first line of pain control in patients under the provisions of WAC 246-840-4653, unless not clinically appropriate.

(2) The advanced registered nurse practitioner, or practitioner's authorized designee as defined in WAC 246-470-050, shall conduct queries of the prescription monitoring program (PMP) in accordance with the provisions of WAC 246-840-4990 to identify any Schedule II-V medications or drugs of concern received by the patient, and document their review and any concerns.

(3) If the advanced registered nurse practitioner prescribes opioids for effective pain control, such prescription must not be in greater quantity than needed for the expected duration of pain severe enough to require opioids. A three-day supply or less will often be sufficient; more than a seven-day supply will rarely be needed. The advanced registered nurse practitioner shall not prescribe beyond a seven-day supply without clinical documentation in the patient record to justify the need for such a quantity.

(4) The advanced registered nurse practitioner shall reevaluate the patient who does not follow the expected

course of recovery. If significant and documented improvement in function or pain control has not occurred, the advanced registered nurse practitioner shall reconsider the continued use of opioids, or whether tapering or discontinuing opioids is clinically indicated.

(5) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations to investigate causes of continued acute nonoperative pain or other treatments.

(6) Long-acting or extended release opioids are not typically indicated for acute nonoperative pain. Should an advanced registered nurse practitioner need to prescribe a long-acting opioid for acute pain, that reason must be documented in the patient record.

(7) Medication assisted treatment (MAT) medications shall not be discontinued when treating acute pain, except as consistent with the provisions of WAC 246-840-4970.

(8) If the advanced registered nurse practitioner elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the advanced registered nurse practitioner shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-840-4665 and 246-840-4667, shall apply.

NEW SECTION

WAC 246-840-4663 Treatment plan—Acute perioperative pain. The advanced registered nurse practitioner shall comply with the requirements in this section when prescribing opioid analgesics for perioperative pain and shall document completion of these requirements in the patient's record.

(1) The advanced registered nurse practitioner shall consider prescribing nonopioid analgesics as the first line of pain control in patients under the provisions of WAC 246-840-4653, unless not clinically appropriate.

(2) The advanced registered nurse practitioner, or practitioner's authorized designee as defined in WAC 246-470-050, shall conduct queries of the prescription monitoring program (PMP) in accordance with the provisions of WAC 246-840-4990 to identify any Schedule II-V medications or drugs of concern received by the patient, and document in the patient record their review and any concerns.

(3) If the advanced registered nurse practitioner prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. A three-day supply or less will often be sufficient; more than a fourteen-day supply will rarely be needed for perioperative pain. The advanced registered nurse practitioner shall not prescribe beyond a fourteen-day supply from the time of discharge without clinical documentation in the patient record to justify the need for such a quantity. For more specific best practices, the advanced registered nurse practitioner may refer to clinical practice guidelines including, but not limited to, those produced by the agency medical directors' group (AMDG), the Centers for Disease Control and Prevention (CDC), or the Bree Collaborative.

(4) The advanced registered nurse practitioner shall reevaluate a patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the advanced registered nurse practitioner shall reconsider the continued use of opioids, or whether tapering or discontinuing opioids is clinically indicated.

(5) Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations or other treatments.

(6) If the advanced registered nurse practitioner elects to prescribe a combination of opioids with a medication listed in WAC 246-840-4960 or to a patient known to be receiving a medication listed in WAC 246-840-4960 from another practitioner, such prescribing must be in accordance with WAC 246-840-4960.

(7) If the advanced registered nurse practitioner elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the advanced registered nurse practitioner shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain, WAC 246-840-4665 and 246-840-4667, shall apply unless there is documented improvement in function or pain control, and there is a documented plan and timing for discontinuation of all opioid medications.

NEW SECTION

WAC 246-840-4665 Patient evaluation and patient record—Subacute pain. The advanced registered nurse practitioner shall comply with the requirements in this section when prescribing opioid analgesics for subacute pain and shall document completion of these requirements in the patient record.

(1) Prior to prescribing an opioid for subacute pain, the advanced registered nurse practitioner shall:

(a) Conduct an appropriate history and physical examination or review and update the patient's existing history and examination taken during the acute nonoperative or acute perioperative phase;

(b) Evaluate the nature and intensity of the pain;

(c) Inquire about other medications the patient is prescribed or taking including type, dosage, and quantity prescribed;

(d) Conduct, or cause the practitioner's authorized designee as defined in WAC 246-470-050 to conduct, a query of the prescription monitoring program (PMP) in accordance with the provisions of WAC 246-840-4990, to identify any

Schedule II-V medications or drugs of concern received by the patient, and document their review and any concerns;

(e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the advanced registered nurse practitioner determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone;

(f) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating; and

(g) Screen or refer the patient for further consultation for psychosocial factors that may be impairing recovery including, but not limited to, depression or anxiety.

(2) The advanced registered nurse practitioner treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following are documented in the patient record:

(a) The presence of one or more recognized diagnoses or indications for the use of opioid pain medication;

(b) The observed significant and documented improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;

(c) The result of any queries of the PMP;

(d) All medications the patient is known to be prescribed or taking;

(e) An appropriate pain treatment plan, including the consideration of, or attempts to use, nonpharmacological modalities and nonopioid therapy;

(f) Results of any aberrant biological specimen testing results and the risk-benefit analysis if opioids are to be continued;

(g) Results of screening or referral for further consultation for psychosocial factors that may be impairing recovery including, but not limited to, depression or anxiety;

(h) Results of screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy;

(i) The risk-benefit analysis of any combination of prescribed opioid and benzodiazepines or sedative-hypnotics, if applicable; and

(j) All other required components of the patient record, as established in statute or rule.

(3) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations or other treatments.

NEW SECTION

WAC 246-840-4667 Treatment plan—Subacute pain. (1) The advanced registered nurse practitioner shall recognize the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase and take into consideration the risks and benefits of continued opioid prescribing for the patient.

(2) If tapering has not begun prior to the six- to twelve-week subacute phase, the advanced registered nurse practitioner shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the advanced registered nurse practitioner shall reconsider the continued use of opioids, or whether tapering or discontinuing opioids is clinically indicated. The advanced registered nurse practitioner shall make reasonable attempts to discontinue the use of opioids prescribed for the acute pain event by no later than the twelve-week conclusion of the subacute phase.

(3) If the advanced registered nurse practitioner prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. The advanced registered nurse practitioner shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity during the subacute phase.

(4) If the advanced registered nurse practitioner elects to prescribe a combination of opioids with a medication listed in WAC 246-840-4960 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-840-4960 from another practitioner, such prescribing must be in accordance with WAC 246-840-4960.

(5) If the advanced registered nurse practitioner elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the advanced registered nurse practitioner shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain, WAC 246-840-467 through 246-840-4940, shall apply.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-467 Patient evaluation and patient record. The advanced registered nurse practitioner shall ((~~obtain,~~)) evaluate((~~,~~)) and document the patient's health history and physical examination in the patient's health record prior to treating for chronic ((~~noncancer~~)) pain.

(1) The patient's health history shall include:

(a) The nature and intensity of the pain;

(b) The effect of pain on physical and psychosocial function;

(c) Current and past treatments for pain, including medications and their efficacy;

(((~~(b)~~))) (d) Review of any significant comorbidities; ((~~and (c)~~))) (e) Any current or historical substance ((~~abuse~~)) use disorder;

(f) Current medications and, as related to treatment of the pain, the efficacy of medications tried; and

(g) Medication allergies.

(2) ((~~The patient's health history should include:~~

~~(a) A review of any available prescription monitoring program or emergency department-based information exchange; and~~

~~(b) Any relevant information from a pharmacist provided to advanced registered nurse practitioners.~~

~~(3)~~)) The ((~~initial~~)) patient evaluation ((~~shall~~)) prior to opioid prescribing must include:

(a) Appropriate physical examination;

(b) ((~~The nature and intensity of the pain;~~

~~(c) The effect of the pain on physical and psychological function;~~

~~(d)~~)) Consideration of the risks and benefits of chronic pain treatment for the patient;

(c) Medications the patient is taking including indication(s), ((~~date,~~)) type, dosage, ((~~and~~)) quantity prescribed((~~;~~

~~(e) A risk screening of the patient for potential comorbidities and risk factors using an appropriate screening tool. The screening should address:~~

~~(i) History of addiction;~~

~~(ii) Abuse or aberrant behavior regarding opioid use;~~

~~(iii) Psychiatric conditions;~~

~~(iv) Regular concomitant use of benzodiazepines, alcohol, or other central nervous system medications;~~

~~(v) Poorly controlled depression or anxiety;~~

~~(vi) Evidence or risk of significant adverse events, including falls or fractures;~~

~~(vii) Receipt of opioids from more than one prescribing practitioner or practitioner group;~~

~~(viii) Repeated visits to emergency departments seeking opioids;~~

~~(ix) History of sleep apnea or other respiratory risk factors;~~

~~(x) Possible or current pregnancy; and~~

~~(xi) History of allergies or intolerances.~~

~~(4) The initial patient evaluation should include:~~

~~(a) Any available diagnostic, therapeutic, and laboratory results; and~~

~~(b) Any available consultations.~~

~~(5) The health record shall be maintained in an accessible manner, readily available for review, and should include:~~

~~(a) The diagnosis, treatment plan, and objectives;~~

~~(b) Documentation of the presence of one or more recognized indications for the use of pain medication;~~

~~(c) Documentation of any medication prescribed;~~

~~(d) Results of periodic reviews;~~

~~(e) Any written agreements for treatment between the patient and the advanced registered nurse practitioner; and~~

~~(f) The advanced registered nurse practitioner's instructions to the patient~~)), and as related to treatment of the pain, efficacy of medications tried;

(d) Review of the prescription monitoring program (PMP) to identify any Schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-840-4990;

(e) Any available diagnostic, therapeutic, and laboratory results;

(f) Use of a risk assessment tool and assignment of the patient to a high, moderate, or low risk category. The advanced registered nurse practitioner should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high risk;

(g) Any available consultations, particularly as related to the patient's pain;

(h) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;

(i) Written agreements, as described in WAC 246-840-475 for treatment between the patient and the advanced registered nurse practitioner;

(j) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy;

(k) Treatment plan and objectives including:

(i) Documentation of any medication prescribed;

(ii) Biologic specimen testing ordered; and

(iii) Any labs or imaging ordered.

(3) The health record must be maintained in an accessible manner, readily available for review, and contain documentation of requirements in subsections (1) and (2) of this section, and all other required components of the patient record, as set out in statute or rule.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-470 Treatment plan. (1) When the patient enters the chronic pain phase, the advanced registered nurse shall reevaluate the patient by treating the situation as a new disease.

(2) The ((~~written~~)) chronic pain treatment plan ((~~shall~~)) must state the objectives that will be used to determine treatment success and ((~~shall~~)) must include, at a minimum:

(a) Any change in pain relief;

(b) Any change in physical and psychosocial function; and

(c) Additional diagnostic evaluations or other planned treatments.

(((~~(2)~~))) (3) After treatment begins, the advanced registered nurse practitioner ((~~should~~)) shall adjust drug therapy to the individual health needs of the patient.

(4) The advanced registered nurse practitioners shall ((~~include indications for medication use on the prescription and require photo identification of the person picking up the prescription in order to fill. Advanced registered nurse practitioners shall advise the patient that it is the patient's responsibility to safeguard all medications and keep them in a secure location.~~

~~(3) Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment~~)) complete patient notification in accordance with the provisions of WAC 246-840-4651.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-475 Written agreement for treatment. ((~~Chronic noncancer pain patients should receive all chronic pain management prescriptions from one advanced registered nurse practitioner and one pharmacy whenever possible. If the patient is at high risk for medication abuse, or has a history of substance abuse, or psychiatric comorbidities, the prescribing~~)) The advanced registered nurse practitioner shall use a written agreement for treatment with the patient ((~~outlining patient~~)) who requires long-term opioid therapy for

chronic pain that outlines the patient's responsibilities. This written agreement for treatment ((~~shall~~)) must include:

(1) The patient's agreement to provide biological samples for ((~~urine/serum medical level screening~~)) biological specimen testing when requested by the advanced registered nurse practitioner;

(2) The patient's agreement to take medications at the dose and frequency prescribed, with a specific protocol for lost prescriptions and early refills or renewals;

(3) Reasons for which ((~~drug~~)) opioid therapy may be discontinued (((~~e.g., violation of agreement~~)));

(4) The requirement that all chronic ((~~pain management~~)) opioid prescriptions are provided by a single prescriber, a single clinic, or a multidisciplinary pain clinic ((~~and~~));

(5) The requirement that all chronic opioid prescriptions are to be dispensed by a single pharmacy or pharmacy system whenever possible;

(((~~5~~))) (6) The patient's agreement to not abuse ((~~alcohol or use other medically unauthorized substances;~~

~~(6)~~)) substances that can put the patient at risk for adverse outcomes;

(7) A written authorization for:

(a) The advanced registered nurse practitioner to release the agreement for treatment to:

(i) Local emergency departments((~~,~~));

(ii) Urgent care facilities((~~, and~~));

(iii) Other practitioners caring for the patient who might prescribe pain medications; and

(iv) Pharmacies((~~; and~~)).

(b) Other practitioners to report violations of the agreement ((~~back~~)) to the advanced registered nurse practitioner((~~;~~

~~(7) A written authorization that the advanced registered nurse practitioner may notify the proper authorities if he or she has reason to believe the patient has engaged in illegal activity;~~

~~(8) Acknowledgment that a violation of the agreement may result in a tapering or discontinuation of the prescription;~~

~~(9)~~)) treating the patient's chronic pain and to the prescription monitoring program (PMP).

(8) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

(((~~10~~))) (9) Acknowledgment that, if the patient violates the terms of the agreement, the violation and the advanced registered nurse practitioner's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-477 Periodic review. (1) The advanced registered nurse practitioner shall periodically review the course of treatment for chronic ((~~noncancer~~)) pain((~~, the patient's state of health, and any new information about the etiology of the pain. Generally, periodic reviews shall take place at least every six months. However, for treatment of stable patients with chronic noncancer pain involving nonescalating daily dosages of forty milligrams of a morphine equivalent dose (MED) or less, periodic reviews shall take place at least annually.~~

~~(1)~~)). The frequency of visits, biological testing, and prescription monitoring program (PMP) queries are determined based on the patient's risk category:

(a) For a high-risk patient, at least quarterly;

(b) For a moderate-risk patient, at least semiannually;

(c) For a low-risk patient, at least annually;

(d) Immediately upon indication of concerning aberrant behavior; and

(e) More frequently at the advanced registered nurse practitioner's discretion.

(2) During the periodic review, the advanced registered nurse practitioner shall determine:

(a) Patient's compliance with any medication treatment plan;

(b) If pain, function, or quality of life have improved ((~~or~~)), diminished, or are maintained using objective evidence((~~, considering any available information from family members or other caregivers~~)); and

(c) If continuation or modification of medications for pain management treatment is necessary based on the advanced registered nurse practitioner's evaluation of progress towards treatment objectives.

(((~~2~~))) (3) Periodic or patient evaluations must also include:

(a) History and physical examination related to the pain;

(b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and

(c) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient at a frequency determined by the patient's risk category, and otherwise in accordance with the provisions of WAC 246-840-4990 and subsection (1) of this section.

(4) The advanced registered nurse practitioner shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with current treatment plan is unsatisfactory. The advanced registered nurse practitioner shall consider tapering, changing, or discontinuing treatment ((~~when:~~

~~(a) Function or pain does not improve after a trial period;~~

~~(b) There is evidence of significant adverse effects;~~

~~(c) Other treatment modalities are indicated; or~~

~~(d) There is evidence of misuse, addiction, or diversion.~~

~~(3) The advanced registered nurse practitioner should periodically review information from any available prescription monitoring program or emergency department-based information exchange.~~

~~(4) The advanced registered nurse practitioner should periodically review any relevant information from a pharmacist provided to the advanced registered nurse practitioner~~)) in accordance with the provisions of WAC 246-840-4935.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-485 Consultation—Recommendations and requirements. (1) The advanced registered nurse

practitioner shall consider and document referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic ((~~noncancer~~)) pain patients who are under eighteen years of age((~~,~~)) or who are ((~~at risk for medication misuse, abuse, or diversion~~)) potential high-risk patients. The management of pain in patients with a history of substance ((~~abuse~~)) use or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold ((~~for adults~~)) is one hundred twenty milligrams morphine equivalent dose (MED)(((~~oral~~))). ((~~In the event~~)) If an advanced registered nurse practitioner prescribes a dosage amount that meets or exceeds the mandatory consultation threshold of one hundred twenty milligrams MED (((~~orally~~))) per day, a consultation with a pain management specialist as described in WAC 246-840-493, 246-853-750, 246-854-330, 246-817-965, 246-918-880, 246-919-940, or 246-922-750 is required, unless the consultation is exempted under WAC 246-840-487 or 246-840-490. ((~~Great caution should be used when prescribing opioids to children with chronic noncancer pain and appropriate referrals to a specialist is encouraged.~~

~~(a)~~)) The mandatory consultation shall consist of at least one of the following:

(((~~i~~))) (a) An office visit with the patient and the pain management specialist;

(((~~ii) A telephone~~)) (b) A consultation between the pain management specialist and the advanced registered nurse practitioner;

(((~~iii) An electronic consultation between the pain management specialist and the advanced registered nurse practitioner; or~~

~~(iv)~~)) (c) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the advanced registered nurse practitioner or with a licensed health care practitioner designated by the advanced registered nurse practitioner or the pain management specialist; or

(d) Other chronic pain evaluation services as approved by the commission.

(((~~(b) An~~)) (3) The advanced registered nurse practitioner shall document each ((~~mandatory~~)) consultation with the pain management specialist. Any written record of ((~~the~~)) a consultation by the pain management specialist shall be maintained as a patient record by the specialist. If the pain management specialist provides a written record of the consultation to the advanced registered nurse practitioner, the advanced registered nurse practitioner shall maintain it as part of the patient record.

(((~~(3) Nothing in this chapter shall limit any person's ability to contractually require a consultation with a pain management specialist as defined in WAC 246-840-493, at any time. For the purposes of WAC 246-840-460 through 246-840-493, "person" means an individual, a trust or estate, a firm, a partnership, a corporation (including associations, joint stock companies, and insurance companies), the state, or a political subdivision or instrumentality of the state, including a municipal corporation or a hospital district.~~)) (4) The advanced registered nurse practitioner shall use great caution when prescribing opioids to children and adolescents with chronic pain; appropriate referral to a specialist is encouraged.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-487 Consultation—Exemptions for exigent and special circumstances. An advanced registered nurse practitioner is not required to consult with a pain management specialist as ((~~described~~)) defined in WAC 246-840-493 when ((~~he or she~~)) the advanced registered nurse practitioner has documented adherence to all standards of practice as defined in WAC 246-840-460 through 246-840-493, and when any one or more of the following conditions apply:

(1) The patient is following a tapering schedule;

(2) The patient requires treatment for acute pain, which may or may not include hospitalization, requiring a temporary escalation in opioid dosage((~~,~~)) with expected return to ((~~or below~~)) their baseline dosage level or below;

(3) The advanced registered nurse practitioner documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty milligrams morphine equivalency dosage (MED) per day without first obtaining a consultation; or

(4) The advanced registered nurse practitioner documents the patient's pain and function is stable, and the patient is on a nonescalating dosage of opioids.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-490 Consultation—Exemptions for the advanced registered nurse practitioner. The advanced registered nurse practitioner is exempt from the consultation requirement in WAC 246-840-485 if one or more of the following qualifications are met:

(1) The advanced registered nurse practitioner is a pain management specialist under WAC 246-840-493;

(2) The advanced registered nurse practitioner has successfully completed, within the last two years, a minimum of twelve continuing education hours on chronic pain management approved by ((~~the profession's~~)) a continuing education accrediting organization((~~, with~~)). At least two of these hours must be dedicated to ((~~long-acting opioids, to include methadone~~)) substance use disorder;

(3) The advanced registered nurse practitioner is a pain management practitioner working in a multidisciplinary chronic pain ((~~treatment center,~~)) clinic or a multidisciplinary academic research facility; or

(4) The advanced registered nurse practitioner has a minimum three years of clinical experience in a chronic pain management ((~~setting~~)) clinic, and at least thirty percent of ((~~his or her~~)) the advanced registered nurse practitioners' current practice is the direct provision of pain management care.

AMENDATORY SECTION (Amending WSR 11-10-064, filed 5/2/11, effective 7/1/11)

WAC 246-840-493 Pain management specialist. ((~~A~~)) An advanced registered nurse practitioner pain management specialist, functioning as a consultant for the prescribing of chronic opioid therapy, shall meet ((~~one or more of~~)) the following qualifications:

(1) ((~~If a physician or osteopathic physician:~~

~~(a) Board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology; or~~

~~(b) Has a subspecialty certificate in pain medicine by an ABMS-approved board; or~~

~~(c) Has a certification of added qualification in pain management by the AOA; or~~

~~(d) A minimum of three years of clinical experience in a chronic pain management care setting; and~~

~~(i) Credentialed in pain management by an entity approved by the Washington state medical quality assurance commission for physicians or the Washington state board of osteopathic medicine and surgery for osteopathic physicians; and~~

~~(ii) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and~~

~~(iii) At least thirty percent of the physician's or osteopathic physician's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.~~

~~(2) If a dentist: Board certified or board eligible in oral medicine or orofacial pain by the American Board of Oral Medicine or the American Board of Orofacial Pain.~~

~~(3) If an advanced registered nurse practitioner (ARNP):~~

~~(a) A minimum of three years of clinical experience in a chronic pain management care setting;~~

~~(b)~~)) Credentialed in pain management by a Washington state nursing care quality assurance commission-approved ((~~national professional association, pain association, or other~~)) certifying or credentialing entity((~~;~~

~~(c)~~)); or

(2) Meet all of the following:

(a) A minimum of three years of clinical experience in a chronic pain management care setting;

(b) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and

(((~~(d)~~))) (c) At least thirty percent of the ((~~ARNP's~~)) advanced registered nurse practitioner's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(((~~(4) If a podiatric physician:~~

~~(a) Board certified or board eligible in a specialty that includes a focus on pain management by the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, or other accredited certifying board as approved by the Washington state podiatric medical board; or~~

~~(b) A minimum of three years of clinical experience in a chronic pain management care setting; and~~

~~(c) Credentialed in pain management by a Washington state podiatric medical board, approved national professional association, pain association, or other credentialing entity; and~~

~~(d) Successful completion of a minimum of at least eighteen hours of continuing education in pain management during the past two years, and at least thirty percent of the podiatric physician's current practice is the direct provision of pain management care.~~))

NEW SECTION

WAC 246-840-4935 Assessment of treatment plan. The advanced registered nurse practitioner shall assess and document the appropriateness of continued use of the current treatment plan if the patient's response to, or compliance with, the current treatment plan is unsatisfactory. The advanced registered nurse practitioner shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

(1) The patient requests;

(2) The patient experiences a deterioration in function or pain;

(3) The patient is noncompliant with the written agreement;

(4) Other treatment modalities are indicated;

(5) There is evidence of misuse, abuse, substance use disorder, or diversion;

(6) The patient experiences a severe adverse event or overdose;

(7) There is unauthorized escalation of doses; or

(8) There is continued dose escalation with no improvement in pain, function, or quality of life.

NEW SECTION

WAC 246-840-4940 Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner. (1) When a patient receiving chronic opioid pain medication(s) changes to a new advanced registered nurse practitioner, the advanced registered nurse practitioner shall query the prescription monitoring program (PMP). It is normally appropriate for the new advanced registered nurse practitioner to initially maintain the patient's current opioid doses. Over time, the advanced registered nurse practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) An advanced registered nurse practitioner's treatment of a new high dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-840-485 and the tapering requirements of WAC 246-840-4935 if:

(a) The patient was previously being treated with a dosage of opioids in excess of one hundred twenty milligram MED for chronic pain under an established written agreement for treatment of the same chronic condition or conditions;

(b) The patient's dose is stable and nonescalating;

(c) The patient has a demonstrated history in their record of compliance with treatment plans and written agreements as documented by medical records and PMP queries; and

(d) The patient has documented functional stability, pain control, or improvements in function or pain control, at the dose in excess to one hundred twenty milligram MED.

(3) With respect to the treatment of a new patient under subsection (1) or (2) of this section, this exemption applies for the first three months of newly established care, after which the requirements of WAC 246-840-485 and 246-840-4935 shall apply.

NEW SECTION

WAC 246-840-4950 Special populations—Patients twenty-five years of age or under, pregnant patients, and aging populations. (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the advanced registered nurse practitioner shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and adjust the dosage prescribed accordingly.

(2) Pregnant patients. Use of medication assisted treatment (MAT) opioids, such as methadone or buprenorphine, by a pregnant patient shall not be discontinued without oversight by the MAT prescribing practitioner. The advanced registered nurse practitioner shall weigh carefully the risks and benefits of opioid detoxification during pregnancy.

(3) Aging populations. As people age, their tolerance and metabolizing of opioids may change. The advanced registered nurse practitioner shall consider the distinctive needs of patients who are sixty-five years of age or older and who have been on chronic opioid therapy or who are initiating opioid treatment.

NEW SECTION

WAC 246-840-4955 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the advanced registered nurse practitioner knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the advanced registered nurse practitioner shall review the prescription monitoring program (PMP) to identify any Schedule II-V or drugs of concern received by the patient and document in the patient record their review and any concerns.

(2) An advanced registered nurse practitioner providing episodic care to a patient who the advanced registered nurse practitioner knows is being treated with opioids for chronic pain should provide additional opioids to be equal to the severity of the acute pain. If opioids are provided, the advanced registered nurse practitioner shall limit the use of opioids to the minimum amount necessary to control the acute nonoperative pain, acute perioperative pain, or similar acute exacerbation of pain until the patient can receive care from the practitioner who is managing the patient's chronic pain treatment.

(3) The episodic care advanced registered nurse practitioner shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment.

(4) The episodic care advanced registered nurse practitioner shall coordinate care with the patient's chronic pain treatment practitioner if that person is known to the episodic care advanced registered nurse practitioner, when practicable.

NEW SECTION

WAC 246-840-4960 Coprescribing with certain medications. (1) The advanced registered nurse practitioner shall not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation in the patient record of clinical judgment and discussion of risks with the patient:

(a) Benzodiazepines;

(b) Barbiturates;

(c) Sedatives;

(d) Carisoprodol; or

(e) Nonbenzodiazepine hypnotics also known as Z drugs.

(2) If a patient receiving an opioid prescription is known to be concurrently prescribed one or more of the medications listed in subsection (1) of this section, the advanced registered nurse practitioner prescribing opioids shall consult with the other prescriber(s) to establish a patient care plan for the use of the medications concurrently or consider whether one of the medications should be tapered.

NEW SECTION

WAC 246-840-4970 Coprescribing of opioids for patients receiving medication assisted treatment (MAT). (1) Where practicable, the advanced registered nurse practitioner providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving medication assisted treatment (MAT) shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or a pain specialist.

(2) The advanced registered nurse practitioner shall not discontinue MAT medications when treating acute nonoperative pain or acute perioperative pain without documentation of the reason for doing so, nor shall use of these medications be used to deny necessary operative intervention.

NEW SECTION

WAC 246-840-4980 Coprescribing of naloxone. (1) The advanced registered nurse practitioner shall confirm or provide a current prescription for naloxone when fifty milligrams MED or above, or when prescribed to a high-risk patient.

(2) The advanced registered nurse practitioner should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.

NEW SECTION

WAC 246-840-4990 Prescription monitoring program—Required registration, queries, and documentation. (1) The advanced registered nurse practitioner shall register to access the prescription monitoring program (PMP) or demonstrate proof of having registered to access the PMP if they prescribe opioids in Washington state.

(2) The advanced registered nurse practitioner is permitted to delegate performance of a required PMP query to an authorized designee, as defined in WAC 246-470-050.

(3) At a minimum, the advanced registered nurse practitioner shall ensure a PMP query is performed prior to the prescription of an opioid at the following times:

(a) First opioid prescription for acute pain unless clinical exception is documented; such exceptions should be rare, occurring in less than ten percent of the first prescriptions;

(b) First refill for acute pain if not checked with initial prescription due to documented clinical exception;

(c) Time of transition from acute to subacute pain;

(d) Time of transition from subacute to chronic pain; and

(e) Time of preoperative assessment for any elective surgery or prior to discharge for nonelective surgery.

(4) For chronic pain management, the advanced registered nurse practitioner shall ensure a PMP query is performed at a minimum frequency determined by the patient's risk assessment, as follows:

(a) For a high-risk patient, a PMP query shall be completed at least quarterly.

(b) For a moderate-risk patient, a PMP query shall be completed at least semiannually.

(c) For a low-risk patient, a PMP query shall be completed at least annually.

(5) The advanced registered nurse practitioner shall ensure a PMP query is performed for any chronic pain patient immediately upon identification of aberrant behavior.

(6) The advanced registered nurse practitioner shall ensure a PMP query is performed when providing episodic care to a patient who the advanced registered nurse practitioner knows to be receiving opioids for chronic pain, in accordance with WAC 246-840-4955.

(7) For the purposes of this section, the requirement to consult the PMP does not apply when the PMP or the electronic medical record (EMR) cannot be accessed by the advanced registered nurse practitioner due to a temporary technological or electrical failure. The query shall be completed as soon as technically feasible.

(8) Pertinent concerns discovered in the PMP shall be documented in the patient record.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-840-473	Informed consent.
WAC 246-840-480	Long-acting opioids, including methadone.
WAC 246-840-483	Episodic care.

WSR 18-20-087
PERMANENT RULES
DEPARTMENT OF HEALTH
(Board of Osteopathic Medicine and Surgery)

[Filed October 1, 2018, 10:35 a.m., effective November 1, 2018]

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

Purpose: Chapter 246-853 WAC, Osteopathic physicians and surgeons and chapter 246-854 WAC, Osteopathic physician assistants, the board of osteopathic medicine and surgery (board) has adopted new sections, amendments, and repeal of sections to existing rules that establish requirements and standards for prescribing opioid drugs by osteopathic physicians and osteopathic physicians assistants. The adopted rules provide a necessary framework and structure for safe, consistent opioid prescribing practice that comply with the directives of ESHB 1427.

Citation of Rules Affected by this Order: New WAC 246-853-675, 246-853-680, 246-853-685, 246-853-690, 246-853-695, 246-853-700, 246-853-705, 246-853-710, 246-853-715, 246-853-720, 246-853-725, 246-853-730, 246-853-735, 246-853-740, 246-853-745, 246-853-750, 246-853-755, 246-853-760, 246-853-765, 246-853-770, 246-853-775, 246-853-780, 246-853-785, 246-853-790, 246-854-255, 246-854-260, 246-854-265, 246-854-270, 246-854-275, 246-854-280, 246-854-285, 246-854-290, 246-854-295, 246-854-300, 246-854-305, 246-854-310, 246-854-315, 246-854-320, 246-854-325, 246-854-330, 246-854-335, 246-854-340, 246-854-345, 246-854-350, 246-854-355, 246-854-360, 246-854-365 and 246-854-370; repealing WAC 246-853-663, 246-853-664, 246-853-665, 246-853-666, 246-853-667, 246-853-668, 246-853-669, 246-853-670, 246-853-671, 246-853-672, 246-853-673, 246-854-243, 246-854-244, 246-854-245, 246-854-246, 246-854-247, 246-854-248, 246-854-249, 246-854-250, 246-854-251, 246-854-252 and 246-854-253; and amending WAC 246-853-660, 246-853-661, 246-853-662, 246-854-240, 246-854-241, and 246-854-242.

Statutory Authority for Adoption: RCW 18.57.800 and 18.57A.800.

Other Authority: ESHB 1427 (chapter 297, Laws of 2017), codified as part of RCW 18.57.800 and 18.57A.800.

Adopted under notice filed as WSR 18-14-088 on July 2, 2018.

Changes Other than Editing from Proposed to Adopted Version: (1) WAC 246-853-662 and 246-854-242, the board is adding definitions of "low-risk," "high-risk," and "cancer-related pain" to the rule. These terms are used in the rule, so definitions were added for clarification.

(2) WAC 246-853-750 and 246-854-330, the board will refer to WAC sections of the other professions' rules describing pain management specialist qualifications rather than list out the requirements for other practitioners in the osteopathic rules. This change ensures that if changes are made to other professions' pain management specialist requirements, the osteopathic rules will remain accurate.

(3) WAC 246-853-695, 246-853-700, 246-853-710, 246-854-275, 246-854-280, and 246-854-290, the board changed "normal course of recovery" to "expected course of recovery" in sections related to treatment plans for acute and subacute pain. The board determined that the word "normal" is subjective and not defined. The board is replacing it with

the word "expected" because that word better indicates that it is up to the practitioner to determine whether the course of recovery is proceeding according to expectations.

(4) WAC 246-853-735 and 246-854-315, the board removed the sentence that reads "Any written record of a consultation by the pain management specialist must be maintained as a patient record by the specialist" in the Consultation - Recommendations and requirements sections. This change was made because not all pain management specialists are osteopathic practitioners and this may establish a requirement for nonosteopathic practitioners in the osteopathic rules.

A final cost-benefit analysis is available by contacting Brett Cain, P.O. Box 47852, Olympia, WA 98504-7852, phone 360-236-4766, fax 360-236-2901, TTY 360-833-6388 or 711, email brett.cain@doh.wa.gov, web site doh.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 48, Amended 6, Repealed 22.

Number of Sections Adopted at the 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 48, Amended 6, Repealed 22.

Date Adopted: August 22, 2018.

C. Hunter, DO
Chair

OPIOID PRESCRIBING—GENERAL PROVISIONS

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-853-660 ((~~Pain management —~~))Intent and scope. ((~~These rules~~)) WAC 246-853-660 through 246-853-790 govern the ((~~use of opioids in the treatment of patients for chronic noncancer~~)) prescribing of opioids in the treatment of pain.

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-853-661 Exclusions. ((~~The rules adopted under~~)) WAC 246-853-660 through ((~~246-853-673~~)) 246-853-790 do not apply to:

(1) The treatment of patients with cancer-related pain;

(2) The provision of palliative, hospice, or other end-of-life care; ((~~or~~

~~(2) The management of acute pain caused by an injury or surgical procedure.~~))

(3) The treatment of inpatient hospital patients. As used in this section, "inpatient" means a person who has been admitted to a hospital for more than twenty-four hours; or

(4) The provision of procedural premedications.

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-853-662 Definitions. The definitions in this section apply in WAC ((~~246-853-600~~)) 246-853-660 through ((~~246-853-673~~)) 246-853-790 unless the context clearly requires otherwise.

(1) "Aberrant behavior" means behavior that indicates misuse, diversion, or substance use disorder. This includes, but is not limited to, multiple early refills or obtaining prescriptions of the same or similar drugs from more than one osteopathic physician or other health care practitioner.

(2) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. ((~~It is generally time-limited, often less than three months in duration, and usually less than six months.~~

~~(2) "Addiction" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include:~~

~~(a) Impaired control over drug use;~~

~~(b) Craving;~~

~~(c) Compulsive use; or~~

~~(d) Continued use despite harm.~~

~~(3)~~)) Acute pain is considered to be six weeks or less in duration.

(3) "Biological specimen test" or "biological specimen testing" means tests of urine, hair, or other biological samples for various drugs and metabolites.

(4) "Cancer-related pain" means pain resulting from cancer in a patient who is less than two years postcompletion of curative anticancer treatment with current evidence of disease.

(5) "Chronic ((~~noncancer~~)) pain" means a state in which ((~~noncancer~~)) pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years((~~.~~

~~(4) "Comorbidity" means a preexisting or coexisting physical or psychiatric disease or condition.~~

~~(5) "Episodic care" means medical care provided by a provider other than the designated primary provider in the acute care setting, for example, urgent care or emergency department.~~

~~(6)~~)). Chronic pain may include pain resulting from cancer or treatment of cancer in a patient who is two years postcompletion of curative anticancer treatment with no current evidence of disease.

(6) "High-dose" means ninety milligrams MED, or more, per day.

(7) "High-risk" is a category of patient at increased risk of morbidity or mortality, such as from comorbidities, poly-

pharmacy, history of substance use disorder or abuse, aberrant behavior, high-dose opioid prescription, or the use of any central nervous system depressant.

(8) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less. ((~~Hospice involves an interdisciplinary approach to provide health care, pain management, and emotional and spiritual support. The emphasis is on comfort, quality of life and patient and family support. Hospice can be provided in the patient's home as well as freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities.~~

~~(7)~~))

(9) "Hospital" means any institution, place, building, or agency licensed by the department under chapter 70.41 or 71.12 RCW, or designated under chapter 72.23 RCW to provide accommodations, facilities, and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care of two or more individuals not related to the operator who are suffering from illness, injury, deformity, or abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis.

(10) "Low-risk" means a category of patient at low risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, and dose of opioids of less than a fifty milligram morphine equivalent dose.

(11) "Medication assisted treatment" or "MAT" means the use of pharmacologic therapy, often in combination with counseling and behavioral therapies, for the treatment of substance use disorders.

(12) "Moderate-risk" means a category of patient at a moderate risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, past history of substance use disorder or abuse, aberrant behavior, and dose of opioids between fifty and ninety milligram morphine equivalent doses.

(13) "Morphine equivalent dose" or "MED" means a conversion of various opioids to a morphine equivalent dose by the use of accepted conversion tables.

(((~~8~~))) (14) "Multidisciplinary pain clinic" means a ((~~clinic or office~~)) facility that provides comprehensive pain management and ((~~may~~)) includes care provided by multiple available disciplines, practitioners, or treatment modalities((~~; for example, physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, advanced registered nurse practitioners, physical therapy, occupational therapy, or other complementary therapies.~~

~~(9)~~)).

(15) "Nonoperative pain" means acute pain which does not occur as a result of surgery.

(16) "Opioid analgesic" or "opioid" means a drug that is either an opiate derived from the opium poppy or opiate-like that is a semi-synthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, and methadone.

(17) "Palliative" means care that improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness. With palliative care particular attention is given to the prevention, assessment, and treatment of pain and other symptoms, and to the provision of psychological, spiritual, and emotional support.

(18) "Pain" means an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(19) "Perioperative pain" means acute pain that occurs as the result of surgery.

(20) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW.

(21) "Practitioner" means an advanced registered nurse practitioner licensed under chapter 18.79 RCW, a dentist licensed under chapter 18.32 RCW, a physician licensed under chapter 18.71 or 18.57 RCW, a physician assistant licensed under chapter 18.71A or 18.57A RCW, or a podiatric physician licensed under chapter 18.22 RCW.

(22) "Subacute pain" is considered to be a continuation of pain, of six to twelve weeks in duration.

(23) "Substance use disorder" means a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Substance use disorder is not the same as physical dependence or tolerance characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

NEW SECTION

WAC 246-853-675 Patient notification, secure storage, and disposal. (1) The osteopathic physician shall provide information to the patient educating them of risks associated with the use of opioids as appropriate to the medical condition, type of patient, and phase of treatment. The osteopathic physician shall document such notification in the patient record.

(2) Patient notification must occur, at a minimum, at the following points of treatment:

(a) The first issuance of a prescription for an opioid; and

(b) The transition between phases of treatment, as follows:

(i) Acute nonoperative pain or acute perioperative pain to subacute pain; and

(ii) Subacute pain to chronic pain.

(3) Patient notification must include information regarding:

(a) The safe and secure storage of opioid prescriptions; and

(b) The proper disposal of unused opioid medications including, but not limited to, the availability of recognized drug take-back programs.

NEW SECTION

WAC 246-853-680 Use of alternative modalities for pain treatment. The osteopathic physician shall consider multimodal pharmacologic and nonpharmacologic therapy for pain rather than defaulting to the use of opioid therapy alone whenever reasonable, evidence-based, clinically appropriate alternatives exist. An osteopathic physician may com-

bine opioids with other medications and treatments including, but not limited to, acetaminophen, acupuncture, chiropractic, cognitive behavior therapy, nonsteroidal anti-inflammatory drugs (NSAIDs), osteopathic manipulative treatment, physical therapy, massage, or sleep hygiene.

NEW SECTION

WAC 246-853-685 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, an osteopathic physician licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids and the current opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.

(2) The osteopathic physician shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the osteopathic physician's first full continuing education reporting period after January 1, 2019, or during the first full continuing education reporting period after initial licensure, whichever is later.

(3) The continuing education required under this section counts toward meeting any applicable continuing education requirements.

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

NEW SECTION

WAC 246-853-690 Patient evaluation and patient record. Prior to prescribing opioids for acute nonoperative pain or acute perioperative pain, the osteopathic physician shall:

(1) Conduct and document an appropriate history and physical examination, including screening for risk factors for overdose and severe postoperative pain;

(2) Evaluate the nature and intensity of the pain or anticipated pain following surgery; and

(3) Inquire about any other medications the patient is prescribed or is taking, including date, type, dosage and quantity prescribed.

NEW SECTION

WAC 246-853-695 Treatment plan—Acute nonoperative pain. The osteopathic physician shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record:

(1) The osteopathic physician shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-853-680, unless not clinically appropriate.

(2) The osteopathic physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-853-790 to identify any Schedule II-V medications or drugs of concern received by the patient and document their review and any concerns.

(3) If the osteopathic physician prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids.

(a) A three-day supply or less will often be sufficient.

(b) More than a seven-day supply will rarely be needed.

(c) The osteopathic physician shall not prescribe beyond a seven-day supply without clinical documentation in the patient record to justify the need for such a quantity.

(4) The osteopathic physician shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

(5) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function;

(d) Additional planned diagnostic evaluations to investigate causes of continued acute nonoperative pain or other treatments.

(6) Long-acting or extended release opioids are not indicated for acute nonoperative pain. Should an osteopathic physician need to prescribe a long-acting opioid for acute pain, the osteopathic physician must document the reason in the patient record.

(7) An osteopathic physician shall not discontinue medication assisted treatment medications when treating acute pain, except as consistent with the provisions of WAC 246-853-780.

(8) If the osteopathic physician elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the osteopathic physician shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain in WAC 246-853-705 and 246-853-710 shall apply.

NEW SECTION

WAC 246-853-700 Treatment plan—Acute perioperative pain. The osteopathic physician shall comply with the requirements in this section when prescribing opioid analgesics for perioperative pain and shall document completion of these requirements in the patient record:

(1) The osteopathic physician shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-853-680, unless not clinically appropriate.

(2) The osteopathic physician, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-853-790 to identify any Schedule II-V medications or drugs of concern received by the patient and document in the patient record their review and any concerns.

(3) If the osteopathic physician prescribes opioids for effective pain control, such prescription shall be in no greater

quantity than needed for the expected duration of pain severe enough to require opioids.

(a) A three-day supply or less will often be sufficient.

(b) More than a fourteen-day supply will rarely be needed for perioperative pain.

(c) The osteopathic physician shall not prescribe beyond a fourteen-day supply from the time of discharge without clinical documentation in the patient record to justify the need for such a quantity. For more specific best practices, the osteopathic physician may refer to clinical practice guidelines.

(4) The osteopathic physician shall reevaluate a patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

(5) Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations or other treatments.

(6) If the osteopathic physician elects to prescribe a combination of opioids with a medication listed in WAC 246-853-775 or to a patient known to be receiving a medication listed in WAC 246-853-775 from another practitioner, the osteopathic physician must prescribe in accordance with WAC 246-853-775.

(7) If the osteopathic physician elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the osteopathic physician shall document in the patient record that the patient is transitioning from acute to subacute pain. Rules governing the treatment of subacute pain in WAC 246-853-705 and 246-853-710 shall apply unless there is documented improvement in function or pain control and there is a documented plan and timing for discontinuation of all opioid medications.

OPIOID PRESCRIBING—SUBACUTE PAIN

NEW SECTION

WAC 246-853-705 Patient evaluation and patient record. The osteopathic physician shall comply with the requirements in this section when prescribing opioid analgesics for subacute pain and shall document completion of these requirements in the patient record.

(1) Prior to prescribing opioids for subacute pain, the osteopathic physician shall:

(a) Conduct an appropriate history and physical examination or review, and update the patient's existing history and examination taken during the acute nonoperative or acute perioperative phase;

(b) Evaluate the nature and intensity of the pain;

(c) Inquire about other medications the patient is prescribed or taking, including date, type, dosage, and quantity prescribed;

(d) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-853-790 to identify any Schedule II-V medications or drugs of concern received by the patient and document the review for any concerns;

(e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the osteopathic physician determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone;

(f) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating; and

(g) Screen or refer the patient for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety.

(2) The osteopathic physician treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following are documented in the patient record:

(a) The presence of one or more recognized diagnoses or indications for the use of opioid pain medication;

(b) The observed significant and documented improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;

(c) The result of any queries of the PMP and any concerns the osteopathic physician may have;

(d) All medications the patient is known to be prescribed or taking;

(e) An appropriate pain treatment plan, including the consideration of, or attempts to use, nonpharmacological modalities and nonopioid therapy;

(f) Results of any aberrant biological specimen testing and the risk-benefit analysis if opioids are to be continued;

(g) Results of screening or referral for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety;

(h) Results of screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy;

(i) The risk-benefit analysis of any combination of prescribed opioid and benzodiazepines or sedative-hypnotics, if applicable; and

(j) All other required components of the patient record, as established in statute or rule.

(3) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations or other treatments.

NEW SECTION

WAC 246-853-710 Treatment plan—Subacute pain. (1) The osteopathic physician shall recognize the progression

of a patient from the acute nonoperative or acute perioperative phase to the subacute phase and take into consideration the risks and benefits of continued opioid prescribing for the patient.

(2) If tapering has not begun prior to the six- to twelve-week subacute phase, the osteopathic physician shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated. The osteopathic physician shall make reasonable attempts to discontinue the use of opioids prescribed for the acute pain event by no later than the twelve-week conclusion of the subacute phase.

(3) If the osteopathic physician prescribes opioids for effective pain control, such prescription must not be in a greater quantity than needed for the expected duration of pain severe enough to require opioids. The osteopathic physician shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity during the subacute phase.

(4) If the osteopathic physician elects to prescribe a combination of opioids with a medication listed in WAC 246-853-775 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-853-775 from another practitioner, the osteopathic physician shall prescribe in accordance with WAC 246-853-775.

(5) If the osteopathic physician elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the osteopathic physician shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain in WAC 246-853-715 through 246-853-760 shall apply.

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

NEW SECTION

WAC 246-853-715 Patient evaluation and patient record. (1) For the purposes of this section, "risk assessment tool" means professionally developed, clinically accepted questionnaires appropriate for identifying a patient's level of risk for substance abuse or misuse.

(2) The osteopathic physician shall evaluate and document the patient's health history and physical examination in the patient record prior to treating for chronic pain.

(a) History. The patient's health history must include:

(i) The nature and intensity of the pain;

(ii) The effect of pain on physical and psychosocial function;

(iii) Current and past treatments for pain, including medications and their efficacy;

(iv) Review of any significant comorbidities;

(v) Any current or historical substance use disorder;

(vi) Current medications and, as related to treatment of pain, the efficacy of medications tried; and

(vii) Medication allergies.

(b) Evaluation. The patient evaluation prior to opioid prescribing must include:

(i) Appropriate physical examination;

(ii) Consideration of the risks and benefits of chronic pain treatment for the patient;

(iii) Medications the patient is taking including indication(s), date, type, dosage, quantity prescribed, and, as related to treatment of the pain, efficacy of medications tried;

(iv) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-853-790;

(v) Any available diagnostic, therapeutic, and laboratory results;

(vi) Use of a risk assessment tool and assignment of the patient to a high-, moderate-, or low-risk category. The osteopathic physician should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk.

(vii) Any available consultations, particularly as related to the patient's pain;

(viii) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;

(ix) Treatment plan and objectives including:

(A) Documentation of any medication prescribed;

(B) Biologic specimen testing ordered; and

(C) Any labs or imaging ordered;

(x) Written agreements, also known as a "pain contract," for treatment between the patient and the osteopathic physician; and

(xi) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.

NEW SECTION

WAC 246-853-720 Treatment plan. (1) When the patient enters the chronic pain phase, the osteopathic physician shall reevaluate the patient by treating the situation as a new disease.

(2) The chronic pain treatment plan must state the objectives that will be used to determine treatment success and must include:

(a) Any change in pain relief;

(b) Any change in physical and psychosocial function; and

(c) Additional diagnostic evaluations or other planned treatments.

(3) After treatment begins, the osteopathic physician shall adjust drug therapy to the individual health needs of the patient.

(4) The osteopathic physician shall complete patient notification in accordance with the provisions of WAC 246-853-675.

NEW SECTION

WAC 246-853-725 Written agreement for treatment. The osteopathic physician shall use a written agreement for treatment with the patient who requires long-term opioid therapy for chronic pain that outlines the patient's responsibilities. This written agreement for treatment must include:

(1) The patient's agreement to provide biological samples for biological specimen testing when requested by the osteopathic physician;

(2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills or renewals;

(3) Reasons for which opioid therapy may be discontinued including, but not limited to, the patient's violation of an agreement;

(4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, single clinic, or a multidisciplinary pain clinic;

(5) The requirement that all chronic opioid prescriptions are to be dispensed by a single pharmacy or pharmacy system whenever possible;

(6) The patient's agreement to not abuse substances that can put the patient at risk for adverse outcomes;

(7) A written authorization for:

(a) The osteopathic physician to release the agreement for treatment to:

(i) Local emergency departments;

(ii) Urgent care facilities;

(iii) Other practitioners caring for the patient who might prescribe pain medications; and

(iv) Pharmacies.

(b) The osteopathic physician to release the agreement to other practitioners so other practitioners can report violations of the agreement to the osteopathic physician treating the patient's chronic pain and to the PMP.

(8) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

(9) Acknowledgment that if the patient violates the terms of the agreement, the violation and the osteopathic physician's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

For the purposes of this section, "refill" means a second or subsequent filling of a previously issued prescription that is authorized to be dispensed when the patient has exhausted their current supply. For the purposes of WAC 246-853-660 through 246-853-790, refills are subject to the same limitations and requirements as initial prescriptions.

NEW SECTION

WAC 246-853-730 Periodic review. (1) The osteopathic physician shall periodically review the course of treatment for chronic pain. The osteopathic physician shall base the frequency of visits, biological testing, and PMP queries, in accordance with the provisions of WAC 246-853-790 on the patient's risk category:

(a) For a high-risk patient, at least quarterly;

(b) For a moderate-risk patient, at least semiannually;

(c) For a low-risk patient, at least annually;

(d) Immediately upon indication of concerning or aberrant behavior; and

(e) More frequently at the osteopathic physician's discretion.

(2) During the periodic review, the osteopathic physician shall determine:

(a) The patient's compliance with any medication treatment plan;

(b) If pain, function, or quality of life have improved, diminished, or are maintained using objective evidence; and

(c) If continuation or modification of medications for pain management treatment is necessary based on the osteopathic physician's evaluation of progress towards treatment objectives.

(3) Periodic patient evaluations must also include:

(a) History and physical exam related to the pain;

(b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and

(c) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient at a frequency determined by the patient's risk category, and otherwise in accordance with the provisions of WAC 246-853-790 and subsection (1) of this section.

(4) The osteopathic physician shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with the current treatment plan is unsatisfactory. The osteopathic physician shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-853-755.

NEW SECTION

WAC 246-853-735 Consultation—Recommendations and requirements. (1) The osteopathic physician shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold is one hundred twenty milligrams MED. Unless the consultation is exempted under WAC 246-853-740 or 246-853-745, an osteopathic physician who prescribes a dosage amount that meets or exceeds the mandatory consultation threshold must comply with the pain management specialist consultation requirements described in WAC 246-853-750. The mandatory consultation must consist of at least one of the following:

(a) An office visit with the patient and the pain management specialist;

(b) A consultation between the pain management specialist and the osteopathic physician;

(c) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the osteopathic physician or with a licensed health care practitioner designated by the osteopathic physician or the pain management specialist; or

(d) Other chronic pain evaluation services as approved by the board.

(3) The osteopathic physician shall document in the patient record each consultation with the pain management specialist. If the pain management specialist provides a writ-

ten record of the consultation to the osteopathic physician, the osteopathic physician shall maintain it as part of the patient record.

(4) The osteopathic physician shall use great caution when prescribing opioids to children or adolescents with chronic pain; appropriate referral to a specialist is encouraged.

NEW SECTION

WAC 246-853-740 Consultation—Exemptions for exigent and special circumstances. An osteopathic physician is not required to consult with a pain management specialist as defined in WAC 246-853-750 when the osteopathic physician has documented adherence to all standards of practice as defined in WAC 246-853-715 through 246-853-760, and when one or more of the following conditions are met:

(1) The patient is following a tapering schedule;

(2) The patient requires treatment for acute pain, which may or may not include hospitalization, requiring a temporary escalation in opioid dosage with expected return to their baseline dosage level or below;

(3) The osteopathic physician documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty milligrams MED per day without first obtaining a consultation; or

(4) The osteopathic physician documents the patient's pain and function is stable and the patient is on a nonescalating dosage of opioids.

NEW SECTION

WAC 246-853-745 Consultation—Exemptions for the osteopathic physician. An osteopathic physician is exempt from the consultation requirement in WAC 246-853-735 if one or more of the following qualifications are met:

(1) The osteopathic physician is a pain management specialist under WAC 246-853-750;

(2) The osteopathic physician has successfully completed every four years a minimum of twelve continuing education hours on chronic pain management approved by the profession's continuing education accrediting organizations. At least two of these hours must be in substance use disorders;

(3) The osteopathic physician is a pain management practitioner working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; or

(4) The osteopathic physician has a minimum three years of clinical experience in a chronic pain management setting, and at least thirty percent of their current practice is the direct provision of pain management care.

NEW SECTION

WAC 246-853-750 Pain management specialist. (1) A pain management specialist shall meet one or more of the following qualifications:

(a) An osteopathic physician shall be board certified or board eligible by an American Board of Medical Specialties-approved board (ABMS) or by the American Osteopathic Association (AOA) in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology;

(b) Have a subspecialty certificate in pain medicine by an ABMS-approved board;

(c) Have a certification of added qualification in pain management by the AOA;

(d) Be credentialed in pain management by an entity approved by the board; or

(e) Have a minimum of three years of clinical experience in a chronic pain management care setting including:

(i) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past three years for an osteopathic physician; and

(ii) At least thirty percent of the osteopathic physician's current practice is the direct provision of pain management care or in a multidisciplinary pain clinic.

(2) An osteopathic physician assistant shall meet requirements in WAC 246-854-330.

(3) An allopathic physician shall meet requirements in WAC 246-919-945.

(4) An allopathic physician assistant shall meet requirements in WAC 246-918-895.

(5) A dentist shall meet requirements in WAC 246-817-965.

(6) An advanced registered nurse practitioner (ARNP) shall meet requirements in WAC 246-840-493.

(7) A podiatric physician shall meet requirements in WAC 246-922-750.

NEW SECTION

WAC 246-853-755 Tapering requirements. (1) The osteopathic physician shall assess and document the appropriateness of continued use of the current treatment plan if the patient's response to or compliance with the current treatment is unsatisfactory.

(2) The osteopathic physician shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

(a) The patient requests;

(b) The patient experiences a deterioration in function or pain;

(c) The patient is noncompliant with the written agreement;

(d) Other treatment modalities are indicated;

(e) There is evidence of misuse, abuse, substance use disorder, or diversion;

(f) The patient experiences a severe adverse event or overdose;

(g) There is unauthorized escalation or doses; or

(h) The patient is receiving an escalation in opioid dosage with no improvement in pain, function, or quality of life.

NEW SECTION

WAC 246-853-760 Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner. (1) When a patient receiving chronic opioid pain medications changes to a new practi-

tioner, it is normally appropriate for the new practitioner to initially maintain the patient's current opioid doses. Over time, the practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) An osteopathic physician's treatment of a new high-dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-853-735 and the tapering requirements of WAC 246-853-755 if:

(a) The patient was previously being treated with a dosage of opioids in excess of one hundred twenty milligrams MED for chronic pain under an established written agreement for treatment of the same chronic condition or conditions;

(b) The patient's dose is stable and nonescalating;

(c) The patient has a demonstrated history in their record of compliance with treatment plans and written agreements as documented by medical records and PMP queries; and

(d) The patient has documented functional stability, pain control, or improvements in function or pain control, at the dose in excess of one hundred twenty milligrams MED.

(3) With respect to the treatment of a new patient under subsection (1) or (2) of this section, this exemption applies for the first three months of newly established care, after which the requirements of WAC 246-853-735 and 246-853-755 shall apply.

OPIOID PRESCRIBING—SPECIAL POPULATIONS

NEW SECTION

WAC 246-853-765 Special populations—Patients twenty-five years of age or under, pregnant patient, and aging populations. (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the osteopathic physician shall treat pain in a manner equal to that of an adult but must account for the weight of the patient and reduce the dosage prescribed accordingly.

(2) Pregnant patients. The osteopathic physician shall not discontinue the use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient without oversight by the MAT prescribing practitioner. The osteopathic physician shall weigh carefully the risks and benefits of opioid detoxification during pregnancy.

(3) Aging populations. As people age, their tolerance and metabolizing of opioids may change. The osteopathic physician shall consider the distinctive needs of patients who are sixty-five years of age or older and who have been on chronic opioid therapy or who are initiating opioid treatment.

NEW SECTION

WAC 246-853-770 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the osteopathic physician knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the osteopathic physician shall review the PMP to identify any Schedule II-V or drugs of concern received by the patient and document in the patient record their review and any concerns.

(2) An osteopathic physician providing episodic care to a patient who the osteopathic physician knows is being treated with opioids for chronic pain should provide additional opioids to be equal to the severity of the acute pain. If opioids are provided, the osteopathic physician shall limit the use of opioids to the minimum amount necessary to control the acute nonoperative pain, acute perioperative pain, or similar acute exacerbation of pain until the patient can receive care from the practitioner who is managing the patient's chronic pain treatment.

(3) The osteopathic physician providing episodic care shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment, when reasonable.

(4) The osteopathic physician providing episodic care shall coordinate care with the patient's chronic pain treatment practitioner if that person is known to the osteopathic physician providing episodic care, when reasonable.

(5) For the purposes of this section, "episodic care" means medical care provided by a practitioner other than the designated primary practitioner in the acute care setting; for example, urgent care or emergency department.

OPIOID PRESCRIBING—COPRESCRIBING

NEW SECTION

WAC 246-853-775 Coprescribing of opioids with certain medications. (1) The osteopathic physician must not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation in the patient record of clinical judgment:

(a) Benzodiazepines;

(b) Barbiturates;

(c) Sedatives;

(d) Carisoprodol; or

(e) Sleeping medications, also known as Z drugs.

(2) If a patient receiving an opioid prescription is known to be concurrently prescribed one or more of the medications listed in subsection (1) of this section, the osteopathic physician prescribing opioids shall consult with the other prescriber(s) to establish a patient care plan for the use of the medications concurrently or consider whether one of the medications should be tapered.

NEW SECTION

WAC 246-853-780 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where practicable, the osteopathic physician providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving MAT shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or pain specialist.

(2) The osteopathic physician shall not discontinue MAT medications when treating acute nonoperative pain or acute perioperative pain without documentation of the reason for doing so, nor shall use of these medications be used to deny necessary intervention.

NEW SECTION

WAC 246-853-785 Coprescribing of naloxone. (1) The osteopathic physician shall confirm or provide a current prescription for naloxone when high dose opioids are prescribed.

(2) The osteopathic physician should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

NEW SECTION

WAC 246-853-790 Prescription monitoring program—Required registration, queries, and documentation. (1) The osteopathic physician shall register to access the PMP or demonstrate proof of having registered to access the PMP if they prescribe opioids in Washington state.

(2) The osteopathic physician may delegate the retrieval of a required PMP query to an authorized designee, in accordance with WAC 246-470-050.

(3) At a minimum, the osteopathic physician shall ensure a PMP query is performed prior to the issuance of any prescription of an opioid or of a benzodiazepine.

(4) For the purposes of this section, the requirement to consult the PMP does not apply in situations when it cannot be accessed by the osteopathic physician or their authorized designee due to a temporary technological or electrical failure.

(5) In cases of technical or electrical failure, the osteopathic physician shall document in the patient record the date(s) and time(s) of attempts to access the PMP and shall check the PMP for that patient as soon as is practicable after the failure is resolved, but not later than the next prescription.

(6) Pertinent concerns discovered in the PMP shall be documented in the patient record.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-853-663 Patient evaluation.

WAC 246-853-664 Treatment plan.

WAC 246-853-665 Informed consent.

WAC 246-853-666 Written agreement for treatment.

WAC 246-853-667 Periodic review.

WAC 246-853-668 Long-acting opioids, including methadone.

WAC 246-853-669 Episodic care.

WAC 246-853-670 Consultation—Recommendations and requirements.

WAC 246-853-671 Consultation—Exemptions for exigent and special circumstances.

WAC 246-853-672 Consultation—Exemptions for the osteopathic physician.

WAC 246-853-673 Pain management specialist.

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-854-240 ((~~Pain management—~~))Intent and scope. ((~~These rules~~)) WAC 246-854-240 through 246-854-370 govern the ((~~use of opioids in the treatment of patients for chronic noncancer~~)) prescribing of opioids in the treatment of pain. Nothing in these rules in any way restricts the current scope of practice of osteopathic physician assistants as set forth in chapters 18.57 and 18.57A RCW and the working agreements between the osteopathic physician and the osteopathic physician assistant, which may include pain management.

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-854-241 Exclusions. ((~~The rules adopted under~~)) WAC 246-854-240 through ((~~246-854-253~~)) 246-854-370 do not apply to:

(1) The treatment of patients with cancer-related pain;

(2) The provision of palliative, hospice, or other end-of-life care; ((~~or~~

~~(2) The management of acute pain caused by an injury or surgical procedure.~~))

(3) The treatment of inpatient hospital patients. As used in this section, "inpatient" means a person who has been admitted to a hospital for more then twenty-four hours; or

(4) The provision of procedural premedications.

AMENDATORY SECTION (Amending WSR 11-10-062, filed 5/2/11, effective 7/1/11)

WAC 246-854-242 Definitions. The definitions in this section apply ((~~in~~)) to WAC 246-854-240 through ((~~246-854-253~~)) 246-854-370 unless the context clearly requires otherwise.

(1) "Aberrant behavior" means behavior that indicates misuse, diversion, or substance use disorder. This includes, but is not limited to, multiple early refills or obtaining prescriptions of the same or similar drugs from more than one osteopathic physician or other health care practitioner.

(2) "Acute pain" means the normal, predicted physiological response to a noxious chemical, thermal, or mechanical stimulus and typically is associated with invasive procedures, trauma, and disease. ((~~It is generally time-limited, often less than three months in duration, and usually less than six months.~~

~~(2) "Addiction" means a primary, chronic, neurobiologic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include:~~

~~(a) Impaired control over drug use;~~

~~(b) Craving;~~

~~(c) Compulsive use; or~~

~~(d) Continued use despite harm.~~

~~(3)~~)) Acute pain is considered to be six weeks or less in duration.

(3) "Biological specimen test" or "biological specimen testing" means tests of urine, hair, or other biological samples for various drugs and metabolites.

(4) "Cancer-related pain" means pain resulting from cancer in a patient who is less than two years postcompletion of curative anticancer treatment with current evidence of disease.

(5) "Chronic ((~~noncancer~~)) pain" means a state in which ((~~noncancer~~)) pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years. Chronic pain may include pain resulting from cancer or treatment of cancer in a patient who is two years postcompletion of curative anticancer treatment with no current evidence of disease.

(((~~(4) "Comorbidity" means a preexisting or coexisting physical or psychiatric disease or condition.~~

~~(5) "Episodic care" means medical care provided by a provider other than the designated primary provider in the acute care setting, for example, urgent care or emergency department.~~))

(6) "High-dose" means ninety milligrams, MED, or more per day.

(7) "High-risk" is a category of patient at increased risk of morbidity or mortality, such as from comorbidities, polypharmacy, history of substance use disorder or abuse, aberrant behavior, high-dose opioid prescription, or the use of any central nervous system depressant.

(8) "Hospice" means a model of care that focuses on relieving symptoms and supporting patients with a life expectancy of six months or less((~~. Hospice involves an interdisciplinary approach to provide health care, pain management, and emotional and spiritual support. The emphasis is on comfort, quality of life and patient and family support. Hospice can be provided in the patient's home as well as freestanding hospice facilities, hospitals, nursing homes, or other long-term care facilities~~)).

(((~~(7)~~))) (9) "Hospital" means any institution, place, building, or agency licensed by the department under chapter 70.41 or 71.12 RCW, or designated under chapter 72.23 RCW to provide accommodations, facilities, and services over a continuous period of twenty-four hours or more, for observation, diagnosis, or care of two or more individuals not related to the operator who are suffering from illness, injury, deformity, abnormality, or from any other condition for which obstetrical, medical, or surgical services would be appropriate for care or diagnosis.

(10) "Low-risk" means a category of patient at low risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, and dose of opioids of less than a fifty milligram morphine equivalent dose.

(11) "Medication assisted treatment" or "MAT" means the use of pharmacologic therapy, often in combination with counseling and behavioral therapies, for the treatment of substance use disorders.

(12) "Moderate-risk" means a category of patient at a moderate risk of opioid-induced morbidity or mortality, based on factors and combinations of factors such as medical and behavioral comorbidities, polypharmacy, past history of substance use disorder or abuse, aberrant behavior, and dose of opioids between fifty and ninety milligram morphine equivalent doses.

(13) "Morphine equivalent dose" or "MED" means a conversion of various opioids to a morphine equivalent dose by the use of accepted conversion tables.

(((~~(8)~~))) (14) "Multidisciplinary pain clinic" means a ((~~clinic or office~~)) facility that provides comprehensive pain management and ((~~may~~)) includes care provided by multiple available disciplines, practitioners, or treatment modalities((~~; for example, physicians, physician assistants, osteopathic physicians, osteopathic physician assistants, advanced registered nurse practitioners, physical therapy, occupational therapy, or other complementary therapies~~)).

(((~~(9)~~))) (15) "Nonoperative pain" means acute pain which does not occur as a result of surgery.

(16) "Opioid analgesic" or "opioid" means a drug that is either an opiate derived from the opium poppy or opiate-like that is a semi-synthetic or synthetic drug. Examples include morphine, codeine, hydrocodone, oxycodone, fentanyl, meperidine, and methadone.

(17) "Palliative" means care that improves the quality of life of patients and their families facing serious, advanced, or life-threatening illness. With palliative care particular attention is given to the prevention, assessment, and treatment of pain and other symptoms, and to the provision of psychological, spiritual, and emotional support.

(18) "Pain" means an unpleasant sensory or emotional experience associated with actual or potential tissue damage, or described in terms of such damage.

(19) "Perioperative pain" means acute pain that occurs as the result of surgery.

(20) "Prescription monitoring program" or "PMP" means the Washington state prescription monitoring program authorized under chapter 70.225 RCW.

(21) "Practitioner" means an advanced registered nurse practitioner licensed under chapter 18.79 RCW, a dentist licensed under chapter 18.32 RCW, a physician licensed under chapter 18.71 or 18.57 RCW, a physician assistant licensed under chapter 18.71A or 18.57A RCW, or a podiatric physician licensed under chapter 18.22 RCW.

(22) "Subacute pain" is considered to be a continuation of pain, of six to twelve weeks in duration.

(23) "Substance use disorder" means a primary, chronic, neurobiological disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. Substance use disorder is not the same as physical dependence or tolerance characterized by behaviors that include, but are not limited to, impaired control over drug use, craving, compulsive use, or continued use despite harm.

NEW SECTION

WAC 246-854-255 Patient notification, secure storage, and disposal. (1) The osteopathic physician assistant shall provide information to the patient educating them of risks associated with the use of opioids as appropriate to the medical condition, type of patient, and phase of treatment. The osteopathic physician assistant shall document such notification in the patient record.

(2) Patient notification must occur, at a minimum, at the following points of treatment:

(a) The first issuance of a prescription for an opioid; and

(b) The transition between phases of treatment, as follows:

(i) Acute nonoperative pain or acute perioperative pain to subacute pain; and

(ii) Subacute pain to chronic pain.

(3) Patient notification must include information regarding:

(a) The safe and secure storage of opioid prescriptions; and

(b) The proper disposal of unused opioid medications including, but not limited to, the availability of recognized drug take-back programs.

NEW SECTION

WAC 246-854-260 Use of alternative modalities for pain treatment. The osteopathic physician assistant shall consider multimodal pharmacologic and nonpharmacologic therapy for pain rather than defaulting to the use of opioid therapy alone whenever reasonable, evidence-based, clinically appropriate alternatives exist. An osteopathic physician assistant may combine opioids with other medications and treatments including, but not limited to, acetaminophen, acupuncture, chiropractic, cognitive behavior therapy, nonsteroidal anti-inflammatory drugs (NSAIDs), osteopathic manipulative treatment, physical therapy, massage, or sleep hygiene.

NEW SECTION

WAC 246-854-265 Continuing education requirements for opioid prescribing. (1) In order to prescribe an opioid in Washington state, an osteopathic physician assistant licensed to prescribe opioids shall complete a one-time continuing education requirement regarding best practices in the prescribing of opioids and the current opioid prescribing rules in this chapter. The continuing education must be at least one hour in length.

(2) The osteopathic physician assistant shall complete the one-time continuing education requirement described in subsection (1) of this section by the end of the osteopathic physician assistant's first full continuing education reporting period after January 1, 2019, or during the first full continuing education reporting period after initial licensure, whichever is later.

(3) The continuing education required under this section counts toward meeting any applicable continuing education requirements.

OPIOID PRESCRIBING—ACUTE NONOPERATIVE PAIN AND ACUTE PERIOPERATIVE PAIN

NEW SECTION

WAC 246-854-270 Patient evaluation and patient record. Prior to prescribing opioids for acute nonoperative pain or acute perioperative pain, the osteopathic physician assistant shall:

(1) Conduct and document an appropriate history and physical examination, including screening for risk factors for overdose and severe postoperative pain;

(2) Evaluate the nature and intensity of the pain or anticipated pain following surgery; and

(3) Inquire about any other medications the patient is prescribed or is taking, including date, type, dosage, and quantity prescribed.

NEW SECTION

WAC 246-854-275 Treatment plan—Acute nonoperative pain. The osteopathic physician assistant shall comply with the requirements in this section when prescribing opioid analgesics for acute nonoperative pain and shall document completion of these requirements in the patient record:

(1) The osteopathic physician assistant shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-854-260, unless not clinically appropriate.

(2) The osteopathic physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-854-370 to identify any Schedule II-V medications or drugs of concern received by the patient and document their review and any concerns.

(3) If the osteopathic physician assistant prescribes opioids for effective pain control, such prescription must not be in a quantity greater than needed for the expected duration of pain severe enough to require opioids.

(a) A three-day supply or less will often be sufficient.

(b) More than a seven-day supply will rarely be needed.

(c) The osteopathic physician assistant shall not prescribe beyond a seven-day supply without clinical documentation in the patient record to justify the need for such a quantity.

(4) The osteopathic physician assistant shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician assistant shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

(5) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations to investigate causes of continued acute nonoperative pain or other treatments.

(6) Long-acting or extended release opioids are not indicated for acute nonoperative pain. Should an osteopathic physician assistant need to prescribe a long-acting opioid for acute pain, the osteopathic physician assistant must document the reason in the patient record.

(7) An osteopathic physician assistant shall not discontinue medication assistant treatment medications when treating acute pain, except as consistent with the provisions of WAC 246-854-360.

(8) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six-week time period of acute nonoperative pain, the osteopathic physician assistant shall document in the patient record that the patient is transitioning from acute pain to subacute pain. Rules governing the treatment of subacute pain in WAC 246-854-285 and 246-854-290 shall apply.

NEW SECTION

WAC 246-854-280 Treatment plan—Acute perioperative pain. The osteopathic physician assistant shall comply with the requirements in this section when prescribing opioid analgesics for perioperative pain and shall document completion of these requirements in the patient record:

(1) The osteopathic physician assistant shall consider prescribing nonopioid analgesics as the first line of pain control in patients in accordance with the provisions of WAC 246-854-260, unless not clinically appropriate.

(2) The osteopathic physician assistant, or their designee, shall conduct queries of the PMP in accordance with the provisions of WAC 246-854-370 to identify any Schedule II-V medications or drugs of concern received by the patient and document in the patient record their review and any concerns.

(3) If the osteopathic physician assistant prescribes opioids for effective pain control, such prescription shall be in no greater quantity than needed for the expected duration of pain severe enough to require opioids.

(a) A three-day supply or less will often be sufficient.

(b) More than a fourteen-day supply will rarely be needed for perioperative pain.

(c) The osteopathic physician assistant shall not prescribe beyond a fourteen-day supply from the time of discharge without clinical documentation in the patient record to justify the need for such a quantity. For more specific best practices, the osteopathic physician assistant may refer to clinical practice guidelines.

(4) The osteopathic physician assistant shall reevaluate a patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician assistant shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated.

(5) Follow-up visits for pain control should include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations or other treatments.

(6) If the osteopathic physician assistant elects to prescribe a combination of opioids with a medication listed in WAC 246-854-355 or to a patient known to be receiving a medication listed in WAC 246-854-355 from another practitioner, the osteopathic physician assistant must prescribe in accordance with WAC 246-854-355.

(7) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six-week time period of acute perioperative pain, the osteopathic physician assistant shall document in the patient record that the patient is transitioning from acute to subacute pain. Rules governing the treatment of subacute pain in WAC 246-854-285 and 246-854-290 shall apply unless there is documented improvement in function or pain control and there is a documented plan and timing for discontinuation of all opioid medications.

OPIOID PRESCRIBING—SUBACUTE PAIN

NEW SECTION

WAC 246-854-285 Patient evaluation and patient record. The osteopathic physician assistant shall comply with the requirements in this section when prescribing opioid analgesics for subacute pain and shall document completion of these requirements in the patient record.

(1) Prior to prescribing opioids for subacute pain, the osteopathic physician assistant shall:

(a) Conduct an appropriate history and physical examination or review, and update the patient's existing history and examination taken during the acute nonoperative or acute perioperative phase;

(b) Evaluate the nature and intensity of the pain;

(c) Inquire regarding other medications the patient is prescribed or taking, including date, type, dosage, and quantity prescribed;

(d) Conduct, or cause their designee to conduct, a query of the PMP in accordance with the provisions of WAC 246-854-370 to identify any Schedule II-V medications or drugs of concern received by the patient and document the review for any concerns;

(e) Screen and document the patient's potential for high-risk behavior and adverse events related to opioid therapy. If the osteopathic physician assistant determines the patient is high-risk, consider lower dose therapy, shorter intervals between prescriptions, more frequent visits, increased biological specimen testing, and prescribing rescue naloxone;

(f) Obtain a biological specimen test if the patient's function is deteriorating or if pain is escalating; and

(g) Screen or refer the patient for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety.

(2) The osteopathic physician assistant treating a patient for subacute pain with opioids shall ensure that, at a minimum, the following are documented in the patient record:

(a) The presence of one or more recognized diagnoses or indications for the use of opioid pain medication;

(b) The observed significant and documented improvement in function or pain control forming the basis to continue prescribing opioid analgesics beyond the acute pain episode;

(c) The results of any queries of the PMP and any concerns the osteopathic physician assistant has;

(d) All medications the patient is known to be prescribed or taking;

(e) An appropriate pain treatment plan including, the consideration of, or attempts to use, nonpharmacological modalities and nonopioid therapy;

(f) Results of any aberrant biological specimen testing and the risk-benefit analysis if opioids are to be continued;

(g) Results of screening or referral for further consultation for psychosocial factors which may be impairing recovery including, but not limited to, depression or anxiety;

(h) Results of screening for the patient's level of risk for aberrant behavior and adverse events related to opioid therapy;

(i) The risk-benefit analysis of any combination of prescribed opioid and benzodiazepines or sedative-hypnotics, if applicable; and

(j) All other required components of the patient record, as established in statute or rule.

(3) Follow-up visits for pain control must include objectives or metrics to be used to determine treatment success if opioids are to be continued. This includes, at a minimum:

(a) Change in pain level;

(b) Change in physical function;

(c) Change in psychosocial function; and

(d) Additional planned diagnostic evaluations or other treatments.

NEW SECTION

WAC 246-854-290 Treatment plan—Subacute pain. (1) The osteopathic physician assistant shall recognize the progression of a patient from the acute nonoperative or acute perioperative phase to the subacute phase and take into consideration the risks and benefits of continued opioid prescribing for the patient.

(2) If tapering has not begun prior to the six- to twelve-week subacute phase, the osteopathic physician assistant shall reevaluate the patient who does not follow the expected course of recovery. If significant and documented improvement in function or pain control has not occurred, the osteopathic physician assistant shall reconsider the continued use of opioids or whether tapering or discontinuing opioids is clinically indicated. The osteopathic physician assistant shall make reasonable attempts to discontinue the use of opioids prescribed for the acute pain event by no later than the twelve-week conclusion of the subacute phase.

(3) If the osteopathic physician assistant prescribes opioids for effective pain control, such prescription must not be in no greater quantity than needed for the expected duration of pain severe enough to require opioids. The osteopathic physician assistant shall not prescribe beyond a fourteen-day supply of opioids without clinical documentation to justify the need for such a quantity during the subacute phase.

(4) If the osteopathic physician assistant elects to prescribe a combination of opioids with a medication listed in WAC 246-854-355 or prescribes opioids to a patient known to be receiving a medication listed in WAC 246-854-355 from another practitioner, the osteopathic physician assistant shall prescribe in accordance with WAC 246-854-355.

(5) If the osteopathic physician assistant elects to treat a patient with opioids beyond the six- to twelve-week subacute phase, the osteopathic physician assistant shall document in the patient record that the patient is transitioning from subacute pain to chronic pain. Rules governing the treatment of chronic pain in WAC 246-854-295 through 246-854-340, shall apply.

OPIOID PRESCRIBING—CHRONIC PAIN MANAGEMENT

NEW SECTION

WAC 246-854-295 Patient evaluation and patient record. (1) For the purposes of this section, "risk assessment tool" means professionally developed, clinically accepted questionnaires appropriate for identifying a patient's level of risk for substance abuse or misuse.

(2) The osteopathic physician assistant shall evaluate and document the patient's health history and physical examination in the patient record prior to treating for chronic pain.

(a) History. The patient's health history must include:

(i) The nature and intensity of the pain;

(ii) The effect of pain on physical and psychosocial function;

(iii) Current and past treatments for pain, including medications and their efficacy;

(iv) Review of any significant comorbidities;

(v) Any current or historical substance use disorder;

(vi) Current medications and, as related to treatment of pain, the efficacy of medications tried; and

(vii) Medication allergies.

(b) Evaluation. The patient evaluation prior to opioid prescribing must include:

(i) Appropriate physical examination;

(ii) Consideration of the risks and benefits of chronic pain treatment for the patient;

(iii) Medications the patient is taking including indication(s), date, type, dosage, quantity prescribed, and, as related to treatment of the pain, efficacy of medications tried;

(iv) Review of the PMP to identify any Schedule II-V medications or drugs of concern received by the patient in accordance with the provisions of WAC 246-854-370;

(v) Any available diagnostic, therapeutic, and laboratory results;

(vi) Use of a risk assessment tool and assignment of the patient to a high, moderate, or low-risk category. The osteopathic physician assistant should use caution and shall monitor a patient more frequently when prescribing opioid analgesics to a patient identified as high-risk;

(vii) Any available consultations, particularly as related to the patient's pain;

(viii) Pain related diagnosis, including documentation of the presence of one or more recognized indications for the use of pain medication;

(ix) Treatment plan and objectives including:

(A) Documentation of any medication prescribed;

(B) Biologic specimen testing ordered; and

(C) Any labs or imaging ordered.

(x) Written agreements, also known as a "pain contract," for treatment between the patient and the osteopathic physician assistant; and

(xi) Patient counseling concerning risks, benefits, and alternatives to chronic opioid therapy.

NEW SECTION

WAC 246-854-300 Treatment plan. (1) When the patient enters the chronic pain phase, the osteopathic physician assistant shall reevaluate the patient by treating the situation as a new disease.

(2) The chronic pain treatment plan must state the objectives that will be used to determine treatment success and must include, at a minimum:

(a) Any change in pain relief;

(b) Any change in physical and psychosocial function; and

(c) Additional diagnostic evaluations or other planned treatments.

(3) After treatment begins, the osteopathic physician assistant shall adjust drug therapy to the individual health needs of the patient.

(4) The osteopathic physician assistant shall complete patient notification in accordance with the provisions of WAC 246-854-255.

NEW SECTION

WAC 246-854-305 Written agreement for treatment. The osteopathic physician assistant shall use a written agreement for treatment with the patient who requires long-term opioid therapy for chronic pain that outlines the patient's responsibilities. This written agreement for treatment must include:

(1) The patient's agreement to provide biological samples for biological specimen testing when requested by the osteopathic physician assistant;

(2) The patient's agreement to take medications at the dose and frequency prescribed with a specific protocol for lost prescriptions and early refills or renewals;

(3) Reasons for which opioid therapy may be discontinued including, but not limited to, the patient's violation of an agreement;

(4) The requirement that all chronic opioid prescriptions are provided by a single prescriber, single clinic, or a multidisciplinary pain clinic;

(5) The requirement that all chronic opioid prescriptions are to be dispensed by a single pharmacy or pharmacy system whenever possible;

(6) The patient's agreement to not abuse substances that can put the patient at risk for adverse outcomes;

(7) A written authorization for:

(a) The osteopathic physician assistant to release the agreement for treatment to:

(i) Local emergency departments;

(ii) Urgent care facilities;

(iii) Other practitioners caring for the patient who might prescribe pain medications; and

(iv) Pharmacies.

(b) The osteopathic physician assistant to release the agreement to other practitioners so other practitioners can report violations of the agreement to the osteopathic physician assistant treating the patient's chronic pain and to the PMP.

(8) Acknowledgment that it is the patient's responsibility to safeguard all medications and keep them in a secure location; and

(9) Acknowledgment that if the patient violates the terms of the agreement, the violation and the osteopathic physician assistant's response to the violation will be documented, as well as the rationale for changes in the treatment plan.

For the purposes of this section, "refill" means a second or subsequent filling of a previously issued prescription that is authorized to be dispensed when the patient has exhausted their current supply. For the purposes of WAC 246-854-240 through 246-854-370, refills are subject to the same limitations and requirements as initial prescriptions.

NEW SECTION

WAC 246-854-310 Periodic review. (1) The osteopathic physician assistant shall periodically review the course of treatment for chronic pain. The osteopathic physician assistant shall base the frequency of visits, biological testing, and PMP queries, in accordance with the provisions of WAC 246-854-370 on the patient's risk category:

(a) For a high-risk patient, at least quarterly;

(b) For a moderate-risk patient, at least semiannually;

(c) For a low-risk patient, at least annually;

(d) Immediately upon indication of concerning or aberrant behavior; and

(e) More frequently at the osteopathic physician assistant's discretion.

(2) During the periodic review, the osteopathic physician assistant shall determine:

(a) The patient's compliance with any medication treatment plan;

(b) If pain, function, or quality of life have improved, diminished, or are maintained using objective evidence; and

(c) If continuation or modification of medications for pain management treatment is necessary based on the osteopathic physician assistant's evaluation of progress towards treatment objectives.

(3) Periodic patient evaluations must also include:

(a) History and physical exam related to the pain;

(b) Use of validated tools to document either maintenance of function and pain control or improvement in function and pain level; and

(c) Review the PMP to identify any Schedule II-V medications or drugs of concern received by the patient at a frequency determined by the patient's risk category, and otherwise in accordance with the provisions of WAC 246-854-370 and subsection (1) of this section.

(4) The osteopathic physician assistant shall assess the appropriateness of continued use of the current treatment plan if the patient's progress or compliance with the current

treatment plan is unsatisfactory. The osteopathic physician assistant shall consider tapering, changing, or discontinuing treatment in accordance with the provisions of WAC 246-854-335.

NEW SECTION

WAC 246-854-315 Consultation—Recommendations and requirements. (1) The osteopathic physician assistant shall consider referring the patient for additional evaluation and treatment as needed to achieve treatment objectives. Special attention should be given to those chronic pain patients who are under eighteen years of age or who are potential high-risk patients. The management of pain in patients with a history of substance abuse or with comorbid psychiatric disorders may require extra care, monitoring, documentation, and consultation with, or referral to, an expert in the management of such patients.

(2) The mandatory consultation threshold is one hundred twenty milligrams MED. Unless the consultation is exempted under WAC 246-854-320 or 246-854-325, an osteopathic physician assistant who prescribes a dosage amount that meets or exceeds the mandatory consultation threshold must comply with the pain management specialist consultation requirements described in WAC 246-854-330. The mandatory consultation must consist of at least one of the following:

(a) An office visit with the patient and the pain management specialist;

(b) A consultation between the pain management specialist and the osteopathic physician assistant;

(c) An audio-visual evaluation conducted by the pain management specialist remotely, where the patient is present with either the osteopathic physician assistant or with a licensed health care practitioner designated by the osteopathic physician assistant or the pain management specialist; or

(d) Other chronic pain evaluation services as approved by the board.

(3) The osteopathic physician assistant shall document in the patient record each consultation with the pain management specialist. If the pain management specialist provides a written record of the consultation to the osteopathic physician assistant, the osteopathic physician assistant shall maintain it as part of the patient record.

(4) The osteopathic physician assistant shall use great caution when prescribing opioids to children or adolescents with chronic pain; appropriate referral to a specialist is encouraged.

NEW SECTION

WAC 246-854-320 Consultation—Exemptions for exigent and special circumstances. An osteopathic physician assistant is not required to consult with a pain management specialist as defined in WAC 246-854-330 when the osteopathic physician assistant has documented adherence to all standards of practice as defined in WAC 246-854-295 through 246-854-340, and when one or more of the following conditions are met:

(1) The patient is following a tapering schedule;

(2) The patient requires treatment for acute pain, which may or may not include hospitalization, requiring a temporary escalation in opioid dosage with expected return to their baseline dosage level or below;

(3) The osteopathic physician assistant documents reasonable attempts to obtain a consultation with a pain management specialist and the circumstances justifying prescribing above one hundred twenty MED per day without first obtaining a consultation; or

(4) The osteopathic physician assistant documents the patient's pain and function is stable and the patient is on a nonescalating dosage of opioids.

NEW SECTION

WAC 246-854-325 Consultation—Exemptions for the osteopathic physician assistant. An osteopathic physician assistant is exempt from the consultation requirement in WAC 246-854-315 if one or more of the following qualifications are met:

(1) The osteopathic physician assistant is a pain management specialist under WAC 246-854-330;

(2) The osteopathic physician assistant has successfully completed every four years a minimum of twelve continuing education hours on chronic pain management approved by the profession's continuing education accrediting organizations. At least two of these hours must be in substance use disorders;

(3) The osteopathic physician assistant is a pain management practitioner working in a multidisciplinary chronic pain treatment center or a multidisciplinary academic research facility; or

(4) The osteopathic physician assistant has a minimum of three years clinical experience in a chronic pain management setting, and at least thirty percent of their current practice is the direct provision of pain management care.

NEW SECTION

WAC 246-854-330 Pain management specialist. A pain management specialist shall meet one or more of the following qualifications:

(1) An osteopathic physician assistant shall have a delegation agreement with a physician pain management specialist and meet all of the following educational requirements and practice requirements:

(a) A minimum of three years clinical experience in a chronic pain management care setting;

(b) Credentialed in pain management by an entity approved by the Washington state board of osteopathic medicine and surgery for an osteopathic physician assistant;

(c) Successful completion of a minimum of at least eighteen continuing education hours in pain management during the past two years; and

(d) At least thirty percent of the osteopathic physician assistant's current practice is the direct provision of pain management care or is in a multidisciplinary pain clinic.

(2) An osteopathic physician shall meet requirements in WAC 246-853-750.

(3) An allopathic physician shall meet requirements in WAC 246-919-945.

(4) An allopathic physician assistant shall meet requirements in WAC 246-918-895.

(5) A dentist shall meet requirements in WAC 246-817-965.

(6) An advanced registered nurse practitioner (ARNP) shall meet requirements in WAC 246-840-493.

(7) A podiatric physician shall meet requirements in WAC 246-922-750.

NEW SECTION

WAC 246-854-335 Tapering requirements. (1) The osteopathic physician assistant shall assess and document the appropriateness of continued use of the current treatment plan if the patient's response to or compliance with the current treatment is unsatisfactory.

(2) The osteopathic physician assistant shall consider tapering, changing, discontinuing treatment, or referral for a substance use disorder evaluation when:

(a) The patient requests;

(b) The patient experiences a deterioration in function or pain;

(c) The patient is noncompliant with the written agreement;

(d) Other treatment modalities are indicated;

(e) There is evidence of misuse, abuse, substance use disorder, or diversion;

(f) The patient experiences a severe adverse event or overdose;

(g) There is unauthorized escalation or doses; or

(h) The patient is receiving an escalation in opioid dosage with no improvement in pain, function, or quality of life.

NEW SECTION

WAC 246-854-340 Patients with chronic pain, including those on high doses, establishing a relationship with a new practitioner. (1) When a patient receiving chronic opioid pain medications changes to a new practitioner, it is normally appropriate for the new practitioner to initially maintain the patient's current opioid doses. Over time, the practitioner may evaluate if any tapering or other adjustments in the treatment plan can or should be done.

(2) An osteopathic physician assistant's treatment of a new high-dose chronic pain patient is exempt from the mandatory consultation requirements of WAC 246-854-315 and the tapering requirements of WAC 246-854-335 if:

(a) The patient was previously being treated with a dosage of opioids in excess of one hundred twenty milligrams MED for chronic pain under an established written agreement for treatment of the same chronic condition or conditions;

(b) The patient's dose is stable and nonescalating;

(c) The patient has a demonstrated history in their record of compliance with treatment plans and written agreements as documented by medical records and PMP queries; and

(d) The patient has documented functional stability, pain control, or improvements in function or pain control, at the dose in excess of one hundred twenty milligrams MED.

(3) With respect to the treatment of a new patient under subsection (1) or (2) of this section, this exemption applies for the first three months of newly established care, after which the requirements of WAC 246-854-315 and 246-854-335 shall apply.

OPIOID PRESCRIBING—SPECIAL POPULATIONS

NEW SECTION

WAC 246-854-345 Special populations—Patients twenty-five years of age or under, pregnant patients, and aging populations. (1) Patients twenty-five years of age or under. In the treatment of pain for patients twenty-five years of age or under, the osteopathic physician assistant shall treat pain in a manner equal with that of an adult but must account for the weight of the patient and reduce the dosage prescribed accordingly.

(2) Pregnant patients. The osteopathic physician assistant shall not discontinue the use of MAT opioids, such as methadone or buprenorphine, by a pregnant patient without oversight by the MAT prescribing practitioner. The osteopathic physician assistant shall weigh carefully the risks and benefits of opioid detoxification during pregnancy.

(3) Aging populations. As people age, their tolerance and metabolizing of opioids may change. The osteopathic physician assistant shall consider the distinctive needs of patients who are sixty-five years of age or older and who have been on chronic opioid therapy or who are initiating opioid treatment.

NEW SECTION

WAC 246-854-350 Episodic care of chronic opioid patients. (1) When providing episodic care for a patient who the osteopathic physician assistant knows is being treated with opioids for chronic pain, such as for emergency or urgent care, the osteopathic physician assistant shall review the PMP to identify any Schedule II-V or drugs of concern received by the patient and document in the patient record their review and any concerns.

(2) An osteopathic physician assistant providing episodic care to a patient who the osteopathic physician assistant knows is being treated with opioids for chronic pain should provide additional opioids to be equal to the severity of the acute pain. If opioids are provided, the osteopathic physician assistant shall limit the use of opioids to the minimum amount necessary to control the acute nonoperative pain, acute perioperative pain, or similar acute exacerbation of pain until the patient can receive care from the practitioner who is managing the patient's chronic pain treatment.

(3) The osteopathic physician assistant providing episodic care shall report known violations of the patient's written agreement to the patient's treatment practitioner who provided the agreement for treatment, when reasonable.

(4) The osteopathic physician assistant providing episodic care shall coordinate care with the patient's chronic pain treatment practitioner if that person is known to the osteopathic physician assistant providing episodic care, when reasonable.

(5) For the purposes of this section, "episodic care" means medical care provided by a practitioner other than the designated primary practitioner in the acute care setting; for example, urgent care or emergency department.

OPIOID PRESCRIBING—COPRESCRIBING

NEW SECTION

WAC 246-854-355 Coprescribing of opioids with certain medications. (1) The osteopathic physician assistant must not knowingly prescribe opioids in combination with the following Schedule II-IV medications without documentation in the patient record of clinical judgment:

(a) Benzodiazepines;

(b) Barbiturates;

(c) Sedatives;

(d) Carisoprodol; or

(e) Sleeping medications, also known as Z drugs.

(2) If a patient receiving an opioid prescription is known to be concurrently prescribed one or more of the medications listed in subsection (1) of this section, the osteopathic physician assistant prescribing opioids shall consult with the other prescriber(s) to establish a patient care plan for the use of the medications concurrently or consider whether one of the medications should be tapered.

NEW SECTION

WAC 246-854-360 Coprescribing of opioids for patients receiving medication assisted treatment. (1) Where practicable, the osteopathic physician assistant providing acute nonoperative pain or acute perioperative pain treatment to a patient known to be receiving MAT shall prescribe opioids for pain relief either in consultation with the MAT prescribing practitioner or pain specialist.

(2) The osteopathic physician assistant shall not discontinue MAT medications when treating acute nonoperative pain or acute perioperative pain without documentation of the reason for doing so, nor shall use of these medications be used to deny necessary intervention.

NEW SECTION

WAC 246-854-365 Coprescribing of naloxone. (1) The osteopathic physician assistant shall confirm or provide a current prescription for naloxone when high-dose opioids are prescribed.

(2) The osteopathic physician assistant should counsel and provide an option for a current prescription for naloxone to patients being prescribed opioids as clinically indicated.

OPIOID PRESCRIBING—PRESCRIPTION MONITORING PROGRAM

NEW SECTION

WAC 246-854-370 Prescription monitoring program—Required registration, queries, and documentation. (1) The osteopathic physician assistant shall register to access the PMP or demonstrate proof of having registered to access the PMP if they prescribe opioids in Washington state.

(2) The osteopathic physician assistant may delegate the retrieval of a required PMP query to an authorized designee, in accordance with WAC 246-470-050.

(3) At a minimum, the osteopathic physician assistant shall ensure a PMP query is performed prior to the issuance of any prescription of an opioid or a benzodiazepine.

(4) For the purposes of this section, the requirement to consult the PMP does not apply in situations when it cannot be accessed by the osteopathic physician assistant or their authorized designee due to a temporary technical or electrical failure.

(5) In cases of technical or electrical failure, the osteopathic physician assistant shall document in the patient record the date(s) and time(s) of attempts to access the PMP and shall check the PMP for that patient as soon as is practicable after the failure is resolved, but not later than the next prescription.

(6) Pertinent concerns discovered in the PMP shall be documented in the patient record.

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 246-854-243	Patient evaluation.
WAC 246-854-244	Treatment plan.
WAC 246-854-245	Informed consent.
WAC 246-854-246	Written agreement for treatment.
WAC 246-854-247	Periodic review.
WAC 246-854-248	Long-acting opioids, including methadone.
WAC 246-854-249	Episodic care.
WAC 246-854-250	Consultation—Recommendations and requirements.
WAC 246-854-251	Consultation—Exemptions for exigent and special circumstances.
WAC 246-854-252	Consultation—Exemptions for the osteopathic physician assistant.
WAC 246-854-253	Pain management specialist.

WSR 18-20-089
PERMANENT RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2018-03—Filed October 1, 2018, 2:24 p.m., effective November 1, 2018]

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

Purpose: WAC 284-36-010 cites RCW 48.36.410 which has been repealed. This rule amends this citation to reference the current statute, RCW 48.36A.390.

Citation of Rules Affected by this Order: Amending WAC 284-36-010.

Statutory Authority for Adoption: RCW 48.02.060.

Adopted under notice filed as WSR 18-17-144 on August 21, 2018.

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 the 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: October 1, 2018.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Order R 75-5, filed 10/22/75)

WAC 284-36-010 Application. This regulation, WAC 284-36-010 through 284-36-040, shall apply only as to domestic fraternal mutual property insurers, as defined in RCW ((~~48.36.410~~)) 48.36A.040 and 48.36A.390, and to any domestic stock insurer while it is a subsidiary of such a fraternal mutual property insurer.

WSR 18-20-090
PERMANENT RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2018-02—Filed October 1, 2018, 2:25 p.m., effective January 1, 2019]

Effective Date of Rule: January 1, 2019.

Purpose: Adoption of rules consistent with the National Association of Insurance Commissioners' corporate governance annual disclosure model rule.

Citation of Rules Affected by this Order: New 5 [WAC 284-07-700, 284-07-710, 284-07-720, 284-07-730, and 284-07-740].

Statutory Authority for Adoption: RCW 48.02.060 and 48.195.030.

Other Authority: Chapter 48.195 RCW.

Adopted under notice filed as WSR 18-16-033 on July 24, 2018.

Changes Other than Editing from Proposed to Adopted Version: The citations to session law enacting the Corporate Governance Act contained in the proposed rule have been amended to the codified RCW citations.

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 5, Amended 0, Repealed 0.

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

Number of Sections Adopted on the Agency's own Initiative: New 5, 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 5, Amended 0, Repealed 0.

Date Adopted: October 1, 2018.

Mike Kreidler
Insurance Commissioner

CORPORATE GOVERNANCE ANNUAL DISCLOSURE

NEW SECTION

WAC 284-07-700 Purpose. The purpose of WAC 284-07-700 through 284-07-740 is to set forth the procedures for filing and the required contents of the corporate governance annual disclosure (CGAD), deemed necessary by the commissioner to carry out the provisions of chapter 48.195 RCW.

NEW SECTION

WAC 284-07-710 Definitions. The definitions in this section apply throughout WAC 284-07-720 through 284-07-730 unless the context clearly requires otherwise.

(1) "Commissioner" means the insurance commissioner of this state.

(2) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in RCW 48.31B.005.

(3) "Insurer" has the same meaning as set forth in RCW 48.31B.005, except that it does not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(4) "Senior management" means any corporate officer responsible for reporting information to the board of directors at regular intervals or providing this information to shareholders or regulators and shall include, for example and without limitation, the chief executive officer (CEO), chief financial officer (CFO), chief operations officer (COO), chief procurement officer (CPO), chief legal officer (CLO), chief information officer (CIO), chief technology officer (CTO), chief revenue officer (CRO), chief visionary officer (CVO), or any other "C" level executive.

NEW SECTION

WAC 284-07-720 Filing procedures. (1) An insurer, or the insurance group of which the insurer is a member, required to file a CGAD by chapter 48.195 RCW, must annually, no later than June 1st, submit to the commissioner a CGAD that contains the information described in WAC 284-07-730.

(2) The CGAD must include a signature of the insurer's or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer or insurance group has implemented the corporate governance practices and that a copy of the CGAD has been provided to the insurer's or insurance group's board of directors (hereafter "board") or the appropriate committee thereof.

(3) The insurer or insurance group has discretion regarding the appropriate format for providing the information required by WAC 284-07-700 through 284-07-730 and is permitted to customize the CGAD to provide the most relevant information necessary to permit the commissioner to gain an understanding of the corporate structure, policies and practices utilized by the insurer or insurance group.

(4) For purposes of completing the CGAD, the insurer or insurance group may choose to provide information on governance activities that occur at either: (a) The ultimate controlling parent level; (b) an intermediate holding company level; or (c) the individual legal entity level, or any combination of (a), (b), or (c) of this subsection, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it must indicate which of the three criteria was used to determine the level of reporting and explain any subsequent changes in level of reporting.

(5) Notwithstanding subsection (1) of this section, and as outlined in RCW 48.195.020, if the CGAD is completed at the insurance group level, then it must be filed with the lead state of the group as determined by the procedures outlined in the most recent financial analysis handbook adopted by the National Association of Insurance Commissioners. In these instances, a copy of the CGAD must also be provided to the chief regulatory official of any state in which the insurance group has a domestic insurer, upon request.

(6) An insurer or insurance group may comply with this section by referencing other existing documents (e.g., ORSA summary report, Holding Company Form B or F filings, Securities and Exchange Commission (SEC) proxy statements, foreign regulatory reporting requirement, etc.) if the documents provide information that is comparable to the information described in WAC 284-07-730. The insurer or insurance group must clearly reference the location of the relevant information within the CGAD and attach the referenced document if it is not already filed or available to the commissioner.

(7) Annually following the initial filing of the CGAD, the insurer or insurance group must file an amended version of the previously filed CGAD indicating where changes have been made. If no changes were made in the information or activities reported by the insurer or insurance group, the filing must so state.

NEW SECTION

WAC 284-07-730 Contents of corporate governance annual disclosure. (1) The insurer or insurance group must be as descriptive as possible in completing the CGAD, with inclusion of attachments or example documents that are used in the governance process, since these may provide a means to demonstrate the strengths of their governance framework and practices.

(2) The CGAD must describe the insurer's or insurance group's corporate governance framework and structure including consideration of the following:

(a) The board and various committees thereof ultimately responsible for overseeing the insurer or insurance group and the level(s) at which that oversight occurs (e.g., ultimate control level, intermediate holding company, legal entity, etc.). The insurer or insurance group must describe and discuss the rationale for the current board size and structure; and

(b) The duties of the board and each of its significant committees and how they are governed (e.g., bylaws, charters, informal mandates, etc.), as well as how the board's leadership is structured, including a discussion of the roles of chief executive officer (CEO) and chairman of the board within the organization.

(3) The insurer or insurance group must describe the policies and practices of the most senior governing entity and significant committees thereof, including a discussion of the following factors:

(a) How the qualifications, expertise and experience of each board member meet the needs of the insurer or insurance group;

(b) How an appropriate amount of independence is maintained on the board and its significant committees;

(c) The number of meetings held by the board and its significant committees over the past year as well as information on director attendance;

(d) How the insurer or insurance group identifies, nominates and elects members to the board and its committees. The discussion must include, for example:

(i) Whether a nomination committee is in place to identify and select individuals for consideration;

(ii) Whether term limits are placed on directors;

(iii) How the election and reelection process function; and

(iv) Whether a board diversity policy is in place and if so, how it functions.

(e) The processes in place for the board to evaluate its performance and the performance of its committees, as well as any recent measures taken to improve performance (including any board or committee training programs that have been put into place).

(4) The insurer or insurance group must describe the policies and practices for directing senior management, including a description of the following factors:

(a) Any processes or practices (i.e., suitability standards) to determine whether officers and key persons in control functions have the appropriate background, experience and integrity to fulfill their respective roles, including:

(i) Identification of the specific positions for which suitability standards have been developed and a description of the standards employed; and

(ii) Any changes in an officer's or key person's suitability as outlined by the insurer's or insurance group's standards and procedures to monitor and evaluate such changes.

(b) The insurer's or insurance group's code of business conduct and ethics, the discussion of which considers, for example:

(i) Compliance with laws, rules, and regulations; and

(ii) Proactive reporting of any illegal or unethical behavior.

(c) The insurer's or insurance group's processes for performance evaluation, compensation and corrective action to ensure effective senior management throughout the organization, including a description of the general objectives of significant compensation programs and what the programs are designed to reward. The description must include sufficient detail to allow the commissioner to understand how the organization ensures that compensation programs do not either encourage or reward, or both, excessive risk taking. Elements to be discussed may include, for example:

(i) The board's role in overseeing management compensation programs and practices;

(ii) The various elements of compensation awarded in the insurer's or insurance group's compensation programs and how the insurer or insurance group determines and calculates the amount of each element of compensation paid;

(iii) How compensation programs are related to both company and individual performance over time;

(iv) Whether compensation programs include risk adjustments and how those adjustments are incorporated into the programs for employees at different levels;

(v) Any clawback provisions built into the programs to recover awards or payments if the performance measures upon which they are based are restated or otherwise adjusted; and

(vi) Any other factors relevant in understanding how the insurer or insurance group monitors its compensation policies to determine its risk management objectives are met by incentivizing its employees.

(d) The insurer's or insurance group's plans for CEO and senior management succession.

(5) The insurer or insurance group must describe the processes by which the board, its committees and senior management ensure an appropriate amount of oversight to the critical risk areas impacting the insurer's business activities, including discussion of:

(a) How oversight and management responsibilities are delegated between the board, its committees and senior management;

(b) How the board is kept informed of the insurer's strategic plans, the associated risks, and steps senior management is taking to monitor and manage those risks;

(c) How reporting responsibilities are organized for each critical area. The description must allow the commissioner to understand the frequency at which information on each critical risk area is reported to and reviewed by senior management and the board. This description may include, for example, the follow critical risk areas of the insurer:

(i) Risk management processes (an ORSA summary report filer may refer to its ORSA summary report pursuant to the Risk Management and Own Risk and Solvency Assessment Act, chapter 48.05A RCW);

(ii) Actuarial function;

(iii) Investment decision-making processes;

(iv) Reinsurance decision-making processes;

(v) Business strategy/finance decision-making processes;

(vi) Compliance function;

(vii) Financial reporting/internal auditing; and

(viii) Market conduct decision-making processes.

NEW SECTION

WAC 284-07-740 Severability clause. If any provision of WAC 284-07-700 through 284-07-730, or the application to any person or circumstance is held invalid, the remainder of WAC 284-07-700 through 284-07-730 or the application of the provision to other persons or circumstances is not affected.

WSR 18-20-098
PERMANENT RULES
UTILITIES AND TRANSPORTATION COMMISSION

[Docket UE-171033, General Order R-595—Filed October 2, 2018, 8:58 a.m., effective November 2, 2018]

In the matter of adopting chapter 480-103 WAC relating to community solar companies.

1 **STATUTORY OR OTHER AUTHORITY:** The Washington utilities and transportation commission (commission) takes this action under Notice No. WSR 18-17-134, filed with the code reviser on August 20, 2018. The commission brings this proceeding pursuant to RCW 80.01.040 and 80.04.160**.**

2 **STATEMENT OF COMPLIANCE:** This proceeding complies with the Administrative Procedure Act (chapter 34.05 RCW), the State Register Act (chapter 34.08 RCW), the State Environmental Policy Act of 1971 (chapter 43.21C RCW), and the Regulatory Fairness Act (chapter 19.85 RCW).

3 **DATE OF ADOPTION:** The commission adopts this rule on the date the commission enters this order.

4 **CONCISE STATEMENT OF PURPOSE AND EFFECT OF THE RULE:** RCW 34.05.325(6) requires the commission to prepare and publish a concise explanatory statement about an adopted rule. The statement must identify the commission's reasons for adopting the rule, describe the differences between the version of the proposed rules published in the register and the rules adopted (other than editing changes), summarize the comments received regarding the proposed rule changes, and state the commission's responses to the comments reflecting the commission's consideration of them.

5 To avoid unnecessary duplication in the record of this docket, the commission designates the discussion in this order, including appendices, as its concise explanatory statement, supplemented where not inconsistent by the commission staff memoranda preceding the filing of the CR-102 proposal and the adoption hearing. Together, these documents provide a complete but concise explanation of the agency actions and its reasons for taking those actions.

6 **REFERENCE TO AFFECTED RULES**: This order adopts WAC 480-103-001 Purpose and application, 480-103-002 Definitions, 480-103-007 Administrators, 480-103-010 Registration and regulatory fees, 480-103-020 Registration as a community solar company, 480-103-030 Annual Reports and payment of regulatory fees, 480-103-040 Suspension and cancellation of a registration, 480-103-050 Disconnection of service, 480-103-100 Information to customers, project participants, and applicants, 480-103-105 Services and charges, 480-103-110 Community solar company personnel, 480-103-115 Application for participation in a community solar project, 480-103-120 Deposits, 480-103-125 Transfer of project participation, 480-103-130 Disclosure of private consumer information, 480-103-135 Complaints and disputes, 480-103-140 Electronic information, 480-103-145 Meter tests, 480-103-150 Retention and preservation of records and reports, 480-103-155 Reports of accidents, and 480-103-999 Adoption by reference.

7 **PREPROPOSAL STATEMENT OF INQUIRY AND ACTIONS THEREUNDER:** The commission filed a preproposal statement of inquiry (CR-101) on October 18, 2017, at WSR 17-21-097. The statement advised interested persons that the commission was initiating a rule making to consider establishing rules to govern community solar companies. The commission also informed persons of this inquiry by providing notice of the subject and the CR-101 to everyone on the commission's list of persons requesting such information pursuant to RCW 34.05.320(3) and by sending notice to all registered electric and gas companies, the commission's list of utility attorneys, and the interested persons in the last solar rule-making docket regarding interconnectivity, Docket UE-112133. Pursuant to the notice, the commission received comments on or about November 20, 2017, and held a workshop on March 6, 2018. The commission received additional comments on March 1, March 22, and July 26, 2018.

8 **SMALL BUSINESS ECONOMIC IMPACT ANALYSIS**: On June 28, 2018, the commission issued a small business economic impact questionnaire to all interested persons. The commission received no responses to this questionnaire. The commission has no evidence that the costs that companies will incur to comply with the proposed rules will be more than minor. Accordingly, no small business economic impact statement is required. In addition, the proposed rules implement statutory requirements and mirror existing processes for registering or certificating companies in the other industries the commission regulates. All costs to comply with the proposed rules, therefore, are the result of legislative requirements and are comparable to the costs other companies incur to comply with current commission practices and procedures.

9 **NOTICE OF PROPOSED RULE MAKING:** The commission filed a notice of proposed rule making (CR-102) on August 20, 2018, at WSR 18-17-134. The commission scheduled this matter for oral comment and adoption under Notice No. WSR 18-17-134 at 1:30 p.m., Wednesday, September 26, 2018, in the Commission's Hearing Room, Second Floor, Richard Hemstad Building, 1300 South Evergreen Park Drive S.W., Olympia, WA. The notice provided interested persons the opportunity to submit written comments to the commission by September 21, 2018.

10 **WRITTEN COMMENTS:** The commission received written comments from the public counsel unit of the office of the Washington attorney general (public counsel) and collectively from Spark Northwest, NW Energy Coalition, and Solar Installers of Washington (joint commenters). We summarize these comments and our responses in paragraphs 13-21 below.

11 **RULE-MAKING HEARING:** The commission considered the proposed rules for adoption at a rule-making hearing on Wednesday, September 26, 2018, before Chairman David W. Danner, Commissioner Ann E. Rendahl, and Commissioner Jay M. Balasbas. The commission heard oral comments from Gregory J. Kopta, administrative law judge, representing commission staff. Representatives from Spark Northwest, public counsel, and the Washington State University extension energy program (WSU energy program) also provided comments.

12 **SUGGESTIONS FOR CHANGES:** Written and oral comments suggested changes to the proposed rules. The commission will not make those changes for the reasons discussed below.

13 Public counsel reiterates comments it made on previous drafts of the proposed rules during the CR-101 process. Specifically, public counsel recommends in its written comments that the rules require an unambiguous disclosure of the type of services to which the participant is subscribing and that the commission maintain and post on its web site all community solar projects, programs, and services. At the hearing, public counsel added that it continues to recommend that the commission require companies to ensure that persons who sign contracts subscribing to their services be at least eighteen years old and have authority to bind the household.

14 We understand public counsel's concerns, but we do not find that they necessitate a change to the proposed rules. Proposed WAC 480-103-100(8) requires the community solar company to disclose "all material terms and conditions of participation in the company's community solar project." That subsection also contains an extensive, nonexclusive list of specific required disclosures, and subsection (n) requires disclosure of any other material terms and conditions. To the extent that the type of project or services is material, the rule thus already requires disclosure of that information. In addition, subsection (10) of this rule requires companies to "provide the commission with current copies of all of the company's disclosure forms, pamphlets, brochures, and bill inserts prior to delivering such materials to customers, project participants, or applicants." Commission staff, therefore, will ensure that those documents disclose all material terms and conditions, including the type of service to which a participant is subscribing.

15 Public counsel's recommendation that the rules prohibit companies from allowing minors to subscribe to their services is similarly unnecessary. Washington law already provides that persons must be at least eighteen years old "[t]o enter into any legal contractual obligation and to be legally bound thereby to the full extent as any other adult person."[1] Any contract a minor signs for participation in a community solar project or service thus would effectively be unenforceable under existing law. As public counsel suggests, however, commission staff will monitor complaints it receives

from consumers to determine whether companies are violating this law and if so, to recommend appropriate commission action.

[1] RCW 26.28.015(4). This statute also provides that minors may disaffirm any contracts they sign. RCW 26.28.030.

16 With respect to posting information on the commission's web site, community solar projects, programs, and services are still under development and do not yet exist. Community solar companies and investor-owned utilities will submit information regarding community solar projects, programs, and services in compliance with proposed WAC 480-103-030, and RCW 82.16.170(10) requires the commission to publish much of that information.[2] The experience the commission gains in implementing the statute and these rules will better enable the commission to determine the form and type of information that will be useful to include on the commission's web site. For the present, we do not find that the rules need to specify how or the extent to which the commission will maintain and publish a list of community solar projects, programs, and services.

[2] The statute requires the commission to "publish, without disclosing proprietary information, a list of the following: (a) Entities other than utilities, including affiliates or subsidiaries of utilities, that organize and administer community solar projects; and (b) community solar projects and related programs and services offered by investor-owned utilities."

17 The joint commenters are disappointed that the rules do not reflect their recommendations and requested clarifications in their previous comments in this docket and state that it is unlikely that any community solar companies will register with the commission in light of the burdens imposed by the statute and these rules. They also express concern that there will not be sufficient funding remaining under the current incentive program to accommodate new entrants. Finally, they urge the commission to take a view of community solar beyond the incentive program established in the statute and begin now to develop a longer term, sustainable model for expanded access and opportunities for low-income customers to benefit from solar deployment. At the adoption hearing, Spark Northwest also advocated exemption of public housing authorities from the rules, contending that they have preexisting relationships with participants and thus the consumer protection rules are unnecessary.

18 We do not find the proposed rules to be unduly burdensome. They closely follow the legislature's direction to the commission to register community solar companies and protect consumers and are comparable to rules the commission has adopted for the other industries it regulates. Commission staff is experienced with these types of requirements and will assist all companies seeking to provide community solar services to understand and comply with applicable regulations. To the extent that a rule is unduly burdensome as applied in certain circumstances, a company may request that the commission modify that rule to better fit the situation while accomplishing the statutory goals. We nevertheless are constrained by the authority the legislature granted to the commission and must comply with statutory requirements.

19 With respect to the availability of incentive funds, Jacob Fey, the WSU energy program director, confirmed at the adoption hearing that $80 million of the program's total grant of $110 million currently is spoken for, and the remainder is going quickly, but money remains available for community solar companies. We will do what we can to promptly register eligible companies so that they can access these financial incentives.

20 Finally, in response to the joint commenters, we are sympathetic to their goal of facilitating low-income consumers' ability to access solar energy projects and services. The commission is open to further discussion about what it can do in that regard, but the commission can only exercise authority the legislature has granted. This rule making was established to implement RCW 80.28.375, and the proposed rules are limited to that purpose. To the extent that the commission has authority to expand the scope of community solar operations beyond the bounds of the current incentive program, we are willing to explore available options, but any such exploration and discussion must occur outside of this rule making.

21 We also cannot grant Spark Northwest's request to exempt public housing authorities from regulation under the proposed rules. The commission's mandate extends to the entities that the statute requires to obtain registration from the commission and comply with consumer protection requirements. The legislature defined community solar companies broadly, and the proposed rules incorporate that definition. Pursuant to both the statute and the proposed rule, a public housing authority is a community solar company subject to regulation if it owns a community solar project in Washington and provides community solar project services to project participants. The commission can waive its rules under appropriate circumstances, but it cannot alter statutes. Accordingly, the commission cannot exempt public housing authorities from regulation if they meet the statutory definition of a community solar company.

22 **COMMISSION ACTION:** After considering all of the information regarding this proposal, the commission finds and concludes that it should adopt the rules as proposed in the CR-102 at WSR 18-17-134.

23 **STATEMENT OF ACTION; STATEMENT OF EFFECTIVE DATE:** After reviewing the entire record, the commission determines that it should adopt chapter 480-103 WAC to read as set forth in Appendix A, as rules of the Washington utilities and transportation commission, to take effect pursuant to RCW 34.05.380(2) on the thirty-first day after filing with the code reviser. The commission is aware that time is of the essence in companies' ability to access funding from the incentive program. The urgency does not arise from a legislative mandate or from imminent danger to public health, safety, or welfare, so we do not find a basis for making the rules effective earlier than the statute requires. We nevertheless will allow companies to file applications for registration as community solar companies consistent with the requirements in the proposed rules as of the effective date of this order so that the commission can begin registering eligible companies as soon as the rules become effective.

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 21, amended 0, repealed 0.

Number of Sections Adopted at Request of a Nongovernmental Entity: New 0, amended 0, repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, amended 0, repealed 0.

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

Number of Sections Adopted using Negotiated Rule Making: New 0, amended 0, repealed 0; Pilot Rule Making: New 0, amended 0, repealed 0; or Other Alternative Rule Making: New 0, amended 0, repealed 0.

ORDER

THE COMMISSION ORDERS:

24 The commission adopts chapter 480-103 WAC to read as set forth in Appendix A, as rules of the Washington utilities and transportation commission, to take effect on the thirty-first day after the date of filing with the code reviser pursuant to RCW 34.05.380(2). In anticipation of the rules becoming effective, the commission will immediately begin to accept applications for registration as a community solar company consistent with the requirements in these rules.

25 This order and the rule set out below, after being recorded in the register of the Washington utilities and transportation commission, shall be forwarded to the code reviser for filing pursuant to chapters 80.01 and 34.05 RCW and 1-21 WAC.

DATED at Olympia, Washington, October 2, 2018.

Washington State Utilities and Transportation Commission

David W. Danner, Chairman
Ann E. Rendahl, Commissioner
Jay M. Balasbas, Commissioner

Appendix A
Revised Rules

Chapter 480-103 WAC

COMMUNITY SOLAR COMPANIES

PART I

GENERAL PROVISIONS

NEW SECTION

WAC 480-103-001 Purpose and application. (1) **Purpose.** The purpose of these rules is to administer and enforce the provisions of chapter 80.28 RCW that govern community solar companies. The rules establish general requirements and specific regulations for registration, consumer protection, records, and reporting for such companies.

(2) **Application.** The rules in this chapter apply to any community solar company, any administrator acting on behalf of a community solar company, and where specified, any investor-owned utility operating a community solar project that is subject to the jurisdiction of the commission under RCW 80.04.010 or chapter 80.28 RCW. These rules also include requirements for customers, project participants, and applicants.

(3) **Nonexclusivity.** These rules do not relieve any community solar company from any of its duties and obligations under the laws of the state of Washington. The commission retains the authority to impose additional or different requirements on any community solar company in appropriate circumstances, consistent with the requirements of applicable law.

NEW SECTION

WAC 480-103-002 Definitions. (1) "Administrator" means a person or entity that organizes and administers a community solar project on behalf of a community solar company. The administrator may be responsible for applying for the renewable energy system incentive on behalf of the system's owners and for performing other administrative tasks including, but not limited to:

(a) Receiving renewable energy incentive payments;

(b) Allocating and paying appropriate amounts of such payments to owners; and

(c) Communicating with WSU and the commission about any changes in program participants.

(2) "Applicant" means any person, corporation, partnership, government agency, or other entity that applies for service from a community solar company.

(3) "Business day" means a day when the commission's offices are open as provided in WAC 480-07-120.

(4) "Commission" means the Washington utilities and transportation commission.

(5) "Customer" means any person, corporation, partnership, government agency, or other entity that has applied for, or is currently receiving, utility service within the state of Washington.

(6) "Community solar company" means a person, firm, or corporation, other than an electric utility or community solar cooperative, that owns a community solar project within the state of Washington and provides community solar project services to project participants.

(7) "Community solar project" means a solar energy system within the state of Washington that has a direct current nameplate generating capacity (i.e., maximum rated output) that is no larger than one thousand kilowatts.

(8) "Community solar project services" means the provision of electricity generated by a community solar project, or the provision of the financial benefits associated with electricity generated by a community solar project, to multiple project participants, and may include other services associated with the use of the community solar project such as system monitoring and maintenance, warranty provisions, performance guarantees, and customer service.

(9) "Deposit" means any moneys provided to the community solar company as an advance toward a purchase of an interest in a community solar project or moneys provided to the company as a guarantee of future payments due to the company.

(10) "Electric utility" means a consumer-owned utility or investor-owned utility as those terms are defined in RCW 19.280.020.

(11) "Private consumer information" means the name, street address, email address, telephone number, and any

other personally identifying information of a customer, project participant, or applicant, as well as information related to the quantity, technical configuration, type, destination, and amount of use of service or products the customer, project participant, or applicant obtains or requests from a community solar company.

(12) "Project participant" means a customer who enters into a lease, power purchase agreement, loan, or other financial agreement with a community solar company to obtain a beneficial interest in, other than direct ownership of, a community solar project.

(13) "Solar energy system" means any device or combination of devices or elements that rely upon direct sunlight as an energy source for use in the generation of electricity.

(14) "WSU" means the Washington State University energy program.

NEW SECTION

WAC 480-103-007 Administrators. A community solar company may contract with or otherwise retain one or more administrators to perform tasks on the company's behalf that are subject to the rules under this chapter. If an administrator engages in conduct that violates any federal, state, or local law or regulation, or any commission order while acting on behalf of the community solar company, the company is subject to commission enforcement actions as if the company itself engaged in that conduct. The community solar company is responsible for maintaining measures designed to prevent and detect an administrator's violation of statutes or rules within the commission's authority to enforce. Upon commission request, a community solar company must make available records regarding the tasks an administrator performs on the company's behalf. Such records must fully enable the commission to audit, investigate, and determine the company's compliance with applicable law.

PART II

REPORTING AND REGISTRATION REQUIREMENTS, REGULATORY AND REGISTRATION FEES

NEW SECTION

WAC 480-103-010 Registration and regulatory fees. Community solar companies must pay the following fees:

Initial registration: $450

Renewal registration: $350

Amended registration: $150

Regulatory fee: See WAC 480-103-030(2), minimum $20

NEW SECTION

WAC 480-103-020 Registration as a community solar company. No person may engage in business as a community solar company in Washington without having registered with the commission. Engaging in business as a community solar company includes advertising, soliciting, offering, providing, or entering into an agreement to provide community solar project services.

(1) **Applications.** Community solar companies must submit applications to the commission for the following purposes:

(a) To initially register as a community solar company prior to engaging in business;

(b) To annually renew the company's registration as a community solar company; or

(c) To amend the company's existing registration to reflect any material change to the company's registered operations.

(2) **Application forms.** Community solar companies must submit the appropriate application on the form furnished by the commission and must include all information, documentation, and support the commission requires in the form or the form's instructions. The commission may refuse to accept an incomplete application. The commission's acceptance of an application does not indicate the commission's approval of the application, nor is the commission precluded from finding that the information the company provides in the application is insufficient.

(3) **Initial registration.** A community solar company must provide the following in its application for initial registration:

(a) The company's name and address;

(b) The name and address of the company's registered agent, if any;

(c) The name and address of all administrators the company currently has contracted with or retained to perform tasks on its behalf;

(d) The name, address, and title of each officer or director of the company;

(e) The company's most current balance sheet;

(f) The company's latest annual report, if any;

(g) A description of the services the company offers or intends to offer, including financing models;

(h) A description of the technical administrative competency of the principal personnel that the company will use to provide the proposed services;

(i) Evidence of adequate financial resources to provide the proposed services;

(j) Disclosure of any pending litigation against the company;

(k) The company's active electrical license or registration number issued by the Washington department of labor and industries, if applicable;

(l) Acknowledgment of the company's responsibilities under WAC 480-103-135;

(m) Evidence of an escrow or trust account where the company will hold deposits collected from customers, project participants, or applicants;

(n) Evidence of the resolution of any outstanding complaints against the company on file with the commission; and

(o) The initial registration fee specified in WAC 480-103-010.

(4) **Renewal registration.** Each community solar company must file an application to renew its registration by May 1st of each year after the calendar year in which the commission initially registered the company. The company must provide the following in its application to renew its registration:

(a) The company's name and address;

(b) The name and address of the company's registered agent, if any;

(c) The name and address of all administrators the company currently has contracted with or retained to perform tasks on its behalf;

(d) Any update to the name, address, and title of each officer or director of the company;

(e) The company's most current balance sheet;

(f) Any update to the description of the services the community solar company offers or intends to offer, including financing models, a description of the technical administrative competency of the personnel the company will use to provide the updated services, and evidence of adequate financial resources to provide the updated services;

(g) Disclosure of any pending litigation against the company;

(h) Any update to the company's active electrical license or registration number issued by the Washington department of labor and industries, if applicable;

(i) Acknowledgment of the company's responsibilities under WAC 480-103-135;

(j) Evidence of an escrow or trust account where the company will hold deposits collected from customers, project participants, or applicants;

(k) The registration renewal fee required by WAC 480-103-010; and

(l) The company's annual report and regulatory fee as required under WAC 480-103-030.

(5) **Amended registration.** A registered community solar company must immediately notify the commission of any material changes to the company's business operations including, but not necessarily limited to, changes to the company's name, services it provides, ownership, or business structure. The company must file an application to amend its existing registration to reflect any such changes.

(6) **Additional information.** The commission may require a community solar company to provide information in addition to the information specified in this rule if necessary to determine whether the company and its proposed or actual operations comply with applicable law and are consistent with the public interest.

(7) **Commission action.** The commission will take one of the following actions within thirty days of receiving a complete application:

(a) Grant the application by letter or order, with or without a hearing;

(b) Issue a notice of hearing to resolve issues of fact or law; or

(c) Deny the application. The commission will not deny an application without a hearing. The commission may deny an application on the following nonexclusive grounds:

(i) Failure to meet the requirements of this rule;

(ii) Failure to provide sufficient protection for deposits the company collects from customers, program participants, or applicants;

(iii) Lack of adequate financial resources to provide service;

(iv) Lack of adequate technical administrative competency to provide service; or

(v) Violations of applicable federal or state law as provided in WAC 480-103-040.

NEW SECTION

WAC 480-103-030 Annual reports and payment of regulatory fees. (1) **Annual reports.**

(a) *Community solar companies*. Each community solar company must file a report on or before May 1st each year on the community solar company's operations within the state of Washington for the prior calendar year. The company must submit the annual report on the form furnished by the commission and must include all information, documentation, and support the commission requires in the form or the form's instructions. The report must include:

(i) A statement under oath of the community solar company's gross operating revenue from intrastate operations during the prior calendar year; and

(ii) A list identifying all of the company's community solar projects and related programs and services within the state of Washington.

(b) *Investor-owned utilities*. On or before May 1st each year, each investor-owned utility operating a community solar project must file a list identifying all of the utility's community solar projects and related programs and services within the state of Washington.

(2) **Regulatory fee.** On or before May 1st each year, each community solar company must pay to the commission a fee equal to one-tenth of one percent of the first fifty thousand dollars of gross intrastate operating revenue the company generated during the previous calendar year, plus two-tenths of one percent of any such gross intrastate operating revenue in excess of fifty thousand dollars. The minimum regulatory fee a community solar company must pay is twenty dollars.

(3) **Enforcement.** The commission will enforce a community solar company's obligations under this rule, including assessment of penalties, as authorized in WAC 480-07-917.

NEW SECTION

WAC 480-103-040 Suspension and cancellation of a registration. (1) **Voluntary cancellation.** A community solar company may petition the commission to cancel the company's registration. The company must notify its project participants of its intent to file any such petition no less than fifteen days in advance of making the filing and when making the filing with the commission. The commission may grant the petition without a hearing.

(2) **Suspension.** The commission may suspend a community solar company's registration for cause. The commission will lift the suspension if the company remedies the cause within the time the commission allows. Cause for suspension includes, but is not limited to:

(a) Failure to provide information the commission needs to perform its regulatory functions including, but not limited to, failure to respond to complaints the commission has received and referred to the company for resolution;

(b) Failure to maintain an adequate escrow or trust account where deposits collected from project participants are or will be held;

(c) Violation of commission rules or orders or violations of the laws or regulations of a state or the United States as found by a court or governmental agency.

(3) **Involuntary cancellation.** The commission may cancel a community solar company's registration for cause. The commission need not suspend a company's registration prior to canceling it. Cause for cancellation includes, but is not limited to:

(a) Failure to file an annual report or pay required regulatory fees;

(b) Failure to correct the conditions leading to any suspension within the time defined in the letter or order of suspension;

(c) Failure to provide information as required by the commission or submitting false, misleading, incomplete, or inaccurate information;

(d) Failure to maintain an adequate escrow or trust account where deposits collected from project participants are or will be held;

(e) Failure to resolve complaints by any interested party, or upon the commission's own motion, after notice and opportunity for hearing; or

(f) Violation of commission rules or orders or violations of the laws or regulations of a state or the United States as found by a court or governmental agency.

(4) **Notice to company.** The commission will issue a notice of its intent to suspend or cancel a community solar company's registration. The notice will provide the company with an opportunity to respond to the commission's proposed action including, but not limited to, requesting a hearing. The commission will conduct an adjudicative proceeding in response to such a request only if the company raises genuine issues of material fact or law that require resolution through an evidentiary proceeding.

(5) **Notice to project participants.** A community solar company must notify its project participants of any pending commission action to suspend or cancel the company's registration within five days of the company receiving notice of such action from the commission.

(6) **Effect of suspension or cancellation.** A community solar company may not engage in business as a community solar company if its registration is suspended or canceled including, but not limited to, collecting any incentive payments described under chapter 82.16 RCW. Suspension or cancellation, however, will not relieve a community solar company of its contractual obligations to its program participants.

(7) **Reregistration.** A community solar company whose registration has been canceled may apply for a new registration under WAC 480-103-020 if the company has corrected the causes of cancellation.

NEW SECTION

WAC 480-103-050 Disconnection of service. An electric utility is not liable for incentive payments to a community solar company's project participants if the utility has disconnected utility service to the company due to the company's violation of a customer service agreement, such as nonpayment of the company's utility bill, or the company's violation of the interconnection agreement between the company and the utility.

PART III

CONSUMER RULES

NEW SECTION

WAC 480-103-100 Information to customers, project participants, and applicants. (1) **Transparent administration.** A community solar company must administer its community solar projects in a transparent manner that allows for fair and nondiscriminatory opportunities for customers, project participants, and applicants to participate.

(2) **Cost recovery and notice.** A community solar company may establish a reasonable fee to cover the costs it incurs to organize and administer its community solar projects. Prior to a customer making the commitment to participate in the project, the company must give clear and conspicuous notice to the customer of the portion of the incentive payment that the company will use for this purpose.

(3) **Service changes.** A community solar company must promptly notify all affected project participants of any substantial change to the community solar project service the company provides. The community solar company must bear all costs in connection with making changes to its own equipment.

(4) **Information on rates, terms, and conditions.** A community solar company must make information regarding its rates, rules, and regulations available at each of its listed business offices and on its web site.

(5) **Information a company must maintain.** A community solar company must maintain and update annually through June 30, 2030, the following information for each community solar project it operates or administers:

(a) Ownership information;

(b) Contact information for any administrator of the community solar project;

(c) Contact information for persons who will respond to technical management questions;

(d) Business address;

(e) Email address at which the company will receive communications from the commission; and

(f) Project design details including, but not limited to, project location, output capacity, equipment list, and interconnection information, and participation information, including rates, fees, terms, and conditions.

(6) **Toll-free number and email address.** The community solar company must have a toll-free telephone number that can accept calls during business hours and an email address to receive inquiries relating to services and rates, to accept and process orders, to explain charges on customer bills, to adjust charges made in error, and to respond to customer and project participant inquiries and complaints. Callers to the telephone number must be able to leave a detailed message in the event that a person does not answer. The company must return all unanswered calls and respond to all emails within one business day.

(7) **Commission publication.** A community solar company must provide each customer or potential project participant with a printed or electronic copy of the commission publication, *Consumer Guide to Community Solar in Washington State* at the time the company solicits participation in its community solar project. The company can obtain the publication from the commission's web site or by contacting the commission, and the company is responsible for making the requisite copies. The commission prescribes the language contained in the publication, and the company may not change that language.

(8) **Disclosure to applicants.** A community solar company must provide to each applicant relevant rate information and a disclosure form that explains the rights and responsibilities of a project participant. The disclosure form must include all material terms and conditions of participation in the company's community solar project including, but not limited to, the following:

(a) The company's regular business hours, mailing address, email address, web site, and toll-free telephone number;

(b) Information about any administrator of the community solar project;

(c) Contact information for questions and complaints;

(d) All financial rights and obligations of a project participant related to the project;

(e) The company's processes for establishing credit, making deposits, and handling delinquent accounts and cancellation;

(f) The company's dispute resolution process and the commission's complaint procedures the project participant may use if the company's process does not resolve the dispute;

(g) The company's billing and payment procedures;

(h) All recurring and nonrecurring charges;

(i) The terms under which the project's share of any incentive payment will be calculated by WSU over the life of the project;

(j) Current project production projections and the methodology used to develop the projections;

(k) Any compensation the company will pay to the participant in the event of project underperformance;

(l) The disposition of the renewable energy credits;

(m) Terms governing the portability or transferability of the project participant's interest in the project, including any potential costs associated with such a transfer; and

(n) Any other material terms and conditions of the services the company provides.

(9) **Annual notice to project participants.** At least once each year, a community solar company must directly advise each of its project participants how to obtain:

(a) A copy of the information, forms, and disclosures described in this section;

(b) The participant's current production projection information;

(c) The current total value of the participant's share of the project;

(d) A copy of the commission's community solar rules under this chapter; and

(e) A copy of the company's current rates, terms, and conditions for the project.

(10) **Copies to the commission.** The community solar company must provide the commission with current copies of all of the company's disclosure forms, pamphlets, brochures, and bill inserts prior to delivering such materials to customers, project participants, or applicants.

(11) **Unique materials.** A community solar company may not use the name, bills, marketing materials, or consumer education materials of another community solar company.

NEW SECTION

WAC 480-103-105 Services and charges. (1) **Services and charges limited.** A community solar company may offer and provide only the community solar project services the commission has registered the company to provide and may provide a project participant only the services the participant has agreed in writing to receive at the rates or charges the participant has agreed to pay.

(2) **No new charges without consent.** A community solar company may not charge a project participant any rate or fee for a new service or service option or impose a new or additional rate or fee for an existing service or service option without the participant's prior consent.

NEW SECTION

WAC 480-103-110 Community solar company personnel. (1) **General standards.** Each community solar company must develop standards and qualifications for the persons it uses to perform the tasks required to administer and operate its community solar projects and provide its project services. A company may not hire, engage, or otherwise use a person to perform such tasks who fails to meet its standards.

(2) **Door-to-door activity personnel.** A community solar company may not permit a person to conduct door-to-door activities on its behalf until it has obtained and reviewed the person's criminal history record.

(a) A company must complete a criminal background check for every person that will conduct door-to-door activities on its behalf;

(b) The company must keep evidence that it has completed a criminal background check for every person the company uses for door-to-door activities for as long as that person performs such activities and for seven years thereafter;

(c) No company may use a person for door-to-door activities who has been convicted of any crime involving theft, burglary, assault, sexual misconduct, identity theft, fraud, or false statements, within five years of the date the company intends to use that person; and

(d) When a community solar company contracts with an independent contractor or vendor to perform door-to-door activities, the company must document that the contractor or vendor has performed criminal background investigations on its personnel in accordance with the requirements in this rule. A company may satisfy this obligation by obtaining from the independent contractor or vendor a written statement affirming that the contractor or vendor performed the requisite

criminal background checks and that all personnel who will be performing door-to-door activities on behalf of the company satisfy the requirements in this section. The company must periodically audit whether the independent contractor or vendor has completed the background checks in accordance with this section.

(3) **Requirements for personnel engaged in door-to-door activities or public events.**

(a) *Training*. A community solar company must establish requirements and training for its employees and persons conducting door-to-door activities or appearing at public events on behalf of the company and must retain documentation of the completion of training as required under WAC 480-103-150.

(b) *Identification*. A community solar company must issue identification badges to be worn and prominently displayed by persons conducting door-to-door activities or appearing at public events on behalf of the company. The badge must:

(i) Accurately identify the community solar company, its trade name, and its logo;

(ii) Display the person's photograph;

(iii) Display the person's full name; and

(iv) Display a customer service phone number for the community solar company.

(c) *Disclosures on initial contact*. Upon first contact with a customer, a person conducting door-to-door activities or appearing at a public event on behalf of a community solar company must:

(i) Identify the community solar company the person represents; and

(ii) State that the person is not working for the customer's local utility or any other community solar company.

(d) *Branding*. When conducting door-to-door activities or appearing at public events on behalf of a community solar company, a person may not display branding elements, such as a logo, that suggests a relationship that does not exist between that person and any utility, government agency, or other community solar company.

(4) **No requirement to choose a company.** A community solar company or a person conducting door-to-door activities or appearing at a public event on behalf of a community solar company may not say or suggest to a customer that the customer is required to choose a community solar company.

NEW SECTION

WAC 480-103-115 Application for participation in a community solar project. (1) **No subscription without consent.** No community solar company may subscribe any person to a community solar energy generation system without that person's prior written consent.

(2) **Identification of application form.** Application forms to participate in a community solar project must be clearly identified as a contract for such participation.

(3) **Permissible applicant information requirements.** If applicable, a community solar company may require the following information from an applicant:

(a) The applicant's name, street address, email address, telephone number, and any alternative contact telephone number;

(b) Proof of identification; provided that the community solar company must allow the applicant to choose one form of identification from a list provided by the company of at least five sources of identification, which must include an option for a current driver's license or other state-issued photographic identification card; and

(c) Additional information the community solar company reasonably needs to provide or bill for service.

NEW SECTION

WAC 480-103-120 Deposits. (1) **Escrow or trust account.** Community solar companies that collect deposits from customers, project participants, or applicants must maintain an escrow or trust account where the company will hold the deposits it collects.

(2) **Interest on deposits.** Community solar companies that collect deposits from customers, project participants, or applicants must pay interest on those deposits from the date the company collects the deposit to the date the company refunds or applies the deposit directly to the customer, project participant, or applicant's account. For each calendar year, the company will pay interest at the rate for the one-year Treasury Constant Maturity calculated by the U.S. Treasury, as published in the *Federal Reserve's Statistical Release H.15* on January 15th of that year, or if January 15th is not a business day, the rate posted on the following business day.

(3) **Refund of deposits.** A community solar company must refund deposits plus interest, less any amounts due from the project participant, when:

(a) The participant's deposits plus interest are not applied toward the participant's account or portion of the community solar project; and

(b) The participant terminates his or her participation in the community solar project; or

(c) The company terminates the participant's participation; or

(d) The community solar project ceases operation.

(4) **Manner of refund.** A community solar company must refund any deposits plus interest in the manner indicated by the project participant at the time of deposit, or as modified by the project participant on a later date, using one of the following methods:

(a) A check issued and mailed to the project participant no later than fifteen days following termination of the participant's participation in the project or termination of the project; or

(b) Another form of payment mutually agreed upon by the company and the participant.

NEW SECTION

WAC 480-103-125 Transfer of project participation. A community solar company must allow project participants to sell or otherwise transfer a portion or all of their interest in a community solar project, subject to the following conditions:

(1) Neither the portion transferred nor any portion retained by the project participant is smaller than the minimum participation size specified in the contract between the participant and the company;

(2) If the transfer is to one or more persons, those individuals must meet the company's participation requirements;

(3) The company may require the program participant to obtain company approval of any transfer to another person, which may not be unreasonably withheld; and

(4) If a program participant is unable or elects not to transfer the participant's interest to another person, the company must allow a transfer back to the company.

NEW SECTION

WAC 480-103-130 Disclosure of private consumer information. (1) **Consent required.** A community solar company may not disclose private consumer information to its affiliates, subsidiaries, or any other third party for the purposes of marketing services or product offerings to a customer, project participant, or applicant who does not already subscribe to that service or product without the person's prior written or electronic consent. The community solar company must obtain such consent for each instance of disclosure of the customer, project participant, or applicant's private consumer information.

(2) **Documentation of consent.** The community solar company must retain documentation of each consent for disclosure of private consumer information, which must include the following information:

(a) Confirmation of consent for the disclosure of private consumer information;

(b) The date of the consent and a list of the affiliates, subsidiaries, or third parties to which the customer, project participant, or applicant authorized disclosure of private consumer information; and

(c) Confirmation that the name, service address, and account number, if applicable, exactly match the community solar company's record for the customer, project participant, or applicant who provided the consent.

(3) **Inapplicability.** This section does not prevent a community solar company from undertaking any of the following:

(a) Disclosing the essential terms and conditions of special contracts as provided in WAC 480-80-143;

(b) Distributing any marketing information in a project participant's billing package; or

(c) Collecting and releasing information in aggregate form related to services and products that customers, project participants, or applicants obtain or request as long as the aggregated information does not enable any specific customer, project participant, or applicant to be identified.

NEW SECTION

WAC 480-103-135 Complaints and disputes. (1) **Complaints to the company.** A community solar company must establish procedures for resolving complaints it receives from a customer, project participant, or applicant. At a minimum, the company must take the following actions when it receives such a complaint:

(a) Acknowledge the company's receipt of the complaint;

(b) Upon request, identify the company representative the complainant can contact concerning the complaint;

(c) Investigate the complaint promptly as required by the particular case;

(d) Report the results of the investigation to the complainant;

(e) Take corrective action, if warranted, as soon as practicable under the circumstances;

(f) Inform the complainant of the right to escalate the complaint to a supervisor at the company if the complainant is dissatisfied with the results, decision, or any corrective action the company has taken; and

(g) Inform the complainant, if still dissatisfied after speaking with a supervisor, of the commission's address and toll-free telephone number and of the complainant's right to file a complaint with the commission.

(2) **Complaints to the commission.** Customers, project participants, or applicants should attempt to resolve their disputes with a community solar company prior to filing a complaint with the commission. Customers, project participants, applicants, or their representatives may file the following types of complaints:

(a) *Informal complaints*. A person may make an informal complaint against the company as provided in WAC 480-07-910. The commission will investigate all such complaints and will work with the company and the complainant to resolve the dispute. As part of that investigation, the company must:

(i) Conduct its own investigation of the complaint and report the results to the commission within five business days or by a date the commission specifies;

(ii) Keep the commission informed of progress the company and the complainant have made toward resolving the complaint; and

(iii) Respond to any commission request for additional information within five business days of the request or by a date the commission specifies.

(b) *Formal complaints*. A person may file a formal complaint against the company as provided in WAC 480-07-370. Upon receipt of a formal complaint, the commission will determine the appropriate action to take including, but not limited to, whether to initiate an adjudication to resolve the dispute.

(3) **Records of complaints.** Each community solar company must keep a record of all complaints it receives, either directly or upon referral from the commission, for at least seven years and, upon request, make those records readily available for commission review. The records for each complaint must contain:

(a) The complainant's name and address;

(b) The date and nature of the complaint;

(c) Any and all actions the company took in response to the complaint;

(d) The final disposition of the complaint; and

(e) All company documents regarding the complaint.

(4) **Actions pending complaint resolution.** The community solar company may not terminate a project participant's contract while the participant is pursuing any remedy or appeal provided by commission rule or while engaged in

the dispute resolution process required by this section. Pending resolution of any complaint, moneys not in dispute must be paid when due, and the company must correct any conditions posing a danger to health, safety, or property. The company must inform the complainant of these requirements when referring the complainant to a company supervisor or to the commission.

NEW SECTION

WAC 480-103-140 Electronic information. (1) **Consent required.** A community solar company may provide in electronic form, rather than paper, information a statute, rule, or commission order requires the company to provide to a customer, project participant, or applicant, only with the prior written or electronic consent of the customer, project participant, or applicant. The electronic communication providing the information must provide a link to that information or otherwise sufficiently advise the customer, project participant, or applicant of how to access the information electronically.

(2) **Format of electronic communications.** All information a community solar company provides in electronic form must meet the requirements for format and any other requirements specified in this chapter.

(3) **Obtaining and documenting consent.** The community solar company must obtain the consent required in this section directly from the customer, project participant, or applicant for each service the company provides to the customer, project participant, or applicant. The company also must comply with the following requirements:

(a) *Content*. At a minimum, the consent must include the following:

(i) The name, address, and account number, if applicable, that exactly matches the community solar company record for such person or account;

(ii) The customer, project participant, or applicant's affirmative decision to receive electronic information;

(iii) Confirmation of the customer, program participant, or applicant's understanding that the community solar company will provide, upon request but subject to the limitations in this section, a paper copy of any document the company sends electronically at no additional charge;

(iv) Confirmation of the customer, project participant, or applicant's understanding that the person may opt out of receiving information electronically at any time and revert to receiving paper documents through the mail at no additional charge;

(v) Confirmation of the customer, project participant, or applicant's understanding that it is that person's responsibility to notify the community solar company of any change to the person's email or other electronic address; and

(vi) Confirmation of the customer, program participant, or applicant's understanding that, in addition to the paperless account statements, the person may receive all notices regarding service in electronic form including, but not limited to, notices of the community solar company's intent to increase rates and make changes in service.

(b) *Consent disclosures*. All consent disclosures must be prominent on the community solar company's written or electronic form, web page, or other electronic format and must be clearly distinguishable from any other content in the document, screen, or web page.

(i) Only information specified in this section may be combined with the consent disclosures, including community solar company contact information.

(ii) The consent disclosures must not have consent boxes or spaces prefilled. The customer, project participant, or applicant must personally check each box or space to give the person's consent to receive electronic communication regarding one or more services.

(c) *Options*. The consent disclosures on the document, screen, or web page may provide for a single consent for all communications related to a specific service or may offer separate, individual opportunities to consent to the following aspects of a service:

(i) Paperless billing;

(ii) Automatic payments including, but not limited to, one-time payments; or

(iii) Payment plans.

(d) *Records*. The community solar company must retain a record of each customer, project participant, or applicant's consent to receive electronic communications for each service the company provides.

(e) *Availability*. The community solar company must make its records of the customer, program participant, or applicant's consent available to that person and to the commission upon request and at no charge.

(4) **Documents requiring paper delivery.** A community solar company must deliver paper copies of the following documents to project participants no less than fifteen days in advance of the noticed event:

(a) Notices of termination or suspension of any community solar project in which the participant has an interest or of community solar project services the participant receives; and

(b) Notices of the company's involuntary termination of a participant's interest in a community solar project.

(5) **Limit on changes to information format.**

(a) A community solar company is not obligated to provide both paper documents and electronic information to a customer, project participant, or applicant on a continuous basis.

(b) A community solar company may limit a customer, project participant, or applicant who has consented to electronic communications to three requests for paper documents in a twelve-month period.

(c) A community solar company may require that a customer, project participant, or applicant who requests an electronic statement also receive all statement inserts electronically.

(d) If a customer, project participant, or applicant is unable to properly receive, view, or understand electronic information the community solar company provides, the company may refuse to provide that information in electronic form to that person.

(6) **Undeliverable electronic information.**

(a) If the community solar company receives a message or otherwise becomes aware that any electronic information it has sent to a customer, project participant, or applicant is

undeliverable or did not reach the intended recipient, the company must take one or both of the following actions by the end of the next business day to ascertain and resolve the issue:

(i) Resend the electronic information to the electronic address the customer, program participant, or applicant provided to the company; or

(ii) Contact the customer, project participant, or applicant by telephone.

(b) If any electronic information remains undeliverable after the community solar company takes one or both of the actions required in (a) of this subsection, the company must send the information by mail to the customer, project participant, or applicant. In the mailing, the company must explain that the company is unable to deliver information to the electronic address in its records and that the company will only send paper copies of future information to the customer, project participant, or applicant until the person provides the company with a functioning electronic address.

NEW SECTION

WAC 480-103-145 Meter tests. (1) **Testing frequency.** A community solar company must test and report to project participants the accuracy of each of its community solar project's meters every twelve months.

(2) **Dispute resolution.** If a project participant disputes any meter test result, the company or the customer may file a complaint with the commission.

(a) When the commission has notified the company that the commission has received a complaint regarding a meter test result, the company may not alter the meter in any manner unless authorized by the commission. The commission may consider any alteration to the meter in violation of this requirement as support for the complaint.

(b) The commission may require the company to perform an additional meter test and report the test results to the commission within ten business days.

PART IV

RECORDS AND REPORTING RULES

NEW SECTION

WAC 480-103-150 Retention and preservation of records and reports. Community solar companies receiving incentive payments must maintain and preserve, for a period of seven years, suitable records as may be necessary to determine the amount of incentive the company applied for and received. Such records must be open for examination at any time upon notice by the utility that made the payment and by the commission. The commission otherwise adopts the standards in the publication, *Regulations to Govern the Preservation of Records of Electric, Gas, and Water Companies*, published by the National Association of Regulatory Utility Commissioners, as the standards for records retention for community solar companies as described in WAC 480-103-999.

NEW SECTION

WAC 480-103-155 Reports of accidents. (1) **Initial notification.** Each community solar company must notify the commission orally or by email of any accident that results in death or serious injury to any person occurring in connection with a company's community solar project or through contact with its facilities no later than the second business day following the company's discovery of the accident.

(2) **Follow-up report.** The community solar company must submit a follow-up written report of the accident to the commission within fifteen business days of the initial notification. The report must include, at a minimum:

(a) The time and place of the accident;

(b) A brief description of how the accident occurred;

(c) Whether the accident resulted in a fatality;

(d) The name and address of the persons injured; and

(e) A brief description of the company's response to the accident including, but not limited to, any medical treatment that was provided to the injured persons.

PART V

ADOPTION BY REFERENCE

NEW SECTION

WAC 480-103-999 Adoption by reference. In this chapter, the commission adopts by reference the regulations and standards in *Regulations to Govern the Preservation of Records of Electric, Gas, and Water Companies*, published by the National Association of Regulatory Utility Commissioners (NARUC) as the standards for records retention for community solar companies unless otherwise specified in these rules. The commission adopts the version of this document in effect in 2007. This is a copyrighted publication, and copies are available from NARUC in Washington, D.C., or at the NARUC publications store online at http://www.naruc.org/store. The publication is also available for inspection at the commission's offices.

WSR 18-20-107

PERMANENT RULES

EXECUTIVE ETHICS BOARD

[Filed October 2, 2018, 1:24 p.m., effective November 2, 2018]

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

Purpose: The purpose of this rule making is to adopt a rule that implements the new Public Records Act (PRA) requirements and provide the necessary findings so that the executive ethics board may use the amended statutory default fee schedule effective July 23, 2017, and explain the procedures for payment of copies and waiver of fees. This rule making will also update the rule to provide clarity to state employees and the public.

Citation of Rules Affected by this Order: Amending WAC 292-130-020, 292-130-050, 292-130-100, 292-130-110, 292-130-130, and 292-130-140.

Statutory Authority for Adoption: RCW 42.52.360.

Adopted under notice filed as WSR 18-16-026 on July 24, 2018.

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 6, Repealed 0.

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

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 6, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 6, Repealed 0.

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

Date Adopted: September 28, 2018.

Ruthann Bryant
Administrative Officer

AMENDATORY SECTION (Amending WSR 16-16-075, filed 7/29/16, effective 8/29/16)

WAC 292-130-020 Agency description—Contact information—Public records officer. (1) The executive ethics board was created by chapter 42.52 RCW to enforce the state's ethics law and rules adopted under it with respect to statewide elected officers and all other officers and employees in the executive branch, boards and commissions, and institutions of higher education.

((~~The executive ethics board consists of five members, appointed by the governor as follows: One member shall be a classified service employee; one member shall be a state officer or state employee in an exempt position; one member shall be a citizen selected from a list of three names submitted by the attorney general; one member shall be a citizen selected from a list of three names submitted by the state auditor; and, one member shall be a citizen at large selected by the governor.~~))

(2) Any person wishing to request access to public records of the executive ethics board, or seeking assistance in making such a request, should contact the public records officer of the executive ethics board:

Executive Director
Executive Ethics Board
2425 Bristol Court S.W.
P.O. Box 40149
Olympia, WA 98504-0149
360-664-0871
360-586-3955 (fax)
ethics@atg.wa.gov

Information and a request form is also available at the executive ethics board's web site at www.ethics.wa.gov. ((~~The office hours are 8:00 a.m. to 5:00 p.m., Monday through Friday except legal holidays and during regularly scheduled board meetings.~~))

(3) The public records officer will oversee compliance with the act but another executive ethics board 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 executive ethics board will provide the "fullest assistance" to requestors; create and maintain for use by the public and executive ethics board officials an index to public records of the executive ethics board; 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 executive ethics board.~~))

AMENDATORY SECTION (Amending WSR 16-16-075, filed 7/29/16, effective 8/29/16)

WAC 292-130-050 Availability of public records. (1) ((~~**Hours for inspection of records.**~~)) Public records are available for inspection and copying Monday through Friday, 9:00 a.m. to noon, and 1:00 p.m. to 4:00 p.m., excluding legal holidays and during scheduled board meetings. Records must be inspected at the offices of the executive ethics board. Many public records are also available for inspection and copying on www.ethics.wa.gov at any time, at no cost.

(2) ((~~**Records index.**~~)) An index of public records is available for use by members of the public, including final orders, stipulations and advisory opinions. The indices for these documents are available upon request.

(3) ((~~**Organization of records.**~~)) The executive ethics board will maintain its records in a reasonably organized manner. The executive ethics board will take reasonable actions to protect records from damage and disorganization. A requestor ((~~shall~~)) must not take executive ethics board records from executive ethics board offices without the permission of the public records officer or designee. A variety of records is available on the executive ethics board web site at www.ethics.wa.gov. 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 executive ethics board should make the request in writing on the executive ethics board request form or through an online portal, or by letter, fax, or email addressed to the public records officer at the email address publicly designated by the executive ethics board, or by submitting the request in person at the executive ethics board office and including the following information:

(((~~(i)~~))) (a) Name of requestor;

(((~~(ii)~~))) (b) Address of requestor;

(((~~(iii)~~))) (c) Other contact information, including telephone number and ((~~any~~)) email address;

(((~~(iv)~~))) (d) Identification of the public records adequate for the public records officer or designee to locate the records; and

(((~~(v)~~))) (e) The date and time of day of the request.

(((~~(b)~~))) (5) If the requestor wishes to have copies of the records made instead of simply inspecting them, he or she should so indicate and make arrangements to pay for copies of the records or a deposit. Pursuant to WAC 292-130-110,

((~~standard black and white and color photocopies will be provided at fifteen cents per page~~)) charges for copies are provided in a fee schedule available at the executive ethics board office or www.ethics.wa.gov.

(((~~(c)~~))) (6) A records request form is available for use by requestors at the executive ethics board office ((~~of the public records officer~~)) and online at www.ethics.wa.gov.

(((~~(d)~~))) (7) The public records officer or designee may accept requests for public records that contain the above information by telephone or in person. If the public records officer or designee accepts such a request, he or she will confirm receipt of the information and the substance of the request in writing.

(8) If requestors refuse to identify themselves or provide sufficient contact information, the agency will respond to the extent feasible and consistent with the law.

AMENDATORY SECTION (Amending WSR 16-16-075, filed 7/29/16, effective 8/29/16)

WAC 292-130-100 Processing of public records requests—General. (1) ((~~**Providing "fullest assistance."** The executive ethics board 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.**~~)) Upon receipt of a request, the executive ethics board will assign it a tracking number and log it in.

(2) The public records officer or designee will evaluate the request according to the nature of the request, volume, and availability of requested records.

(3) Following the initial evaluation of the request under this subsection, and within five business days of receipt of the request, the public records officer or designee will do one or more of the following:

(a) Make the records available for inspection or copying((~~;~~

(~~(b)~~))) including:

(i) If the copies are available on the executive ethics board's web site, provide the internet address and link on the web site to the specific records requested;

(ii) If copies are requested and payment of a deposit for the copies, if any, is made or other terms of payment are agreed upon, send the copies to the requestor((~~;~~

(~~(c)~~)).

(b) Acknowledge receipt of the request and provide a reasonable estimate of when records or an installment of 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)~~))) (c) Acknowledge receipt of the request and ask the requestor to provide clarification for a request that is unclear, and provide, to the greatest extent possible, a reasonable estimate of time the executive ethics board will require to respond to the request if it is not clarified.

(i) Such clarification may be requested and provided by telephone and memorialized in writing;

(ii) If the requestor fails to respond to a request for clarification and the entire request is unclear, the executive ethics board need not respond to it. The executive ethics board will respond to those portions of a request that are clear; or

(d) Deny the request.

((~~(3) **Consequences of failure to respond.**~~)) (4) If the executive ethics board does not respond in writing within five business days of receipt of the request for disclosure, the requestor should ((~~consider contacting~~)) contact the public records officer or designee to determine the reason for the failure to respond.

((~~(4) **Protecting rights of others.**~~)) (5) 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 or designee 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.**~~)) (6) Some records are exempt from disclosure, in whole or in part. If the executive ethics board believes that a record is exempt from disclosure and should be withheld, the public records officer or designee will state the specific exemption and provide a brief written 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 or designee 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~~))) (7) Consistent with other demands, the executive ethics board ((~~shall~~)) will 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~~)) must indicate which documents he or she wishes the executive ethics board to copy.

(((~~b~~))) The requestor must claim or review the assembled records within thirty days of the executive ethics board'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 executive ethics board 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.**~~)) (8) After inspection is complete, the public records officer or designee will make the requested copies or arrange for copying. Where executive ethics board charges for copies, the requestor must pay for the copies.

(((~~(8) **Providing records in installments.**~~)) (9) 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.**~~)) (10) 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 executive ethics board has completed a ((~~diligent~~)) reasonable search for the requested records and made any located nonexempt records available for inspection.

(((~~(10) **Closing withdrawn or abandoned request.**~~)) (11) When the requestor either withdraws the request ((~~or~~)), fails to clarify an entirely unclear request, fails to fulfill his or her obligations to inspect the records ((~~or~~)), pay the deposit, pay the required fees for an installment, or make final payment for the requested copies, the public records officer or designee will close the request and, unless the agency has already indicated in previous correspondence that the request would be closed under the above circumstances, indicate to the requestor that the executive ethics board has closed the request.

(((~~(11) **Later discovered documents.**~~)) (12) If, after the executive ethics board has informed the requestor that it has provided all available records, the executive ethics board 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.

AMENDATORY SECTION (Amending WSR 16-16-075, filed 7/29/16, effective 8/29/16)

WAC 292-130-110 Costs of providing copies of public records—Payments. (1) ((~~**Costs for paper copies.**~~)) There is no fee for inspecting public records((~~. A requestor may obtain standard black and white photocopies or color copies for fifteen cents per page. Copying fees will be waived for twenty-five or fewer photocopies.~~

~~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 executive ethics board 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 one dollar for information on a CD-ROM. There will be no charge for emailing electronic records to a requestor.~~

~~(3) **Costs of mailing.** The executive ethics board 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 executive ethics board.~~)), including inspecting records on the executive ethics board's web site.

(2) The executive ethics board is not calculating actual costs for copying records because to do so would be unduly burdensome for the following reasons: The executive ethics board does not have the resources to conduct a study to determine its actual copying costs; to conduct such a study would interfere with other essential board functions; and the public and requestors have commented on and been informed of authorized fees and costs provided in the Public Records Act including RCW 42.56.120 and other laws. It is more cost efficient, expeditious and in the public interest for the executive ethics board to adopt the state legislature's approved fees and costs for most of the executive ethics board's records, as authorized in RCW 42.56.120 and as published in the executive ethics board's fee schedule.

(3) The executive ethics board will charge for copies of records pursuant to the default fees in RCW 42.56.120 (2)(b) and (c). The executive ethics board will charge for customized services pursuant to RCW 42.56.120(3). Under RCW 42.56.130, the executive ethics board may charge other copy fees authorized by statutes outside of chapter 42.56 RCW. The executive ethics board may enter into an alternative fee agreement with a requestor under RCW 42.56.120(4). The charges for copying methods used by the executive ethics board are summarized in the fee schedule available on the executive ethics board's web site at www.ethics.wa.gov.

(4) Requestors are required to pay for copies in advance of receiving records. Fee waivers are an exception and are available for some small requests under the following conditions:

(a) It is within the discretion of the public records officer or designee to waive copying fees when:

(i) All of the records responsive to an entire request are paper copies only and are twenty-five or fewer pages; or

(ii) All of the records responsive to an entire request are electronic and can be provided in a single email with attachments of a size totaling no more than the equivalent of one hundred printed pages. If that email for any reason is not deliverable, records will be provided through another means of delivery, and the requestor will be charged in accordance with this rule.

(b) Fee waivers are not applicable to records provided in installments.

(5) The public records officer or designee may require an advance deposit of ten percent of the estimated fees when the copying fees for an installment or an entire request, or customized service charge, exceeds twenty-five dollars.

(6) All required fees must be paid in advance of release of the copies or an installment of copies, or in advance of when a deposit is required. The executive ethics board will notify the requestor of when payment is due.

(7) Payment should be made by check or money order to the executive ethics board. The executive ethics board prefers not to receive cash.

(8) The executive ethics board will close a request when a requestor fails by the payment date to pay in the manner prescribed for records, an installment of records, or a required deposit.

AMENDATORY SECTION (Amending WSR 16-16-075, filed 7/29/16, effective 8/29/16)

WAC 292-130-130 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 executive ethics board for inspection and copying:~~

~~Under RCW 42.52.420 the identity of a person filing a complaint under RCW 42.52.410(1) is exempt from public disclosure as provided for in RCW 42.56.240.~~

~~(2) The executive ethics board is prohibited by statute from disclosing lists of individuals for commercial purposes.~~

~~(3)~~)) (2) During the course of an investigation, records generated or collected as a result of the investigation may be exempt from public inspection and copying under RCW 42.56.240.

(a) The investigation is not considered complete until a case is resolved either by a stipulation and settlement that is signed by all parties; or, when the board enters a final order after a public hearing.

(b) The following records are not considered part of the investigation file and are releasable upon request:

(i) Complaints, upon receipt by the respondent;

(ii) The board staff's investigation report;

(iii) The board's findings of reasonable cause or no reasonable cause; and

(iv) Stipulations and settlements, upon receipt by the board.

AMENDATORY SECTION (Amending WSR 16-16-075, filed 7/29/16, effective 8/29/16)

WAC 292-130-140 Review of denials of public records request. (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 email) to the public records officer or designee for review of that decision. The petition should 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 or designee will promptly provide the petition and any other relevant information to the chair of the board or the chair's designee. The chair or the chair's designee will immediately consider the matter and either affirm or reverse such denial within two business days following the executive ethics board's receipt of the petition, or within such other time as mutually agreed upon by the requestor and executive ethics board((~~, or call a special meeting of the board as soon as legally possible to review the denial~~)).

(3) ((~~**Review by the attorney general's office.**~~)) Pursuant to RCW 42.56.530, if the executive ethics board 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 18-20-117
PERMANENT RULES
HEALTH CARE AUTHORITY
(Public Employees Benefits Board)

[Admin #2018-02—Filed October 3, 2018, 8:00 a.m., effective January 1, 2019]

Effective Date of Rule: January 1, 2019.

Purpose: **1. Implement public employees benefits board (PEBB) policy resolutions:**

- Amend WAC 182-08-187 which governs the process an employing agency would use to correct an eligibility or enrollment error.
- Authorize a retiree who is no longer eligible to remain enrolled in a PEBB health plan to remain enrolled in retiree term life insurance coverage.
- Authorize retirees and survivors to defer enrollment in a PEBB health plan if they are enrolled in the Civilian Health and Medical Program of the Department of Veteran's Affairs coverage.

2. Making technical amendments to:

- Change references to the PEBB appeals committee to instead refer to the PEBB appeals unit and changing cross-references to rules in chapter 182-16 WAC.
- Clarify that it is the PEBB program that sends and receives the Consolidated Omnibus Budget Reconciliation Act (COBRA) election form, reviews COBRA eligibility, and receives COBRA payments.
- Clarify in WAC 182-12-146 that enrollees that do not fit the definition of qualified beneficiary under COBRA qualify for continuation of PEBB coverage as authorized by RCW 26.60.015 and PEBB through their policy resolution on May 23, 2000.
- Revise several definitions in WAC 182-08-015 and 182-12-109.
- Make child eligibility consistent within state statutes.
- Correct numbering errors in WAC 182-08-187.
- Clarify in WAC 182-08-197 that an employee's forms must be received by their employing state agency or the applicable contracted vendor no later than thirty-one days after the employee becomes eligible for PEBB benefits.

- Revise WAC 182-08-198 to address when coverage begins for a member who enrolls in a medicare advantage plan.
- Clarify where enrollment forms should be submitted in WAC 182-08-198.
- Revise WAC 182-08-199 to clarify procedures during open enrollment and special open enrollment for flexible spending arrangement and dependent care assistance program and amending multiple rules to better align with salary reduction plan document language. Clarify each employer's responsibility for payment of the employer contribution when an employee transfers from one employing agency to another in WAC 182-08-200.
- Revise WAC 182-08-240 to improve readability.
- Amend procedural requirements in WAC 182-12-171 to add if a retiree employee elects to enroll a dependent in PEBB insurance coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee with a narrow exception.
- Update WAC 182-12-123 to refer to the appropriate WAC reference to enroll in PEBB retiree insurance coverage after deferring.
- Include more detail in WAC 182-12-205 regarding who is eligible and to reference the appropriate WAC for requirements to defer a PEBB retiree health plan.
- Add additional language to WAC 182-12-262 to make clear that a subscriber has to satisfy the enrollment requirements in WAC 182-12-262(4) in order to enroll eligible dependents.
- Clarify the enforcement of the National Medical Support Notice (NMSN) when a terminated employee elects self-only COBRA in WAC 182-12-263.
- Clarify the forty-five day rule related to premium payments and premium refunds by cross-referencing WAC 182-12-146 with WAC 182-08-180, clarify if WAC 182-08-180 is applicable to all or just employees eligible for the employer contribution.
- Clarify rules related to elected officials in WAC 182-12-180.
- Add additional language so it is clear that the surcharges are in addition to the monthly premium and cross-referenced additional rules within WAC 182-08-185 that apply.
- Clarify WAC 182-08-185 that a premium surcharge will be applied when a spouse or state-registered domestic partner is enrolled in medical coverage.
- Clarify that the dependent of a retiree must be enrolled in the same medical and dental plan with narrow exceptions in chapter 182-12 WAC.
- Amend a cross-reference to the definition of separated employee in WAC 182-12-171.
- Remove NMSN from the special open enrollment event rules in chapters 182-08 and 182-12 WAC because it is addressed in a separate rule.
- Clarify that the subscriber must maintain continuous enrollment in one of the types of coverage allowed and clarify timelines for deferral upon retirement and postretirement in WAC 182-12-200 and 182-12-205.
- Clarify COBRA and the deferral process for surviving dependents in WAC 182-12-265 and 182-12-180.

3. Amending rule to improve administration of the PEBB program:

- Revise the employer group application process to authorize alternative requirements for employer groups that are not able to provide historical claims data and cost information as required in WAC 182-08-235.
- Clarify in chapter 182-08 WAC that an employee must provide evidence of the special open enrollment event in addition to the required form in order to make an enrollment change during a special open enrollment.
- Add an exception to WAC 182-12-205 regarding when PEBB insurance coverage will end for a member who enrolls in a medicare advantage plan. Clarifying that once a retiree voluntarily terminates the coverage, the retiree cannot reenroll in PEBB benefits unless the retiree becomes newly eligible.
- Change the reasonable alternative for enrollees who use tobacco products to require enrollees eighteen or older to attest to having enrolled in a cessation program and to require enrollees thirteen through seventeen to have accessed the required web site information.
- Revise WAC 182-12-262 to convey antirescission limitations in the PEBB program's discretion.
- Revise WAC 182-12-300 to include the requirement for subscribers who complete the well-being assessment and earn the $25 gift card to claim the gift card within the same calendar year.

Citation of Rules Affected by this Order: Amending WAC 182-08-015, 182-08-180, 182-08-185, 182-08-187, 182-08-196, 182-08-197, 182-08-198, 182-08-199, 182-08-200, 182-08-235, 182-08-240, 182-12-109, 182-12-113, 182-12-114, 182-12-123, 182-12-128, 182-12-129, 182-12-131, 182-12-133, 182-12-138, 182-12-141, 182-12-142, 182-12-146, 182-12-148, 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-207, 182-12-208, 182-12-209, 182-12-211, 182-12-250, 182-12-260, 182-12-262, 182-12-263, 182-12-265, 182-12-270, and 182-12-300.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: PEBB policy resolutions.

Adopted under notice filed as WSR 18-17-188 on August 22, 2018.

Changes Other than Editing from Proposed to Adopted Version: The authority decided to not make the proposed changes to the definition of long-term disability insurance in WAC 182-08-015 and 182-12-109.

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 the 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 39, 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 39, Repealed 0.

Date Adopted: October 3, 2018.

Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-015 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates other meaning:

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, or federal regulations or guidance issued under the Affordable Care Act.

"Annual open enrollment" means an annual event set aside for a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, or enroll in or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP)((,)) and the medical flexible spending arrangement (FSA)((, or)). They may also enroll in or opt out of the premium payment plan.

"Authority" or "HCA" means the Washington state health care authority.

"Board" means the public employees benefits board established under provisions of RCW 41.05.055.

"Calendar days" or "days" means all days including Saturdays and Sundays.

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of ((PEBB)) health plan coverage available to enrollees after a qualifying event occurs as administered under ((Title XXII of the Public Health Service (PHS) Act)) the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or PEBB insurance coverage extended by the public employees benefits board under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of PEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of PEBB benefits.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in a PEBB health plan by a retiree or an eligible survivor.

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan ((authorized in chapter 41.05 RCW)) under this chapter pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the

Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer" for the public employees benefits board program means the state of Washington.

"Employer-based group health plan" means group medical and group dental related to a current employment relationship. It does not include medical or dental coverage available to retired employees, individual market medical or dental coverage, or government-sponsored programs such as medicare or medicaid.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the authority by a state agency, employer group, or charter school for its eligible employees as described in WAC 182-12-114 and 182-12-131((~~, and the employee's eligible dependents as described in WAC 182-12-260~~)).

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, educational service districts, and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority as described in WAC 182-08-245.

"Employer group rate surcharge" means the rate surcharge described in RCW 41.05.050(2).

"Employer-paid coverage" means PEBB insurance coverage for which an employer contribution is made by a state agency, employer group, or charter school for employees eligible under WAC 182-12-114 and 182-12-131. It also means basic benefits described in RCW 28A.400.270(1) for which an employer contribution is made by school districts or an educational service district.

"Employing agency" for the public employees benefits board program means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; ((~~charter school; or~~)) and a tribal government covered by chapter 41.05 RCW.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in PEBB benefits, and for whom applicable premium payments have been made.

"Exchange" means the Washington health benefit exchange established in RCW 43.71.020, and any other health benefit exchange established under the Affordable Care Act.

"Exchange coverage" means coverage offered by a qualified health plan through an exchange.

"Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose appointment, workload, and duties directly serve the institution's academic mission, as determined under the authority of its enabling statutes, its governing body, and any applicable collective bargaining agreement.

"Health plan" means a plan offering medical or dental, or both, developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Insignificant shortfall" means a premium balance owed that is less than or equal to the lesser of $50 or ten percent of the premium required by the health plan as described in Treasury Regulation 26 C.F.R. 54.4980B-8.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen State College, the community and technical colleges, and the state board for community and technical colleges.

"Large claim" means a claim for more than $25,000 in allowed costs for services in a quarter.

"Layoff," for purposes of this chapter, means a change in employment status due to an employer's lack of funds or an employer's organizational change.

"Life insurance" for eligible employees includes basic life insurance and accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as optional life insurance and optional AD&D insurance offered to and paid for by employees for themselves and their dependents. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"LTD insurance" includes basic long-term disability insurance paid for by the employing agency and long-term disability insurance offered to employees on an optional basis.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan ((~~authorized in chapter 41.05 RCW~~)) under this chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Ongoing large claim" means a claim where the patient is expected to need ongoing case management into the next quarter for which the expected allowed cost is greater than $25,000 in the quarter.

"PEBB" means the public employees benefits board.

((~~"PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB program. The director has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.~~))

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB insurance coverage" means any health plan, life insurance, long-term disability (LTD) insurance, long-term care insurance, or property and casualty insurance administered as a PEBB benefit.

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171((~~,~~)) and 182-12-180), eligible survivors (as described in WAC

182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or ((~~a~~)) an enrolled subscriber's spouse or state registered domestic partner choosing not to enroll in ((~~his or her~~)) their employer-based group medical when:

• ((~~Premiums are~~)) The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the Uniform Medical Plan (UMP) Classic ((~~premiums~~)); and

• The benefits have an actuarial value of ((~~benefits is~~)) at least ninety-five percent of the actuarial value of UMP Classic benefits.

"Qualified health plan" means a medical plan that is certified to be offered through an exchange.

"Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program (DCAP), medical flexible spending arrangement (FSA), or premium payment plan ((~~as authorized in chapter 41.05 RCW~~)) offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. During the special open enrollment subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or ((~~change~~)) revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government and all personnel thereof. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, state agency, or charter school and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of enrollees.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

"Waive" means to interrupt an eligible employee's enrollment in a PEBB health plan because the employee is enrolled in other employer-based group medical, TRICARE plans, or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-180 Premium payments and premium refunds. Premiums and applicable premium surcharges are due as described in this section, except when an employing agency is correcting its enrollment error as described in WAC 182-08-187 (3) or (4).

(1) **Premium payments.** Public employees benefits board (PEBB) insurance coverage premiums and applicable premium surcharges for all subscribers become due the first of the month in which PEBB insurance coverage is effective.

Premiums and applicable premium surcharges are due from the subscriber for the entire month of PEBB insurance coverage and will not be prorated during any month.

(a) For subscribers not eligible for the employer contribution that are electing to enroll in PEBB retiree insurance coverage as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) or (b), 182-12-205 (6)(a) through (f), 182-12-211, and 182-12-265; or electing to enroll in continuation coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270, the first premium payment and applicable premium surcharge are due to the health care authority (HCA) no later than forty-five days after the election period ends as described within the Washington Administrative Code applicable to the subscriber. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental or long-term disability insurance coverage. Premiums associated with life insurance coverage must be made to the contracted vendor. Following the first premium payment, premiums and applicable premium surcharges must be paid as premiums become due.

(b) For employees who are eligible for the employer contribution, premiums and applicable premium surcharges are due to the employing agency. If an employee elects optional

coverage as described in WAC 182-08-197 (1)(a) or (3)(a), the employee is responsible for payment of premiums from the month that the optional coverage begins.

(((~~(b)~~))) (c) Unpaid or underpaid premiums or applicable premium surcharges for all subscribers must be paid, and are due from the employing agency, subscriber, or a subscriber's legal representative to the ((~~health care authority (HCA). A subscriber's~~)) HCA. For subscribers not eligible for the employer contribution or employees eligible for the employer contribution as described in WAC 182-12-138, monthly premiums or applicable premium surcharges that remain((~~s~~)) unpaid for thirty days will be considered delinquent. A subscriber is allowed a grace period of thirty days from the date the monthly premiums or applicable premium surcharges become((~~s~~)) delinquent to pay the unpaid premium balance or surcharges. If a subscriber's monthly premiums or applicable premium surcharges remain((~~s~~)) unpaid for sixty days from the original due date, the subscriber's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premiums and any applicable premium surcharges ((~~was~~)) were paid. If it is determined by the ((~~authority~~)) HCA that payment of the unpaid balance in a lump sum would be considered a hardship, the ((~~authority~~)) HCA may develop a reasonable ((~~repayment~~)) payment plan with the subscriber or the subscriber's legal representative upon request.

(((~~(c) A~~)) (d) Monthly premiums or applicable premium surcharges due from a subscriber who is not eligible for the employer contribution will be considered unpaid if one of the following occurs:

(i) No payment of premiums or applicable premium surcharges ((~~is~~)) are received by the ((~~authority~~)) HCA and the monthly premiums or applicable premium surcharges remain((~~s~~)) unpaid for thirty days; or

(ii) ((~~A~~)) Premium payments or applicable premium surcharges received by the ((~~authority is~~)) HCA are underpaid by an amount greater than an insignificant shortfall and the monthly premiums or applicable premium surcharges remain((~~s~~)) underpaid for thirty days past the date the monthly premiums or applicable premium surcharges ((~~was~~)) were due.

(2) **Premium refunds.** PEBB premiums and applicable premium surcharges will be refunded using the following method:

(a) When a subscriber submits an enrollment change affecting subscriber or dependent eligibility, HCA may allow up to three months of accounting adjustments. HCA will refund to the individual or the employing agency any excess premiums and applicable premium surcharges paid during the three month adjustment period, except as indicated in WAC 182-12-148(5).

(b) If a PEBB subscriber, dependent, or beneficiary submits a written appeal as described in WAC ((~~182-16-025~~)) 182-16-2010, showing proof of extraordinary circumstances beyond ((~~his or her~~)) their control such that it was effectively impossible to submit the necessary information to accomplish an allowable enrollment change within sixty days after the event that created a change of premiums ((~~occurred~~)), the PEBB director, the director's designee, or the PEBB appeals ((~~committee~~)) unit may approve a refund of premiums and applicable premium surcharges which does not exceed twelve months of premiums.

(c) If a federal government entity determines that an enrollee is retroactively enrolled in coverage (for example, medicare) the subscriber or beneficiary may be eligible for a refund of premiums and applicable premium surcharges paid during the time ((~~he or she was~~)) they were enrolled under the federal program if approved by the PEBB director or the director's designee.

(d) HCA errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employing agency, subscriber, or beneficiary.

(e) Employing agency errors will be corrected by returning all excess premiums and applicable premium surcharges paid by the employee or beneficiary.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-08-185 What are the requirements regarding premium surcharges? (1) A subscriber's account will incur a premium surcharge in addition to the subscriber's monthly premium, when any enrollee, thirteen years and older, engages in tobacco use.

(a) A subscriber must attest to whether any enrollee, thirteen years and older, enrolled in ((~~his or her~~)) their public employees benefits board (PEBB) medical engages in tobacco use. The subscriber must attest as described in (a)(i) through (vii) of this subsection:

(i) An employee who is newly eligible or regains eligibility for the employer contribution toward PEBB benefits must complete the required form to enroll in PEBB medical as described in WAC 182-08-197 (1) or (3). The employee must include ((~~his or her~~)) their attestation on that form. The employee must submit the ((~~attestation to his or her~~)) form to their employing agency. If the employee's attestation results in a premium surcharge, it will take effect the same date as PEBB medical begins.

(ii) If there is a change in the tobacco use status of any enrollee, thirteen years and older on the subscriber's PEBB medical, the subscriber must update ((~~his or her~~)) their attestation on the required form. An employee must submit the ((~~updated attestation to his or her~~)) form to their employing agency. Any other subscriber must submit ((~~his or her updated attestation~~)) their form to the PEBB program.

• A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first of the month, the change to the surcharge begins on that day.

• A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first of the month, the change to the surcharge begins on that day.

(iii) If a subscriber submits the required form to enroll a dependent, thirteen years and older, in PEBB medical as described in WAC 182-12-262, the subscriber must ((~~update his or her attestation~~)) attest for their dependent on the required form. An employee must submit the ((~~updated attestation to his or her~~)) form to their employing agency. Any other subscriber must submit ((~~his or her updated attestation~~))

their form to the PEBB program. A change that results in a premium surcharge will take effect the same date as PEBB medical begins.

(iv) An enrollee, thirteen years and older, who elects to continue medical coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, or 182-12-270, must provide an attestation on the required form if ((~~he or she has~~)) they have not previously attested as described in (a) of this subsection. The enrollee must submit ((~~his or her updated attestation~~)) their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(v) An employee or retiree who enrolls in PEBB medical as described in WAC 182-12-171 (1)(a), 182-12-180 (3)(a), 182-12-200 (3)(a) ((~~and~~)) or (b), ((~~or~~)) 182-12-205 (6)(a)((~~, (b), (c), (d), and (e)~~)) through (f), or 182-12-211, must provide an attestation on the required form if ((~~he or she has~~)) they have not previously attested as described in (a) of this subsection. The employee or retiree must submit ((~~his or her updated attestation~~)) their form to the PEBB program. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vi) A surviving spouse, state registered domestic partner, or dependent child, thirteen years and older, who enrolls in PEBB medical as described in WAC 182-12-180 (3)(a), 182-12-250(5) or 182-12-265, must provide an attestation on the required form to the PEBB program if ((~~he or she has~~)) they have not previously attested as described in (a) of this subsection. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

(vii) An employee who previously waived PEBB medical must complete the required form to enroll in PEBB medical as described in WAC 182-12-128(3). The employee must include ((~~his or her~~)) their attestation on that form. An employee must submit the ((~~attestation to his or her~~)) form to their employing agency. An attestation that results in a premium surcharge will take effect the same date as PEBB medical begins.

Exceptions:

(1) A subscriber enrolled in both medicare Parts A and B and in the medicare risk pool is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.

(2) An employee who waives PEBB medical according to WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to ((~~his or her~~)) their account as long as the employee ((~~enrollment~~)) remains in waived status.

(b) A subscriber's account will incur a premium surcharge when a subscriber fails to attest to the tobacco use status of all enrollees as described in subsection (1)(a) of this section.

(c) The PEBB program will provide a reasonable alternative for enrollees who use tobacco products. A subscriber can avoid the tobacco use premium surcharge if the subscriber attests on the required form that all enrollees who use tobacco products enrolled in or accessed the applicable reasonable alternative offered below:

(i) An enrollee who is eighteen years and older and uses tobacco products ((~~has access to a~~)) is currently enrolled in the free tobacco cessation program through ((~~his or her~~)) their PEBB medical.

(ii) An enrollee who is thirteen through seventeen years old and uses tobacco products ((~~may access~~)) accessed the information and resources aimed at teens on the Washington state department of health's web site at ((~~http://teen.smokefree.gov~~)) https://teen.smokefree.gov.

(iii) A subscriber may contact the PEBB program to accommodate a physician's recommendation that addresses an enrollee's use of tobacco products or for information on how to avoid the tobacco use premium surcharge.

(2) A subscriber will incur a premium surcharge in addition to the subscriber's monthly premium, if an enrolled spouse or state registered domestic partner elected not to enroll in another employer-based group medical ((~~that has premiums~~)) where the spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the Uniform Medical Plan (UMP) ((~~Classic's premiums and benefits with~~)) Classic and the benefits have an actuarial value of at least ninety-five percent of the actuarial value of the UMP Classic's benefits.

(a) A subscriber who enrolled a spouse or state registered domestic partner under ((~~his or her~~)) their PEBB medical may only attest during the following times:

(i) When a subscriber becomes eligible to enroll a spouse or state registered domestic partner in PEBB medical or during the annual open enrollment as described in WAC 182-12-262 (1)(a) or (b). A subscriber must complete the required form to enroll ((~~his or her~~)) their spouse or state registered domestic partner. The subscriber must include ((~~his or her~~)) their attestation on that form. The employee must submit the ((~~attestation to his or her~~)) form to their employing agency. Any other subscriber must submit ((~~an attestation~~)) the form to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the same date as PEBB medical begins;

(ii) When a special open enrollment (((~~SOE~~))) event occurs as described in WAC 182-12-262 (1)(c). A subscriber must submit the required form to enroll a spouse or state registered domestic partner in PEBB medical. The subscriber must include ((~~his or her updated~~)) their attestation on that form. An employee must submit ((~~an updated attestation to his or her~~)) the form to their employing agency. Any other subscriber must submit ((~~an updated attestation~~)) the form to the PEBB program. If the subscriber's attestation results in a premium surcharge it will take effect the ((~~first day of the month following receipt of the attestation. If that day is the first day of the month, the change to the surcharge begins on that day~~)) same date as PEBB medical begins;

(iii) During the annual open enrollment. A subscriber must attest if during the month prior to the annual open enrollment the subscriber was:

- Incurring the surcharge;
- Not incurring the surcharge because the spouse's or state registered domestic partner's share of the medical premium through ((~~his or her~~)) their employer-based group medical was more than ninety-five percent of the ((~~UMP Classic's premiums~~)) additional cost an employee would be required to

pay to enroll a spouse or state registered domestic partner in the UMP Classic; or

• Not incurring the surcharge because the actuarial value of benefits provided through the spouse's or state registered domestic partner's employer-based group medical was less than ninety-five percent of the actuarial value of the UMP Classic's ((~~actuarial value~~)) benefits.

A subscriber must update ((~~his or her~~)) their attestation on the required form. An employee must submit ((~~an updated attestation to his or her~~)) the form to their employing agency. Any other subscriber must submit ((~~an updated attestation~~)) the form to the PEBB program. The subscriber's attestation or any correction to a subscriber's attestation must be received no later than December 31st of the year in which the annual open enrollment occurs. If the subscriber's attestation results in a premium surcharge, being added or removed, the change to the surcharge will take effect January 1st of the following year; and

(iv) When there is a change in the spouse's or state registered domestic partner's employer-based group medical. A subscriber must update their attestation on the required form. An employee must submit ((~~an updated attestation to his or her~~)) the form to their employing agency ((~~within~~)) no later than sixty days ((~~of when~~)) after the spouse's or state registered domestic partner's employer-based group medical status changes. Any other subscriber must submit ((~~an updated attestation~~)) the form to the PEBB program no later than sixty days after the spouse's or state registered domestic partner's employer-based group medical status changes.

• A change that results in a premium surcharge will begin the first day of the month following the status change. If that day is the first day of the month, the change to the premium surcharge begins on that day.

• A change that results in removing the premium surcharge will begin the first day of the month following receipt of the attestation. If that day is the first day of the month, the change to the premium surcharge begins on that day.

Exceptions:

(1) A subscriber enrolled in both medicare Parts A and B and in the medicare risk pool is not required to provide an attestation and no premium surcharge will be imposed on the subscriber's account.

(2) An employee who waives PEBB medical according to WAC 182-12-128 is not required to provide an attestation and no premium surcharge will be applied to ((~~his or her~~)) their account as long as the employee remains in waived status.

(3) An employee who covers ((~~his or her~~)) their spouse or state registered domestic partner who has waived ((~~his or her~~)) their own PEBB medical must attest, but a premium surcharge will not be applied.

(4) A subscriber who covers ((~~his or her~~)) their spouse or state registered domestic partner who elected not to enroll in a TRICARE plan must attest, but a premium surcharge will not be applied.

(b) A premium surcharge will be applied to a subscriber who does not attest as described in (a) of this subsection.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-187 How do employing agencies and contracted vendors correct enrollment errors and is there a limit on retroactive enrollment? (1) An employing agency or contracted vendor that makes one or more of the following enrollment errors must correct the error as described in subsections (2) through (4) of this section.

(a) Failure to timely notify an employee of ((~~his or her~~)) their eligibility for public employee benefits board (PEBB) benefits and the employer contribution as described in WAC 182-12-113(2);

(b) Failure to enroll the employee and ((~~his or her~~)) their dependents in PEBB insurance coverage as elected by the employee, if the elections were timely;

(c) Failure to enroll PEBB insurance coverage as described in WAC 182-08-197 (1)(b); ((~~or~~))

(d) Failure to accurately reflect an employee's premium surcharge attestation on the employee's account; or

(e) Enrolling an employee or their dependents in PEBB insurance coverage when they are not eligible as described in WAC 182-12-114 or 182-12-260 and it is clear there was no fraud or intentional misrepresentation by the employee involved.

The employing agency or the applicable contracted vendor must enroll the employee and the employee's dependents, as elected, or terminate enrollment in PEBB benefits as described in subsection ((~~(1)~~)) (2) of this section, reconcile premium payments and applicable premium surcharges as described in subsection ((~~(2)~~)) (3) of this section, and provide recourse as described in subsection ((~~(3)~~)) (4) of this section.

Note: If the employing agency failed to provide the notice required in WAC 182-12-113 or the employer group contract before the end of the employee's thirty-one day enrollment period described in WAC 182-08-197 (1)(a), the employing agency must provide the employee a written notice of eligibility for PEBB benefits and offer a new enrollment period of thirty-one days. Employees who do not return the required enrollment forms by the due date required under the new enrollment period must be defaulted according to WAC 182-08-197 (1)(b). This notice requirement does not remove the ability to offer recourse.

(2) **Enrollment or termination.**

(a) PEBB medical and dental enrollment is effective the first day of the month following the date the enrollment error is identified, unless the authority determines additional recourse is warranted, as described in subsection ((~~(3)~~)) (4) of this section. If the enrollment error is identified on the first day of the month, the enrollment correction is effective that day;

(b) Basic life and basic long-term disability (LTD) insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible, or the first day of the month the employee regained eligibility, as described in WAC 182-08-197. If the employee became newly eligible on the first working day of a month, basic life and basic LTD insurance begins on that date;

(c) Optional life and optional LTD insurance enrollment is retroactive to the first day of the month following the day the employee became newly eligible if the employee elects to

enroll in this coverage (or if previously elected, the first of the month following the signature date of the employee's application for this coverage). If an employing agency enrollment error occurred when the employee regained eligibility for the employer contribution following a period of leave as described in WAC 182-08-197(3):

(i) Optional life and optional LTD insurance is enrolled the first day of the month the employee regained eligibility, at the same level of coverage the employee continued during the period of leave, without evidence of insurability.

(ii) If the employee was not eligible to continue optional LTD insurance during the period of leave, optional LTD insurance is reinstated the first day of the month the employee regained eligibility, to the level of coverage the employee was enrolled in prior to the period of leave, without evidence of insurability.

(iii) If the employee was eligible to continue optional life insurance and optional LTD insurance under the period of leave but did not, the employee must provide evidence of insurability and receive approval from the contracted vendor.

(d) If the employee is eligible and elects (or elected) to enroll in the medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP), enrollment is limited to three months prior to the date enrollment is processed, but not earlier than the current plan year. If an employee was not enrolled in ((~~an~~)) a medical FSA or DCAP as elected, the ((~~employee may adjust his or her election. The~~)) employee may either participate at the amount originally elected with a corresponding increase in contributions for the balance of the plan year, or participate at a reduced amount for the plan year by maintaining the per-pay period contribution in effect.

(e) If the employee or their dependent was not eligible but still enrolled as described in subsection (1)(e) of this section, the employee's or their dependent's PEBB insurance coverage will be terminated prospectively effective as of the last day of the month.

(3) **Premium payments.**

(a) The employing agency must remit to the authority the employer contribution and the employee contribution for health plan premiums, applicable premium surcharges, basic life, and basic LTD from the date PEBB insurance coverage begins as described in subsections ((~~(1)~~)) (2) and ((~~(3)~~)) (4)(a)(i) of this section. If a state agency failed to notify a newly eligible employee of ((~~his or her~~)) their eligibility for PEBB benefits, the state agency may only collect the employee contribution for health plan premiums and applicable premium surcharges for coverage for months following notification of a new enrollment period.

(b) When an employing agency fails to correctly enroll the amount of optional LTD insurance elected by the employee, premiums will be corrected as follows:

(i) When additional premiums are due to the authority, the employee is responsible for premiums for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premiums.

(ii) When premium refunds are due to the employee, the optional LTD insurance vendor is responsible for premium refunds for the most recent twenty-four months of coverage. The employing agency is responsible for additional months of premium refunds.

(c) When an employing agency mistakenly enrolls an employee or their dependent as described in subsection (1)(e) of this section, premiums and any applicable premium surcharges will be refunded by the employing agency to the employee without rescinding the insurance coverage.

(4) **Recourse.**

(a) Employee eligibility for PEBB benefits begins on the first day of the month following the date eligibility is established as described in WAC 182-12-114. Dependent eligibility is described in WAC 182-12-260, and dependent enrollment is described in WAC 182-12-262. When retroactive correction of an enrollment error is limited as described in subsection ((~~(1)~~)) (2) of this section, the employing agency must work with the employee, and receive approval from the authority, to implement retroactive PEBB insurance coverage within the following parameters:

(i) Retroactive enrollment in a PEBB health plan;

(ii) Reimbursement of claims paid;

(iii) Reimbursement of amounts paid for by the employee or dependent medical and dental premiums;

(iv) Other legal remedy received or offered; or

(v) Other recourse, upon approval by the authority.

(b) Recourse must not contradict a specific provision of federal law or statute and does not apply to requests for noncovered services or in the case of an individual who is not eligible for PEBB benefits.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for medicare? (1) Subscribers must select a new health plan within sixty days of their chosen health plan becoming unavailable due to a change in contracting service area or the subscriber or subscriber's dependent ceasing to be eligible for their current plan because of ((~~his or her~~)) their enrollment in medicare.

(a) Employees must submit the required form to their employing agency electing their new health plan.

(b) All other subscribers must submit the required form to notify the PEBB program electing their new health plan.

(c) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received.

(2) The PEBB program will change health plan enrollment as follows if the subscriber fails to select a new health plan as required under subsection (1) of this section:

(a) Employees who fail to select a new health plan within the required time period will be enrolled in a successor plan if one is available or an existing plan designated by the director.

(b) All other subscribers who fail to select a new health plan within the required time period will be enrolled in a successor plan if one is available or a plan designated by the director.

(3) Any subscriber enrolled in a health plan as described in subsection (2) of this section may not change health plans except as allowed in WAC 182-08-198.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-197 When must a newly eligible employee, or an employee who regains eligibility for the employer contribution, select public employees benefits board (PEBB) benefits and complete required forms? An employee who is newly eligible or who regains eligibility for the employer contribution toward public employees benefits board (PEBB) benefits enrolls as described in this section.

(1) When an employee is newly eligible for PEBB benefits:

(a) An employee must complete the required forms indicating ((~~his or her~~)) their enrollment elections, including an election to waive PEBB medical if the employee is eligible to waive PEBB medical and elects to waive PEBB medical as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency. Forms must be received by ((~~his or her~~)) their employing agency no later than thirty-one days after the employee becomes eligible for PEBB benefits under WAC 182-12-114.

(i) An employee may enroll in optional life and optional long-term disability (LTD) insurance up to the guaranteed issue without evidence of insurability if the required forms are returned to the employee's employing agency or contracted vendor as required. An employee may apply for enrollment in optional life and optional LTD insurance over the guaranteed issue at any time during the calendar year by submitting the required form to the contracted vendor for approval.

(ii) If an employee is eligible to participate in the state's salary reduction plan (see WAC 182-12-116), the employee will automatically enroll in the premium payment plan upon enrollment in PEBB medical so employee medical premiums are taken on a pretax basis. To opt out of the premium payment plan, a new employee must complete the required form and return it to ((~~his or her~~)) their state agency. The form must be received by ((~~his or her~~)) their state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(iii) If an employee is eligible to participate in the state's salary reduction plan (see WAC 182-12-116), the employee may enroll in the state's medical flexible spending arrangement (FSA) or dependent care assistance program (DCAP) or both, except as limited by subsection (4) of this section. To enroll in these optional PEBB benefits, the employee must return the required form to ((~~his or her~~)) their state agency. The form must be received by the state agency no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(b) If a newly eligible employee's employing agency, or contracted vendor in the case of life insurance, does not receive the employee's required forms indicating medical, dental, life insurance, and LTD insurance elections, and the employee's tobacco use status attestation within thirty-one days of the employee becoming eligible, ((~~his or her~~)) their enrollment will be as follows for those elections not received within thirty-one days:

(i) Uniform Medical Plan Classic;

(ii) Uniform Dental Plan;

(iii) Basic life insurance;

(iv) Basic long-term disability insurance;

(v) Dependents will not be enrolled; and

(vi) A tobacco use surcharge will be incurred as described in WAC 182-08-185 (1)(b).

(2) The employer contribution toward PEBB insurance coverage ends according to WAC 182-12-131. When an employee's employment ends, participation in the state's salary reduction plan ends.

(3) When an employee loses and later regains eligibility for the employer contribution toward PEBB insurance coverage following a period of leave described in WAC 182-12-133(1) and 182-12-142 (1) and (2). PEBB medical and dental begins on the first day of the month the employee is in pay status eight or more hours:

(a) The employee must complete the required forms indicating ((~~his or her~~)) their enrollment elections, including an election to waive PEBB medical if the employee chooses to waive PEBB medical as described in WAC 182-12-128. The required forms must be returned to the employee's employing agency except as described in (d) of this subsection. Forms must be received by the employing agency, or life insurance contracted vendor, if required, no later than thirty-one days after the employee regains eligibility, except as described in subsection (3)(b) of this section:

(i) An employee who self-paid for optional life PEBB insurance coverage after losing eligibility will have that level of coverage reinstated without evidence of insurability effective the first day of the month in which the employee is in pay status eight or more hours;

(ii) An employee who was eligible to continue optional life ((~~under continuation coverage~~)) but discontinued that PEBB insurance coverage must submit evidence of insurability to the contracted vendor if ((~~he or she~~)) they choose((~~s~~)) to reenroll when ((~~he or she~~)) they regain((~~s~~)) eligibility for the employer contribution;

(iii) An employee who was eligible to continue optional LTD ((~~under continuation coverage~~)) insurance but discontinued that PEBB insurance coverage must submit evidence of insurability for optional LTD insurance to the contracted vendor when ((~~he or she~~)) they regain((~~s~~)) eligibility for the employer contribution.

(b) An employee in any of the following circumstances does not have to return a form indicating optional LTD insurance elections. ((~~His or her~~)) Their optional LTD insurance will be automatically reinstated effective the first day of the month ((~~he or she is~~)) they are in pay status eight or more hours:

(i) The employee continued to self-pay for ((~~his or her~~)) their optional LTD insurance after losing eligibility for the employer contribution;

(ii) The employee was not eligible to continue optional LTD insurance after losing eligibility for the employer contribution.

(c) If an employee's employing agency, or contracted vendor accepting forms directly, does not receive the

required forms within thirty-one days of the employee regaining eligibility, medical, dental, life insurance, tobacco use surcharge, and LTD insurance enrollment will be as described in subsection (1)(b) of this section, except as described in (b) of this subsection.

(d) If an employee is eligible to participate in the state's salary reduction plan (see WAC 182-12-116) the employee may enroll in the state's medical FSA or DCAP or both, except as limited by subsection (4) of this section. To enroll in these optional PEBB benefits, the employee must return the required form to ((~~his or her~~)) the contracted vendor or their state agency. The ((~~form must be received by the~~)) contracted vendor or employee's state agency must receive the form no later than thirty-one days after the employee becomes eligible for PEBB benefits.

(4) If an employee who is eligible to participate in the state's salary reduction plan (see WAC 182-12-116) is hired into a new position that is eligible for PEBB benefits in the same year, the employee may not resume participation in DCAP or medical FSA until the beginning of the next plan year, unless the time between employments is ((~~less than~~)) thirty days ((~~and~~)) or less and within the current plan year. The employee ((~~notifies~~)) must notify their new state agency of the transfer by providing the new state ((~~agency and the DCAP or the medical FSA contracted vendor of his or her employment transfer within the current plan year~~)) agency's personnel, payroll, or benefits office the required form no later than thirty-one days after the employee's first day of work with the new state agency.

(5) An employee's PEBB insurance coverage elections remain the same when an employee transfers from one employing agency to another employing agency without a break in PEBB insurance coverage for one month or more. This includes movement of an employee between any entities described in WAC 182-12-111 and participating in PEBB benefits. PEBB insurance coverage elections also remain the same when an employee has a break in employment that does not interrupt ((~~his or her~~)) their employer contribution toward PEBB insurance coverage.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-198 When may a subscriber change health plans? Subscribers may change health plans at the following times:

(1) **During annual open enrollment:** Subscribers may change health plans during the public employees benefits board (PEBB) annual open enrollment period. The subscriber must submit the required enrollment forms to change ((~~his or her~~)) their health plan. An employee submits the enrollment forms to ((~~his or her~~)) their employing agency. All other subscribers submit the enrollment forms to the PEBB program. The required enrollment forms must be received no later than the last day of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** Subscribers may ((~~change~~)) revoke their health plan((~~s~~)) election and make a new election outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both. To make a health plan change, the subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than sixty days after the event occurs, except as described in (i) of this subsection. An employee submits the enrollment forms to ((~~his or her~~)) their employing agency. All other subscribers submit the enrollment forms to the PEBB program. Subscribers must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day.

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, the new health plan coverage will begin the first day of the month following the date the medicare advantage plan disenrollment form is received.

If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

(i) Marriage or registering a domestic partnership;

(ii) Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(b) Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(c) Subscriber has a change in employment status that affects the subscriber's eligibility for ((~~his or her~~)) their employer contribution toward ((~~his or her~~)) their employer-based group health plan;

(d) The subscriber's dependent has a change in ((~~his or her~~)) their own employment status that affects ((~~his or her~~)) their eligibility for the employer contribution under ((~~his or her~~)) their employer-based group health plan;

Exception: For the purposes of special open enrollment "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(e) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability. If the subscriber moves and the subscriber's current health plan is not available in the new location the subscriber must select a new health plan;

(f) A court order ((~~or national medical support notice (see also WAC 182-12-263)~~)) requires the subscriber or any other individual to provide insurance coverage for an eligible

dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(g) Subscriber or a subscriber's dependent becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(h) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP);

(i) Subscriber or a subscriber's dependent becomes entitled to coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare, or enrolls in or terminates enrollment in a medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or a subscriber's dependent's entitlement to medicare, the subscriber must select a new health plan as described in WAC 182-08-196(1). A subscriber has six months from the date of their or their dependent's enrollment in medicare Part B to enroll in a PEBB medicare supplement plan for which they or their dependent is eligible. The forms must be received by the PEBB program no later than six months after the enrollment in medicare Part B for either the subscriber or the subscriber's dependent;

(j) Subscriber or a subscriber's dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). The health care authority (HCA) may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

(k) Subscriber or a subscriber's dependent experiences a disruption of care that could function as a reduction in benefits for the subscriber or the subscriber's dependent for a specific condition or ongoing course of treatment. The subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

(i) Active cancer treatment such as chemotherapy or radiation therapy for up to ninety days or until medically stable; or

(ii) Transplant within the last twelve months; or

(iii) Scheduled surgery within the next sixty days (elective procedures within the next sixty days do not qualify for continuity of care); or

(iv) Recent major surgery still within the postoperative period of up to eight weeks; or

(v) Third trimester of pregnancy.

If the employee is having premiums taken from payroll on a pretax basis, a health plan change will not be approved if it would conflict with provisions of the salary reduction plan authorized under RCW 41.05.300.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-199 When may an employee enroll ((~~in or change his or her~~)), or revoke an election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP)? An employee who is eligible to participate in the state's salary reduction plan as described in WAC 182-12-116 may enroll ((~~in or change his or her~~)), or revoke their election and make a new election under the premium payment plan, medical flexible spending arrangement (FSA), or dependent care assistance program (DCAP) at the following times:

(1) When newly eligible under WAC 182-12-114, as described in WAC 182-08-197(1).

(2) **During annual open enrollment:** An eligible employee may elect to enroll in or ((~~waive his or her~~)) opt out of participation under the state's premium payment plan during the annual open enrollment by submitting the required form to their employing agency. An eligible employee may elect to enroll or reenroll in the medical FSA, DCAP, or both during the annual open enrollment((~~. For the state's premium payment plan, the required form must be submitted to his or her employing agency. To enroll or reenroll in medical FSA or DCAP the employee must submit the required form to his or her employing agency or the applicable contracted vendor~~)) by submitting the required forms to their employing agency or applicable contracted vendor. All required forms must be received no later than the last day of the annual open enrollment. The enrollment or new election becomes effective January 1st of the following year.

Note: Employees enrolled in a consumer directed health plan (CDHP) with a health savings account (HSA) cannot also enroll in a medical FSA in the same plan year. Employees who elect both will only be enrolled in the CDHP with a HSA.

(3) **During a special open enrollment:** An employee who is eligible to participate in the salary reduction plan may enroll or ((~~change his or her~~)) revoke their election and make a new election under the state's premium payment plan, medical FSA, or DCAP outside of the annual open enrollment if a special open enrollment event occurs. The enrollment or change in election must be allowable under Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment. To make a change or enroll, the employee must submit the required form((~~s as instructed on the forms. The~~)) to their employing agency. The employing agency must receive the required form((~~s must be received~~)) and evidence of the event that created the special open enrollment no later than sixty days after the event occurs. ((~~The employee must provide evidence of the event that created the special open enrollment.~~))

For purposes of this section, an eligible dependent includes any person who qualifies as a dependent of the employee for tax purposes under IRC 26 U.S.C. Sec. 152 without regard to the income limitations of that section. It does not include a state registered domestic partner unless the domestic partner otherwise qualifies as a dependent for tax purposes under IRC 26 U.S.C. Sec. 152.

(a) **Premium payment plan.** An employee may enroll or ((~~change his or her election under~~)) revoke their election and elect to opt out of the premium payment plan when any of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the

event. The enrollment or ((~~change in~~)) election to opt out will be effective the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a domestic partnership when the dependent is a tax dependent of the subscriber;

• Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee's dependent no longer meets public employee benefits board (PEBB) eligibility criteria because:

• Employee has a change in marital status;

• Employee's domestic partnership with a state registered domestic partner who is a tax dependent is dissolved or terminated;

• An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;

• An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or

• An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(iv) Employee has a change in employment status that affects the employee's eligibility for ((~~his or her~~)) their employer contribution toward ((~~his or her~~)) their employer-based group health plan;

(v) The employee's dependent has a change in ((~~his or her~~)) their own employment status that affects ((~~his or her~~)) their eligibility for the employer contribution under ((~~his or her~~)) their employer-based group health plan;

Exception: For the purposes of special open enrollment "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(vi) Employee or an employee's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB annual open enrollment;

(vii) Employee or an employee's dependent has a change in residence that affects health plan availability;

(viii) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;

(ix) A court order ((~~or national medical support notice (see also WAC 182-12-263)~~)) requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(x) Employee or an employee's dependent becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(xi) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP);

(xii) Employee or an employee's dependent becomes entitled to coverage under medicare or the employee or an employee's dependent loses eligibility for coverage under medicare;

(xiii) Employee or an employee's dependent's current health plan becomes unavailable because the employee or enrolled dependent is no longer eligible for a health savings account (HSA). The health care authority (HCA) requires evidence that the employee or employee's dependent is no longer eligible for an HSA;

(xiv) Employee or an employee's dependent experiences a disruption of care that could function as a reduction in benefits for the employee or the employee's dependent for a specific condition or ongoing course of treatment. The employee may not change ((~~his or her~~)) their health plan election if the employee's or dependent's physician stops participation with the employee's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

• Active cancer treatment such as chemotherapy or radiation therapy for up to ninety days or until medically stable; or

• Transplant within the last twelve months; or

• Scheduled surgery within the next sixty days (elective procedures within the next sixty days do not qualify for continuity of care); or

• Recent major surgery still within the postoperative period of up to eight weeks; or

• Third trimester of pregnancy.

(xv) Employee or employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.

If the employee is having premiums taken from payroll on a pretax basis, a plan change will not be approved if it would conflict with provisions of the salary reduction plan authorized under RCW 41.05.300.

(b) **Medical flexible spending arrangement (FSA).** An employee may enroll or ((~~change his or her~~)) revoke their election and make a new election under the medical FSA when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or ((~~change in~~)) new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth,

adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a domestic partnership if the domestic partner qualifies as a tax dependent of the subscriber;

• Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee's dependent no longer meets PEBB eligibility criteria because:

• Employee has a change in marital status;

• Employee's domestic partnership with a state registered domestic partner who qualifies as a tax dependent is dissolved or terminated;

• An eligible dependent child turns age twenty-six or otherwise does not meet dependent child eligibility criteria;

• An eligible dependent ceases to be eligible as an extended dependent or as a dependent with a disability; or

• An eligible dependent dies.

(iii) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(iv) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for the medical FSA;

(v) A court order ((~~or national medical support notice~~)) requires the employee or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(vi) Employee or an employee's dependent becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under medicaid or CHIP;

(vii) Employee or an employee's dependent becomes entitled to coverage under medicare.

(c) **Dependent care assistance program (DCAP).** An employee may enroll or ((~~change his or her~~)) revoke their election and make a new election under the DCAP when any one of the following special open enrollment events occur, if the requested change corresponds to and is consistent with the event. The enrollment or ((~~change in~~)) new election will be effective the first day of the month following the later of the event date or the date the required form and evidence of the event that created the special open enrollment is received by the employing agency. If that day is the first of the month, the enrollment or change in election begins on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, the enrollment or change in election will begin the first of the month in which the event occurs.

(i) Employee acquires a new dependent due to:

• Marriage;

• Registering a domestic partnership if the domestic partner qualifies as a tax dependent of the subscriber;

• Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

• A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(ii) Employee or an employee's dependent has a change in employment status that affects the employee's or a dependent's eligibility for DCAP;

(iii) Employee or an employee's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB annual open enrollment;

(iv) Employee changes dependent care provider; the change to the DCAP election amount can reflect the cost of the new provider;

(v) Employee or the employee's spouse experiences a change in the number of qualifying individuals as defined in IRC 26 U.S.C. Sec. 21 (b)(1);

(vi) Employee's dependent care provider imposes a change in the cost of dependent care; employee may make a change in the DCAP election amount to reflect the new cost if the dependent care provider is not a qualifying relative of the employee as defined in IRC 26 U.S.C. Sec. 152.

AMENDATORY SECTION (Amending WSR 14-20-058, filed 9/25/14, effective 1/1/15)

WAC 182-08-200 Which employing agency is responsible to pay the employer contribution for eligible employees changing agency employment or for faculty employed by more than one institution of higher education? Employing agencies responsible for paying the employer contribution:

(1) **For eligible employees changing agencies:** When an eligible employee's employment relationship terminates with an employing agency at any time ((~~before the end of~~)) during the month for which a premium contribution is due and that employee transfers to another agency, the losing agency is responsible for the ((~~payment of the~~)) employer contribution for that employee for that month. The receiving agency is ((~~not~~)) liable for any employer contribution for ((~~that~~)) the eligible employee ((~~until~~)) beginning the first day of the month following the transfer.

(2) **For eligible faculty employed by more than one institution of higher education:**

(a) When a faculty is eligible for the employer contribution during an anticipated work period (quarter, semester or instructional year), under WAC 182-12-131(3), one institution will pay the entire cost of the employer contribution if the employee is eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes based on its percentage of the employee's total work at all institutions during the anticipated work period.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending

the total premium payment to the health care authority (HCA).

(b) When a faculty is eligible for the employer contribution during the summer or off-quarter/semester, under WAC 182-12-131 (3)(c), one institution will pay the entire cost of the employer contribution if the employee is eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes based on its percentage of the employee's total work at all institutions throughout the instructional year or equivalent nine-month period.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending the total premium payment to HCA.

(c) When a faculty is eligible through two-year averaging under WAC 182-12-131 (3)(d) for the employer contribution, one institution will pay the entire cost of the employer contribution if the employee is eligible by virtue of employment at that single institution. Otherwise:

(i) Each institution contributes to coverage based on its percentage of the employee's total work at all institutions throughout the preceding two academic years. This division of the employer contribution begins the summer quarter or semester following the second academic year and continues through that academic year or until eligibility under two-year averaging ceases.

Note: "Academic year" means summer, fall, winter, and spring quarters or summer, fall, and spring semesters, in that order.

(ii) The institution with the greatest percentage coordinates with the other institutions and is responsible for sending the total premium payment to HCA.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-08-235 Employer group and charter school application process. This section applies to employer groups as defined in WAC 182-08-015 and to charter schools. An employer group or charter school may apply to obtain public employees benefits board (PEBB) insurance coverage through a contract with the health care authority (HCA).

(1) Employer groups and charter schools with less than five hundred employees must apply at least sixty days before the requested coverage effective date. Employer groups and charter schools with five hundred or more employees but with less than five thousand employees must apply at least ninety days before the requested effective date.

Employer groups and charter schools with five thousand or more employees must apply at least one hundred twenty days before the requested coverage effective date. To apply, employer groups and charter schools must submit the documents and information described in subsection (2) of this section to the PEBB program as follows:

(a) School districts, educational service districts, and charter schools are required to provide the documents described in subsections (2)(a) through (c) of this section;

Exception: School districts and educational service districts required by the superintendent of public instruction to purchase PEBB insurance coverage provided by the authority are required to submit documents and information described in subsection (2)(a)(iii), (b), and (c) of this section.

(b) Counties, municipalities, political subdivisions, and tribal governments with fewer than five thousand employees are required to provide the documents and information described in subsection (2)(a) through (f) of this section;

(c) Counties, municipalities, political subdivisions, and tribal governments with five thousand or more employees will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section; and

(d) All employee organizations representing state civil services employees and the Washington health benefit exchange, regardless of the number of employees, will have their application approved or denied through the evaluation criteria described in WAC 182-08-240 and are required to provide the documents and information described in subsection (2)(a) through (d), (f), and (g) of this section.

(2) Documents and information required with application:

(a) A letter of application that includes the information described in (a)(i) through (iv) of this subsection:

(i) A reference to the group's authorizing statute;

(ii) A description of the organizational structure of the group and a description of the employee bargaining unit or group of nonrepresented employees for which the group is applying;

(iii) Employer group or charter school tax ID number (TIN); and

(iv) A statement of whether the group is applying to obtain only medical or all available PEBB insurance coverages. School districts and educational service districts must purchase medical, dental, life, and ((~~LTD~~)) long-term disability insurance.

(b) A resolution from the group's governing body authorizing the purchase of PEBB insurance coverage.

(c) A signed governmental function attestation document that attests to the fact that employees for whom the group is applying are governmental employees whose services are substantially all in the performance of essential governmental functions.

(d) A member level census file for all of the employees for whom the group is applying. The file must be provided in the format required by the authority and contain the following demographic data, by member, with each member classified as employee, spouse or state registered domestic partner, or child:

(i) Employee ID (any identifier which uniquely identifies the employee; for dependents the employee's unique identifier must be used);

(ii) Age;

(iii) Gender;

(iv) First three digits of the member's zip code based on residence;

(v) Indicator of whether the employee is active or retired, if the group is requesting to include retirees; and

(vi) Indicator of whether the member is enrolled in coverage.

(e) Historical claims and cost information that include the following:

(i) Large claims history for twenty-four months by quarter that excludes the most recent three months;

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;

(iii) Summary of historical plan costs; and

(iv) The director or the director's designee may make an exception to the claims and cost information requirements based on the size of the group, except that the current health plan does not have a case management program, then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim. If historical claims and cost information as described in (e)(i) through (iii) of this subsection are unavailable, the director or the director's designee may make an exception to allow all of the following alternative requirements:

• A letter from their carrier indicating they will not or cannot provide claims data.

• Provide information about the health plan most employees are enrolled in by completing the actuarial calculator authorized by the PEBB program.

• Current premiums for the health plan.

((**~~Exception:~~** ~~If the current health plan does not have a case management program then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim.~~))

(f) If the application is for a subset of the group's employees (e.g., bargaining unit), the group must provide a member level census file of all employees eligible under their current health plan who are not included on the member level census file in (d) of this subsection. This includes retired employees participating under the group's current health plan. The file must include the same demographic data by member.

(g) Employer groups described in subsection (1)(c) and (d) of this section must submit to an actuarial evaluation of the group provided by an actuary designated by the PEBB program. The group must pay for the cost of the evaluation. This cost is nonrefundable. A group that is approved will not have to pay for an additional actuarial evaluation if it applies to add another bargaining unit within two years of the evaluation. Employer groups of this size must provide the following:

(i) Large claims history for twenty-four months, by quarter that excludes the most recent three months;

(ii) Ongoing large claims management report for the most recent quarter provided in the large claims history;

(iii) Executive summary of benefits;

(iv) Summary of benefits and certificate of coverage; and

(v) Summary of historical plan costs.

Exception: If the current health plan does not have a case management program then the primary diagnosis code designated by the authority must be reported for each large claimant. If the code indicates a condition which is expected to continue into the next quarter, the claim is counted as an ongoing large claim.

(3) The authority may automatically deny a group application if the group fails to provide the required information and documents described in this section.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-08-240 How will the health care authority (HCA) decide to approve or deny a group application? This section ((~~only~~)) applies to ((~~employee organizations representing state civil service employees and the Washington health benefit exchange, regardless of the number of employees,~~)) counties, municipalities, political subdivisions, and tribal governments with five thousand or more employees. This section also applies to employee organizations representing state civil service employees and the Washington health benefit exchange, regardless of the number of employees. Group applications for participation in public employees benefits board (PEBB) insurance coverage provided through the PEBB program are approved or denied by the health care authority (HCA) based upon the information and documents submitted by the group and the employer group evaluation (EGE) criteria described in this rule.

(1) Groups are evaluated as a single unit. To support this requirement the group must provide a census file, as described in WAC 182-08-235 (2)(d), and additional information as described in WAC 182-08-235 (2)(g) for all employees eligible to participate under the group's current health plan. If the group's application is for both employees and retirees, the census file data and additional information for retired employees participating under the group's current health plan must also be included.

(a) If the group's application is only for participation of its employees, the PEBB enrollment data used to evaluate the group will be state agency employee data.

(b) If a group's application is for participation of both its employees and retirees, the PEBB enrollment data used to evaluate the group will include data from the PEBB nonmedicare risk pool limited to state retiree enrollment data and state agency employee data.

(2) A group must pass the EGE criteria or the actuarial evaluation required in subsection (3) of this section as a single unit before the application can be approved. For purposes of this section a single unit includes all employees eligible under the group's current health plan. If the application is only for a bargaining unit, then the bargaining unit must be evaluated using the EGE criteria in addition to all eligible employees of the group as a single unit. If the group passes the EGE criteria as a single unit, but an individual bargaining unit does not, the group may only participate if all eligible employees of the entity participate.

(3) The authority will use the following criteria to evaluate the group.

(a) The member level census file demographic data must indicate a relative underwriting factor that is equal to or better than the relative underwriting factor as determined by the authority for the like population within the nonmedicare PEBB risk pool as described in subsection (1) of this section;

(b) One of the following two conditions must be met:

(i) The frequency of large claims must be less than or equal to the PEBB historical benchmark frequency for the PEBB like population within the nonmedicare population as described in subsection (1) of this section;

(ii) The ongoing large claims management report must demonstrate that the frequency of ongoing large claims is less than or equal to the recurring benchmark frequency for the PEBB like population within the nonmedicare population as described in subsection (1) of this section.

(c) Provide an executive summary of benefits;

(d) Provide a summary of benefits and certificate of coverage;

(e) Provide a summary of historical plan costs; and

(f) The evaluation of criteria in (c), (d), and (e) of this subsection must indicate that the historical cost of benefits for the group is equal to or less than the historical cost of the PEBB like population within the nonmedicare population as described in subsection (1) of this section for a comparable plan design.

(4) An approved group application is valid for three hundred sixty-five calendar days after the date the application is approved by the authority. If a group applies to add additional bargaining units after the three hundred sixty-five calendar day period has ended, the group must be reevaluated.

(5) An entity whose group application is denied may appeal the authority's decision to the PEBB appeals ((~~committee~~)) unit through the process described in WAC ((~~182-16-038~~)) 182-16-2060.

(6) An entity whose group application is approved may purchase insurance for its employees under the participation requirements described in WAC 182-08-245.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-109 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Affordable Care Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, P.L. 111-152, or federal regulations or guidance issued under the Affordable Care Act.

"Annual open enrollment" means an annual event set aside for a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections for the following plan year. During the annual open enrollment, subscribers may transfer from one health plan to another, enroll or remove dependents from coverage, or enroll or waive enrollment in PEBB medical. Employees eligible to participate in the salary reduction plan may enroll in or change their election under the dependent care assistance program (DCAP)((~~,~~)) or the medical flexible spending arrangement (FSA)((~~, or~~)). They may also enroll in or opt out of the premium payment plan.

"Authority" or "HCA" means the Washington state health care authority.

"Benefits-eligible position" means any position held by an employee who is eligible for benefits under WAC 182-12-114, with the exception of employees who establish eligibility under WAC 182-12-114 (2) or (3)(a)(ii).

"Blind vendor" means a "licensee" as defined in RCW 74.18.200.

"Board" means the public employees benefits board established under provisions of RCW 41.05.055.

"Calendar days" or "days" means all days including Saturdays and Sundays.

"Consolidated Omnibus Budget Reconciliation Act" or "COBRA" means continuation coverage as administered under 42 U.S.C. Secs. 300bb-1 through 300bb-8.

"Continuation coverage" means the temporary continuation of ((~~PEBB~~)) health plan coverage available to enrollees after a qualifying event occurs as administered under ((~~Title XXII of the Public Health Service (PHS) Act,~~)) the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. Secs. 300bb-1 through 300bb-8, the Uniformed Services Employment and Reemployment Rights Act (USERRA), 38 U.S.C. Secs. 4301 through 4335, or PEBB insurance coverage extended by the public employee benefits board under WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

"Contracted vendor" means any person, persons, or entity under contract or agreement with the HCA to provide goods or services for the provision or administration of PEBB benefits. The term "contracted vendor" includes subcontractors of the HCA and subcontractors of any person, persons, or entity under contract or agreement with the HCA that provide goods or services for the provision or administration of PEBB benefits.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in a PEBB health plan by a retiree or an eligible survivor.

"Dependent" means a person who meets eligibility requirements in WAC 182-12-260, except that "surviving spouses, state registered domestic partners, and dependent children" of emergency service personnel who are killed in the line of duty is defined in WAC 182-12-250.

"Dependent care assistance program" or "DCAP" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan ((~~authorized in chapter 41.05 RCW~~)) under this chapter pursuant to 26 U.S.C. Sec. 129 or other sections of the Internal Revenue Code.

"Director" means the director of the authority.

"Documents" means papers, letters, writings, electronic mail, electronic files, or other printed or written items.

"Effective date of enrollment" means the first date when an enrollee is entitled to receive covered benefits.

"Employee" for the public employees benefits board program includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state submits application materials to the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021 (1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(f) and (g); (e) employees of the Washington health benefit exchange if the governing board of the exchange established in RCW 43.71.020 seeks and receives approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021 (1)(g) and (n); and (f) employees of a charter school established under chapter 28A.710 RCW. "Employee" does not include: Adult family home providers; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under RCW 41.05.011 or by the authority under this chapter.

"Employer" for the public employees benefits board program means the state of Washington.

"Employer-based group dental" means group dental related to a current employment relationship. It does not include dental coverage available to retired employees, individual market dental coverage, or government-sponsored programs such as medicaid.

"Employer-based group health plan" means group medical and group dental related to a current employment relationship. It does not include medical or dental coverage available to retired employees, individual market medical or dental coverage, or government-sponsored programs such as medicare or medicaid.

"Employer-based group medical" means group medical related to a current employment relationship. It does not include medical coverage available to retired employees, individual market medical coverage, or government-sponsored programs such as medicare or medicaid.

"Employer contribution" means the funding amount paid to the authority by a state agency, employer group, or charter school for its eligible employees as described under WAC 182-12-114 and 182-12-131 ((~~and the employee's eligible dependents as described in WAC 182-12-260~~)).

"Employer group" means those counties, municipalities, political subdivisions, the Washington health benefit exchange, tribal governments, school districts, educational service districts, and employee organizations representing state civil service employees, obtaining employee benefits through a contractual agreement with the authority as described in WAC 182-08-245.

"Employer-paid coverage" means PEBB insurance coverage for which an employer contribution is made by a state agency, employer group or charter school for employees eligible in WAC 182-12-114 and 182-12-131. It also means basic benefits described in RCW 28A.400.270(1) for which an employer contribution is made by school districts or an educational service district.

"Employing agency" for the public employees benefits board means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; ((~~charter school; or~~)) and a tribal government covered by chapter 41.05 RCW.

"Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in PEBB benefits, and for whom applicable premium payments have been made.

"Exchange" means the Washington health benefit exchange established in RCW 43.71.020, and any other health benefit exchange established under the Affordable Care Act.

"Exchange coverage" means coverage offered by a qualified health plan through an exchange.

"Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose appointment, workload, and duties directly serve the institution's academic mission, as determined under the authority of its enabling statutes, its governing body, and any applicable collective bargaining agreement.

"Federal retiree medical plan" means the Federal Employees Health Benefits program (FEHB) or TRICARE plans which are not employer-based group medical.

"Health plan" means a plan offering medical or dental, or both, developed by the public employees benefits board and provided by a contracted vendor or self-insured plans administered by the HCA.

"Institutions of higher education" means the state public research universities, the public regional universities, The Evergreen State College, the community and technical colleges, and the state board for community and technical colleges.

"Layoff," for purposes of this chapter, means a change in employment status due to an employer's lack of funds or an employer's organizational change.

"Life insurance" for eligible employees includes basic life insurance and accidental death and dismemberment (AD&D) insurance paid for by the employing agency, as well as optional life insurance and optional AD&D insurance offered to and paid for by employees for themselves and their dependent. Life insurance for eligible retirees includes retiree term life insurance offered to and paid for by retirees.

"LTD insurance" includes basic long-term disability insurance paid for by the employing agency and long-term disability insurance offered to employees on an optional basis.

"Medical flexible spending arrangement" or "medical FSA" means a benefit plan whereby eligible state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan ((~~authorized in chapter 41.05 RCW~~)) under this chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Pay status" means all hours for which an employee receives pay.

"PEBB" means the public employees benefits board.

((~~"PEBB appeals committee" means the committee that considers appeals relating to the administration of PEBB benefits by the PEBB program. The director has delegated the authority to hear appeals at the level below an administrative hearing to the PEBB appeals committee.~~))

"PEBB benefits" means one or more insurance coverages or other employee benefits administered by the PEBB program within the health care authority.

"PEBB insurance coverage" means any health plan, life insurance, long-term disability (LTD) insurance, long-term care insurance, or property and casualty insurance administered as a PEBB benefit.

"PEBB program" means the program within the HCA that administers insurance and other benefits for eligible employees (as described in WAC 182-12-114), eligible retired employees (as described in WAC 182-12-171 and 182-12-180), eligible survivors (as described in WAC 182-12-180, 182-12-250, and 182-12-265), eligible dependents (as described in WAC 182-12-250 and 182-12-260) and others as defined in RCW 41.05.011.

"Plan year" means the time period established by the authority.

"Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan.

"Premium surcharge" means a payment required from a subscriber, in addition to the subscriber's medical premium contribution, due to an enrollee's tobacco use or a subscriber's spouse or state registered domestic partner choosing not to enroll in ((~~his or her~~)) their employer-based group medical when:

• ((~~Premiums are~~)) The spouse's or state registered domestic partner's share of the medical premium is less than ninety-five percent of the additional cost an employee would be required to pay to enroll a spouse or state registered domestic partner in the Uniform Medical Plan (UMP) Classic ((~~premiums~~)); and

• The benefits have an actuarial value of ((~~benefits is~~)) at least ninety-five percent of the actuarial value of UMP Classic benefits.

"Qualified health plan" means a medical plan that is certified to be offered through an exchange.

"Salary reduction plan" means a benefit plan whereby ((~~state and~~)) public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program (DCAP), medical flexible spending arrangement (FSA), or premium payment plan ((~~as authorized in chapter 41.05 RCW~~)) offered pursuant to 26 U.S.C. Sec. 125 or other sections of the Internal Revenue Code.

"Season" means any recurring annual period of work at a specific time of year that lasts three to eleven consecutive months.

"Seasonal employee" means an employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

"Special open enrollment" means a period of time when subscribers may make changes to their health plan enrollment and salary reduction elections outside of the annual open enrollment period when specific life events occur. During the special open enrollment subscribers may change health plans and enroll or remove dependents from coverage. Additionally, employees may enroll in or waive enrollment in PEBB medical. Employees eligible to participate in the salary reductions plan may enroll in or ((~~change~~)) revoke their election under the DCAP, medical FSA, or the premium payment plan and make a new election. For special open enrollment events related to specific PEBB benefits, see WAC 182-08-198, 182-08-199, 182-12-128, and 182-12-262.

"State agency" means an office, department, board, commission, institution, or other separate unit or division, however designated, of the state government and all personnel thereof. It includes the legislature, executive branch, and agencies or courts within the judicial branch, as well as institutions of higher education and any unit of state government established by law.

"Subscriber" means the employee, retiree, continuation coverage enrollee, or survivor who has been determined eligible by the PEBB program, employer group, state agency, or charter school and is the individual to whom the PEBB program and contracted vendors will issue all notices, information, requests, and premium bills on behalf of enrollees.

"Tobacco products" means any product made with or derived from tobacco that is intended for human consumption, including any component, part, or accessory of a tobacco product. This includes, but is not limited to, cigars, cigarettes, pipe tobacco, chewing tobacco, snuff, and other tobacco products. It does not include e-cigarettes or United States Food and Drug Administration (FDA) approved quit aids.

"Tobacco use" means any use of tobacco products within the past two months. Tobacco use, however, does not include the religious or ceremonial use of tobacco.

"Tribal government" means an Indian tribal government as defined in Section 3(32) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or an

agency or instrumentality of the tribal government, that has government offices principally located in this state.

"Waive" means to interrupt an eligible employee's enrollment in a PEBB health plan because the employee is enrolled in other employer-based group medical, TRICARE plans, or medicare as allowed under WAC 182-12-128, or is on approved educational leave and obtains another employer-based group health plan as allowed under WAC 182-12-136.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-12-113 What are the obligations of a state agency in the application of employee eligibility? (1) All state agencies must carry out all actions, policies, and guidance issued by the public employees benefits board (PEBB) program necessary for the operation of benefit plans, education of employees, claims administration, and appeals process including those described in chapters 182-08, 182-12, and 182-16 WAC. State agencies must:

(a) Use the methods provided by the PEBB program to determine eligibility and enrollment in benefits, unless otherwise approved in writing;

(b) Provide eligibility determination reports with content and in a format designed and communicated by the PEBB program or otherwise as approved in writing by the PEBB program; and

(c) Carry out corrective action and pay any penalties imposed by the authority and established by the board when the state agency's eligibility determinations fail to comply with the criteria under these rules.

(2) All state agencies must determine employee eligibility for PEBB benefits and employer contribution according to the criteria in WAC 182-12-114 and 182-12-131. State agencies must:

(a) Notify newly hired employees of PEBB rules and guidance for eligibility and appeal rights;

(b) Provide written notice to faculty who are potentially eligible for benefits and employer contribution of their potential eligibility as described in WAC 182-12-114(3) and 182-12-131;

(c) Inform an employee in writing whether or not ((~~he or she is~~)) they are eligible for benefits upon employment. The written communication must include a description of any hours that are excluded in determining eligibility and information about the employee's right to appeal eligibility and enrollment decisions;

(d) Routinely monitor all employees' eligible work hours to establish eligibility and maintain the employer contribution toward PEBB insurance coverage;

(e) Make eligibility determinations based on the criteria of the eligibility category that most closely describes the employee's work circumstances per the PEBB program's direction;

(f) Identify when a previously ineligible employee becomes eligible or a previously eligible employee loses eligibility; and

(g) Inform an employee in writing whether or not ((~~he or she is~~)) they are eligible for benefits and the employer contribution whenever there is a change in work patterns such that the employee's eligibility status changes. At the same time, state agencies must inform employees of the right to appeal eligibility and enrollment decisions.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-114 How do employees establish eligibility for public employees benefits board (PEBB) benefits? Eligibility for an employee whose work circumstances are described by more than one of the eligibility categories in subsections (1) through (5) of this section shall be determined solely by the criteria of the category that most closely describes the employee's work circumstances.

Hours that are excluded in determining eligibility include standby hours and any temporary increases in work hours, of six months or less, caused by training or emergencies that have not been or are not anticipated to be part of the employee's regular work schedule or pattern. Employing agencies must request the public employees benefits board (PEBB) program's approval to include temporary training or emergency hours in determining eligibility.

For how the employer contribution toward PEBB insurance coverage is maintained after eligibility is established under this section, see WAC 182-12-131.

(1) Employees are eligible for PEBB benefits as follows, except as described in subsections (2) through (5) of this section:

(a) **Eligibility.** An employee is eligible if ((~~he or she is~~)) they are anticipated to work an average of at least eighty hours per month and ((~~is~~)) are anticipated to work for at least eight hours in each month for more than six consecutive months.

(b) **Determining eligibility.**

(i) **Upon employment:** An employee is eligible from the date of employment if the employing agency anticipates the employee will work according to the criteria in (a) of this subsection.

(ii) **Upon revision of anticipated work pattern:** If an employing agency revises an employee's anticipated work hours or anticipated duration of employment such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) **Based on work pattern:** An employee who is determined to be ineligible, but later meets the eligibility criteria in (a) of this subsection, becomes eligible the first of the month following the six-month averaging period.

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward PEBB insurance coverage. Employees must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position with hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward PEBB insurance coverage as described in WAC 182-12-131(1).

(d) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, and basic long-term disability (LTD) insurance begin on the first day of the month following the date an employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(2) **Seasonal employees,** as defined in WAC 182-12-109, are eligible as follows:

(a) **Eligibility.** A seasonal employee is eligible if ((~~he or she is~~)) they are anticipated to work an average of at least eighty hours per month and ((~~is~~)) are anticipated to work for at least eight hours in each month of at least three consecutive months of the season.

(b) **Determining eligibility.**

(i) **Upon employment:** A seasonal employee is eligible from the date of employment if the employing agency anticipates that ((~~he or she~~)) they will work according to the criteria in (a) of this subsection.

(ii) **Upon revision of anticipated work pattern.** If an employing agency revises an employee's anticipated work hours or anticipated duration of employment such that the employee meets the eligibility criteria in (a) of this subsection, the employee becomes eligible when the revision is made.

(iii) **Based on work pattern.** An employee who is determined to be ineligible for benefits, but later works an average of at least eighty hours per month and works for at least eight hours in each month and works for more than six consecutive months, becomes eligible the first of the month following a six-month averaging period.

(c) **Stacking of hours.** As long as the work is within one state agency, employees may "stack" or combine hours worked in more than one position or job to establish eligibility and maintain the employer contribution toward PEBB insurance coverage. Employees must notify their employing agency if they believe they are eligible through stacking. Stacking includes work situations in which:

(i) The employee works two or more positions or jobs at the same time (concurrent stacking);

(ii) The employee moves from one position or job to another (consecutive stacking); or

(iii) The employee combines hours from a seasonal position or job with hours from a nonseasonal position or job. An employee who establishes eligibility by stacking hours from a seasonal position or job with hours from a nonseasonal position or job shall maintain the employer contribution toward PEBB insurance coverage as described in WAC 182-12-131(1).

(d) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, and basic ((~~long-term disability~~)) LTD insurance begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(3) **Faculty** are eligible as follows:

(a) **Determining eligibility.** "Half-time" means one-half of the full-time academic workload as determined by each institution, except that half-time for community and technical college faculty employees is governed by RCW 28B.50.489.

(i) **Upon employment:** Faculty who the employing agency anticipates will work half-time or more for the entire instructional year, or equivalent nine-month period, are eligible from the date of employment.

(ii) **For faculty hired on quarter/semester to quarter/semester basis:** Faculty who the employing agency anticipates will not work for the entire instructional year, or equivalent nine-month period, are eligible at the beginning of the second consecutive quarter or semester of employment in which ((~~he or she is~~)) they are anticipated to work, or has actually worked, half-time or more. Spring and fall are considered consecutive quarters/semesters when first establishing eligibility for faculty that work less than half-time during the summer quarter/semester.

(iii) **Upon revision of anticipated work pattern:** Faculty who receive additional workload after the beginning of the anticipated work period (quarter, semester, or instructional year), such that their workload meets the eligibility criteria as described in (a)(i) or (ii) of this subsection become eligible when the revision is made.

(b) **Stacking.** Faculty may establish eligibility and maintain the employer contribution toward PEBB insurance coverage by working as faculty for more than one institution of higher education. Faculty workloads may only be stacked with other faculty workloads to establish eligibility under this section or maintain eligibility as described in WAC 182-12-131(3). When a faculty works for more than one institution of higher education, the faculty must notify ((~~his or her~~)) their employing agencies that ((~~he or she~~)) they work((~~s~~)) at more than one institution and may be eligible through stacking.

(c) **When PEBB insurance coverage begins.**

(i) Medical, dental, basic life insurance, and basic ((~~long-term disability~~)) LTD insurance begin on the first day of the month following the day the faculty becomes eligible. If the faculty becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(ii) For faculty hired on a quarter/semester to quarter/semester basis under (a)(ii) of this subsection, medical, dental, basic life insurance, and basic ((~~long-term disability~~)) LTD insurance begin the first day of the month following the beginning of the second consecutive quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, then PEBB insurance coverage begins at the beginning of the second consecutive quarter/semester.

(4) **Elected and full-time appointed officials of the legislative and executive branches of state government** are eligible as follows:

(a) **Eligibility.** A legislator is eligible for PEBB benefits on the date ((~~his or her~~)) their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible on the date

their terms begin or the date they take the oath of office, whichever occurs first.

(b) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, and basic ((~~long-term disability~~)) LTD insurance begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

(5) **Justices and judges** are eligible as follows:

(a) **Eligibility.** A justice of the supreme court and judges of the court of appeals and the superior courts become eligible for PEBB benefits on the date they take the oath of office.

(b) **When PEBB insurance coverage begins.** Medical, dental, basic life insurance, and basic ((~~long-term disability~~)) LTD insurance begin on the first day of the month following the day the employee becomes eligible. If the employee becomes eligible on the first working day of a month, then PEBB insurance coverage begins on that date.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-12-123 Is dual enrollment prohibited? Public employees benefits board (PEBB) health plan coverage is limited to a single enrollment per individual.

(1) An individual who has more than one source of eligibility for enrollment in PEBB health plan coverage (called "dual eligibility") is limited to one enrollment.

(2) An eligible employee may waive PEBB medical and enroll as a dependent under the health plan of ((~~his or her~~)) their spouse, state registered domestic partner, or parent as described in WAC 182-12-128.

(3) A dependent enrolled in a PEBB health plan who becomes eligible for PEBB benefits as an employee must elect to enroll in PEBB benefits as described in WAC 182-08-197 (1) or (3). This includes making an election to enroll in or waive enrollment in PEBB medical as described in WAC 182-12-128 ((~~(1)(a)~~)).

(a) If the employee does not waive enrollment in PEBB medical, the employee is not eligible to remain enrolled in ((~~his or her~~)) their spouse's, state registered domestic partner's, or parent's PEBB health plan as a dependent. If the employee's spouse, state registered domestic partner, or parent does not remove the employee (who is enrolled as a dependent) from ((~~his or her~~)) their subscriber account, the PEBB program will terminate the employee's enrollment as a dependent the last day of the month before the employee's employer-paid coverage begins.

Exception: An enrolled dependent who becomes newly eligible for PEBB benefits as an employee may be dual-enrolled in PEBB coverage for one month. This exception is only allowed for the first month the dependent is enrolled as an employee, and only if the dependent becomes enrolled as an employee on the first working day of a month that is not the first day of the month.

(b) If the employee elects to waive ((~~his or her~~)) their enrollment in PEBB medical, the employee will remain enrolled in PEBB medical under ((~~his or her~~)) their spouse's, state registered domestic partner's, or parent's PEBB health plan as a dependent.

(4) A child who is eligible for medical and dental under two subscribers may be enrolled as a dependent under the health plan of only one subscriber.

(5) When an employee is eligible for the employer contribution towards PEBB insurance coverage due to employment in more than one PEBB-participating employing agency the following provisions apply:

(a) The employee must choose to enroll under only one employing agency.

Exception: Faculty who stack to establish or maintain eligibility as described in WAC 182-12-114(3) with two or more state institutions of higher education will be enrolled under the employing agency responsible to pay the employer contribution according to WAC 182-08-200(2).

(b) If the employee loses eligibility under the employing agency ((~~he or she chose~~)) they may choose to enroll ((~~under~~)) as described in (a) of this subsection, the employee must notify ((~~his or her~~)) their other employing agency no later than sixty days from the date PEBB coverage ends through the employing agency described in (a) of this subsection to transfer coverage.

(c) The employee's PEBB insurance coverage elections remain the same when an employee transfers enrollment from enrollment under one employing agency to another employing agency without a break in PEBB insurance coverage for one month or more, as described in (b) of this subsection.

(6) A retiree who defers enrollment in a PEBB health plan as described in WAC 182-12-200 by enrolling as an eligible dependent in a health plan sponsored by PEBB, a Washington state school district, a Washington state ((~~education~~)) educational service district, or a Washington state charter school and who loses the employer contribution for such coverage must enroll in PEBB retiree insurance coverage as described in WAC ((~~182-12-171~~)) 182-12-200 or defer enrollment as described in WAC 182-12-205.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-128 When may an employee waive enrollment in public employees benefits board (PEBB) medical and when may ((~~he or she~~)) they enroll in PEBB medical after having waived enrollment? An employee may waive enrollment in public employees benefits board (PEBB) medical if ((~~he or she is~~)) they are enrolled in other employer-based group medical, a TRICARE plan, or medicare. An employee who waives enrollment in PEBB medical must enroll in dental, basic life insurance, and basic long-term disability (LTD) insurance (unless the employing agency does not participate in these PEBB insurance coverages).

(1) To waive enrollment in PEBB medical, the employee must submit the required form to ((~~his or her~~)) their employing agency at one of the following times:

(a) **When the employee becomes eligible:** An employee enrolled in other employer-based group medical, a TRICARE plan, or medicare may waive PEBB medical when ((~~he or she~~)) they become((~~s~~)) eligible for PEBB benefits. The employee must indicate ((~~his or her~~)) their election to

waive enrollment in PEBB medical on the required form and submit the form to ((~~his or her~~)) their employing agency. The ((~~form must be received by the~~)) employing agency must receive the form no later than thirty-one days after the date the employee becomes eligible (see WAC 182-08-197). PEBB medical will be waived as of the date the employee becomes eligible for PEBB benefits.

(b) **During the annual open enrollment:** An employee may waive PEBB medical during the annual open enrollment. The required form must be received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will be waived beginning January 1st of the following year.

(c) **During a special open enrollment:** An employee may waive PEBB medical during a special open enrollment as described in subsection (4) of this section.

The employee must submit the required form to ((~~his or her~~)) their employing agency. The employing agency must receive the form ((~~must be received~~)) no later than sixty days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment to the employing agency.

PEBB medical will be waived the last day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, PEBB medical will be waived the last day of the previous month. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical will be waived the last day of the previous month.

(2) If an employee waives PEBB medical, the employee's eligible dependents may not be enrolled in medical.

(3) Once PEBB medical is waived, the employee is only allowed to enroll in PEBB medical at the following times:

(a) During the annual open enrollment. The required form must be received by the employee's employing agency before the end of the annual open enrollment. PEBB medical will begin January 1st of the following year.

(b) During a special open enrollment. A special open enrollment allows an employee to ((~~change his or her enrollment~~)) revoke their election and make a new election outside of the annual open enrollment. A special open enrollment may be created when one of the events described in subsection (4) of this section occurs.

The employee must submit the required form to ((~~his or her~~)) their employing agency. The employing agency must receive the form ((~~must be received~~)) no later than sixty days after the event that creates the special open enrollment. In addition to the required form, the employee must provide evidence of the event that creates the special open enrollment to the employing agency.

PEBB medical will begin the first day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, coverage is effective on that day. If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, PEBB medical will begin as follows:

(i) For a newly born child, PEBB medical will begin the date of birth;

(ii) For a newly adopted child, PEBB medical will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;

(iii) For an employee enrolling in order to enroll a newly born or newly adopted child, PEBB medical will begin the first day of the month in which the event occurs;

(iv) For the spouse or state registered domestic partner of an employee, PEBB medical will begin the first day of the month in which the event occurs.

(4) **Special open enrollment:** Any one of the events in (a) through (k) of this subsection may create a special open enrollment. The change in enrollment must be allowable under the Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the employee, the employee's dependent, or both.

(a) Employee acquires a new dependent due to:

(i) Marriage or registering for a state domestic partnership;

(ii) Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(b) Employee or an employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(c) Employee has a change in employment status that affects the employee's eligibility for ((~~his or her~~)) their employer contribution toward ((~~his or her~~)) their employer-based group medical;

(d) The employee's dependent has a change in ((~~his or her~~)) their own employment status that affects ((~~his or her~~)) their eligibility for the employer contribution under ((~~his or her~~)) their employer-based group medical;

Exception: For the purposes of special open enrollment "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(e) Employee or an employee's dependent has a change in enrollment under an employer-based group medical plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(f) Employee's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;

(g) A court order ((~~or national medical support notice (see also WAC 182-12-263)~~)) requires the employee or any other individual to provide a health plan for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(h) Employee or an employee's dependent becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the employee or an employee's dependent loses eligibility for coverage under medicaid or CHIP;

(i) Employee or an employee's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP);

(j) Employee or employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan;

(k) Employee becomes eligible and enrolls in medicare, or loses eligibility for medicare.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-12-129 What happens when an employee moves from an eligible to an otherwise ineligible position or job due to a layoff? This section applies to employees employed by state agencies (as defined in this chapter), including benefits-eligible seasonal employees, and is intended to address situations where an employee moves from one position or job to another due to a layoff, as described in WAC 182-12-109. This section does not apply to employees with an anticipated end date.

If an employee moves from an eligible to an otherwise ineligible position due to layoff, the employee may retain ((~~his or her~~)) their eligibility for the employer contribution toward public employees benefits board (PEBB) insurance coverage for each month that the employee is in pay status for at least eight hours. To maintain eligibility using this section the employee must:

• Be hired into a position with a state agency within twenty-four months of the original eligible position ending; and

• Upon hire, notify the employing state agency that ((~~he or she is~~)) they are potentially eligible to use this section.

This section ceases to apply if the employee is employed in a position eligible for PEBB benefits under WAC 182-12-114 within twenty-four months of leaving the original position.

After the twenty-fourth month, the employee must reestablish eligibility as described in WAC 182-12-114.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-131 How do eligible employees maintain the employer contribution toward public employees benefits board (PEBB) insurance coverage? The employer contribution toward public employees benefits board (PEBB) insurance coverage begins on the day that PEBB benefits begin as described in WAC 182-12-114. This section describes under what circumstances employees maintain eligibility for the employer contribution toward PEBB insurance coverage.

(1) **Maintaining the employer contribution.** Except as described in subsections (2), (3), and (4) of this section, employees who have established eligibility for benefits as described in WAC 182-12-114 are eligible for the employer contribution each month in which they are in pay status eight or more hours per month.

(2) **Maintaining the employer contribution - Benefits-eligible seasonal employees.**

(a) Benefits-eligible seasonal employees (eligible as described in WAC 182-12-114(2)) who work a season of less than nine months are eligible for the employer contribution in any month of the season in which they are in pay status eight or more hours during that month. The employer contribution toward PEBB insurance coverage for seasonal employees returning after their off season begins on the first day of the first month of the season in which they are in pay status eight hours or more.

(b) Benefits-eligible seasonal employees (eligible as described in WAC 182-12-114(2)) who work a season of nine months or more are eligible for the employer contribution:

(i) In any month of the season in which they are in pay status eight or more hours during that month; and

(ii) Through the off season following each season worked, but the eligibility may not exceed a total of twelve consecutive calendar months for the combined season and off season.

(3) **Maintaining the employer contribution - Eligible faculty.**

(a) Benefits-eligible faculty anticipated to work half time or more the entire instructional year or equivalent nine-month period (eligible as described in WAC 182-12-114 (3)(a)(i)) are eligible for the employer contribution each month of the instructional year, except as described in subsection (7) of this section.

(b) Benefits-eligible faculty who are hired on a quarter/semester to quarter/semester basis (eligible as described in WAC 182-12-114 (3)(a)(ii)) are eligible for the employer contribution each quarter or semester in which employees work half-time or more.

(c) Summer or off-quarter/semester coverage: All benefits-eligible faculty (eligible as described in WAC 182-12-114 (3)(a) and (b)) who work an average of half-time or more throughout the entire instructional year or equivalent nine-month period and work each quarter/semester of the instructional year or equivalent nine-month period are eligible for the employer contribution toward summer or off-quarter/semester PEBB insurance coverage.

Exception: Eligibility for the employer contribution toward summer or off-quarter/semester PEBB insurance coverage ends on the end date specified in an employing agency's termination notice or an employee's resignation letter, whichever is earlier, if the employing agency has no anticipation that the employee will be returning as faculty at any institution of higher education where the employee has employment. If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, PEBB insurance coverage ends the last day of the month for which employee premiums were deducted.

(d) Two-year averaging: All benefits-eligible faculty (eligible as described in WAC 182-12-114 (3)(a) and (b)) who worked an average of half-time or more in each of the two preceding academic years are potentially eligible to receive uninterrupted employer contribution toward PEBB insurance coverage. "Academic year" means summer, fall,

winter, and spring quarters or summer, fall, and spring semesters and begins with summer quarter/semester. In order to be eligible for the employer contribution through two-year averaging, the faculty must provide written notification of ((~~his or her~~)) their potential eligibility to ((~~his or her~~)) their employing agency or agencies within the deadlines established by the employing agency or agencies. Faculty continue to receive uninterrupted employer contribution for each academic year in which they:

(i) Are employed on a quarter/semester to quarter/semester basis and work at least two quarters or two semesters; and

(ii) Have an average workload of half-time or more for three quarters or two semesters.

Eligibility for the employer contribution under two-year averaging ceases immediately if the eligibility criteria is not met or if the eligibility criteria becomes impossible to meet.

(e) Faculty who lose eligibility for the employer contribution: All benefits-eligible faculty (eligible as described in WAC 182-12-114 (3)(a) and (b)) who lose eligibility for the employer contribution will regain it if they return to a faculty position where it is anticipated that they will work half-time or more for the quarter/semester no later than the twelfth month after the month in which they lost eligibility for the employer contribution. The employer contribution begins on the first day of the month in which the quarter/semester begins.

(4) **Maintaining the employer contribution - Employees on leave and under the special circumstances listed below.**

(a) Employees who are on approved leave under the federal Family and Medical Leave Act (FMLA) continue to receive the employer contribution as long as they are approved under the act.

(b) Unless otherwise indicated in this section, employees in the following circumstances receive the employer contribution only for the months they are in pay status eight hours or more:

(i) Employees on authorized leave without pay;

(ii) Employees on approved educational leave;

(iii) Employees receiving time-loss benefits under workers' compensation;

(iv) Employees called to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA); or

(v) Employees applying for disability retirement.

(5) **Maintaining the employer contribution - Employees who move from an eligible to an otherwise ineligible position due to a layoff** maintain the employer contribution toward PEBB insurance coverage as described in WAC 182-12-129.

(6) **Employees who are in pay status less than eight hours in a month.** Unless otherwise indicated in this section, when there is a month in which employees are not in pay status for at least eight hours, employees:

(a) Lose eligibility for the employer contribution for that month; and

(b) Must reestablish eligibility for PEBB benefits as described in WAC 182-12-114 in order to be eligible for the employer contribution again.

(7) **The employer contribution toward PEBB insurance coverage ends** in any one of these circumstances for all employees:

(a) When employees fail to maintain eligibility for the employer contribution as indicated in the criteria in subsection (1) through (6) of this section.

(b) When the employment relationship is terminated. As long as the employing agency has no anticipation that the employee will be rehired, the employment relationship is terminated:

(i) On the date specified in an employee's letter of resignation; or

(ii) On the date specified in any contract or hire letter or on the effective date of an employer-initiated termination notice.

(c) When employees move to a position that is not anticipated to be eligible for PEBB benefits as described in WAC 182-12-114, not including changes in position due to a layoff.

The employer contribution toward PEBB benefits cease for employees and their enrolled dependents the last day of the month in which employees are eligible for the employer contribution under this section.

Exception: If the employing agency deducted the employee's premium for PEBB insurance coverage after the employee was no longer eligible for the employer contribution, PEBB insurance coverage ends the last day of the month for which employee premiums were deducted.

(8) **Options for continuation coverage by self-paying.** During temporary or permanent loss of the employer contribution toward PEBB insurance coverage, employees have options for providing continuation coverage for themselves and their dependents by self-paying the premium and applicable premium surcharge set by the health care authority (HCA). These options are available as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, 182-12-148, and 182-12-270.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-133 What options for continuation coverage are available to employees and their dependents during certain types of leave or when employment ends due to a layoff? Employees who have established eligibility for public employees benefits board (PEBB) benefits as described in WAC 182-12-114 may continue coverage for themselves and their dependents during certain types of leave or when their employment ends due to a layoff.

(1) Employees who are no longer eligible for the employer contribution toward PEBB insurance coverage due to an event described in (b)(i) through (vi) of this subsection may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharge set by the health care authority (HCA) from the date eligibility for the employer contribution is lost:

(a) Employees may continue any combination of medical, dental, and life insurance; however, only employees on approved educational leave or called in to active duty in the uniformed services as defined under the Uniformed Services Employment and Reemployment Rights Act (USERRA) may

continue either basic or both basic and optional long-term disability (LTD) insurance.

(b) Employees in the following circumstances qualify to continue coverage under this subsection:

(i) Employees who are on authorized leave without pay;

(ii) Employees who are on approved educational leave;

(iii) Employees who are receiving time-loss benefits under workers' compensation;

(iv) Employees who are called to active duty in the uniformed services as defined under USERRA;

(v) Employees whose employment ends due to a layoff as defined in WAC 182-12-109; or

(vi) Employees who are applying for disability retirement.

(c) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the ((~~HCA~~)) PEBB program, whichever is later.

(d) Employees may self-pay for a maximum of twenty-nine months. The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the ((~~employee's election is received by the HCA~~)) election period ends as described in (c) of this subsection.

Premiums and applicable premium surcharges associated with continuing PEBB medical, must be made to the HCA as well as premiums associated with continuing PEBB dental or LTD insurance coverage. Premiums associated with continuing life insurance coverage must be made to the contracted vendor. Following the employee's first premium payment, the employee must pay the premium amounts for PEBB insurance coverage and applicable premium surcharges as premiums become due.

(e) If the employee's monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)(((~~(b)~~))(c).

(2) The number of months that employees self-pay the premium while eligible as described in subsection (1) of this section will count toward the total months of continuation coverage allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). Employees who are no longer eligible for continuation coverage as described in subsection (1) of this section but who have not used the maximum number of months allowed under COBRA coverage may continue medical, dental, or both for the remaining difference in months by self-paying the premium and applicable premium surcharge as described in WAC 182-12-146.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-138 What options are available if an employee is approved for the federal Family and Medical Leave Act (FMLA)? (1) An employee on approved leave under the federal Family and Medical Leave Act (FMLA) may continue to receive the employer contribution toward public employees benefits board (PEBB) insurance coverage in accordance with the federal FMLA. The employee may also continue current optional life and optional long-term disability (LTD) insurance. The employee's employing agency is responsible for determining if the employee is eligible for leave under FMLA and the duration of such leave.

(2) If an employee's monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid.

(3) If an employee exhausts the period of leave approved under FMLA, PEBB insurance coverage may be continued by self-paying the premium and applicable premium surcharge set by the HCA, with no contribution from the employer, as described in WAC 182-12-133(1) while on approved leave.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-141 If an employee reverts from an eligible position, what happens to ((~~his or her~~)) their public employees benefits board (PEBB) insurance coverage? (1) If an employee reverts for reasons other than a layoff and is not eligible for the employer contribution toward public employees benefits board (PEBB) insurance coverage under this chapter, ((~~he or she~~)) they may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharge set by the health care authority (HCA) for up to eighteen months under the same terms as an employee who is granted leave without pay under WAC 182-12-133(1):

(a) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the ((~~HCA~~)) PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the ((~~employee's election is received by the HCA~~)) election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)(((~~(b)~~))(c).

(2) If an employee is reverted due to a layoff, the employee may be eligible for the employer contribution toward PEBB insurance coverage under the criteria of WAC 182-12-129. If determined not to be eligible under WAC 182-12-129, the employee may continue PEBB insurance coverage by self-paying the premium and applicable premium surcharge set by the HCA under WAC 182-12-133.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-142 What options for continuation coverage are available to faculty and seasonal employees who are between periods of eligibility? (1) **Faculty** may continue any combination of medical, dental, and life insurance by self-paying the premium and applicable premium surcharge set by the health care authority (HCA), with no contribution from the employer, for a maximum of twelve months between periods of eligibility:

(a) The employee's election must be received by the public employees benefits board (PEBB) program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the ((~~HCA~~)) PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the ((~~employee's election is received by the HCA~~)) election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)(((~~(b)~~))) (c).

(2) **Benefits-eligible seasonal employees** may continue any combination of medical, dental, and life insurance by self-paying the premium and applicable premium surcharge set by the HCA, with no contribution from the employer, for a maximum of twelve months between periods of eligibility:

(a) The employee's election must be received by the PEBB program no later than sixty days from the date the employee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the ((~~HCA~~)) PEBB program, whichever is later;

(b) The employee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the ((~~employee's election is received by the HCA~~)) election period ends as described in (a) of this subsection. Premiums and applicable premium surcharges associated with continuing PEBB medical must be made to the HCA as well as premiums associated with continuing PEBB dental. Premiums associated with continuing life insurance coverage must be made to the contracted vendor;

(c) Following the employee's first premium payment, the employee must pay the premium amounts associated with PEBB insurance coverage and applicable premium surcharges as premiums become due; and

(d) If the employee's monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, the employee's PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)(((~~(b)~~))) (c).

(3) **COBRA.** An employee who is no longer eligible for continuation coverage as described in subsections (1) and (2) of this section, but who has not used the maximum number of months allowed under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), may continue medical ((~~and~~)), dental, or both for the remaining difference in months by self-paying the premium and applicable premium surcharge set by the HCA under COBRA as described in WAC 182-12-146. The number of months that a faculty or seasonal employee self-pays premiums under the criteria in subsection (1) or (2) of this section will count toward the total months of continuation coverage allowed under COBRA.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-146 When is an enrollee eligible to continue public employee's benefits board (PEBB) health plan coverage under Consolidated Omnibus Budget Reconciliation Act (COBRA)? (1) An enrollee may continue public employee's benefits board (PEBB) health plan coverage under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) by self-paying the premium and applicable premium surcharge set by the health care authority (HCA):

Note: Based on RCW 26.60.015 and public employee benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, an employee's state registered domestic partner and the state registered domestic partner's children may continue PEBB insurance coverage on the same terms and conditions as spouses and other eligible dependents under COBRA.

(a) The enrollee's election must be received by the PEBB program no later than sixty days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the ((~~HCA~~)) PEBB program, whichever is later;

(b) The enrollee's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the ((~~enrollee's election is received by the HCA~~)) election period ends as described in (a) of this subsection. Following the enrollee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(((~~(b)~~))) (c);

(c) Enrollees who request to voluntarily terminate their COBRA coverage must do so in writing. The written termination request must be received by the PEBB program. Enrollees who terminate their COBRA coverage will not be eligible to reenroll in COBRA coverage unless they regain eligibility. COBRA coverage will end on the last day of the month in which the PEBB program receives the termination request. If the termination request is received on the first day of the month, COBRA coverage will end on the last day of the previous month; and

(d) Medical flexible spending arrangement (FSA) enrollees who on the date of the qualifying event, have a greater number of remaining benefits than remaining contribution payments for the current year, will have an opportunity to continue making contributions to their medical FSA by electing COBRA. The enrollee's first premium payment is due to the contracted vendor no later than forty-five days after the ((~~enrollee's election is received by the contracted vendor~~)) election period ends as described below. The enrollee's election must be received by the contracted vendor no later than sixty days from the date the enrollee's PEBB health plan coverage ended or from the postmark date on the election notice sent by the contracted vendor, whichever is later.

(2) An employee or an employee's dependent who loses eligibility for the employer contribution toward PEBB insurance coverage and who qualifies for continuation coverage under COBRA may continue medical, dental, or both.

(3) An employee or an employee's dependent who loses eligibility for continuation coverage described in WAC 182-12-133, 182-12-138, 182-12-141, 182-12-142, or 182-12-148 but who has not used the maximum number of months allowed under COBRA may continue medical, dental, or both for the remaining difference in months.

(4) A retired employee who loses eligibility for PEBB retiree insurance because an employer group, with the exception of school districts, educational service districts, and charter schools ceases participation in PEBB insurance coverage may continue medical, dental, or both.

(5) A retired employee, or a dependent of a retired employee, who is no longer eligible to continue coverage as described in WAC 182-12-171 may continue medical, dental, or both.

(6) A blind vendor who ceases to actively operate a facility as described in WAC 182-12-111 (5)(a) may continue enrollment in PEBB medical for the maximum number of months allowed under COBRA as described in this section.

A blind vendor is not eligible for PEBB retiree insurance coverage.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-148 What options for continuation coverage are available to employees during their appeal of dismissal? (1) Employees awaiting hearing of a dismissal action before any of the following may continue their public employees benefits board (PEBB) insurance coverage by self-paying the premium and applicable premium surcharge set by the health care authority (HCA), with no contribution from the employer, on the same terms as an employee who is granted leave as described in WAC 182-12-133:

(a) The personnel resources board;

(b) An arbitrator; or

(c) A grievance or appeals committee established under a collective bargaining agreement for union represented employees.

(2) The employee must pay premium amounts and applicable premium surcharges associated with PEBB insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium surcharge remains unpaid for sixty days from the original due date, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)(((~~(b)~~))) (c).

(3) If the dismissal is upheld, all PEBB insurance coverage will end at the end of the month in which the decision is entered, or the date to which premiums have been paid, whichever is later, with the exception described in subsection (4) of this section.

(4) If the dismissal is upheld and the employee is eligible under the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), the employee may continue medical ((~~and~~)), dental, or both for the remaining months available under COBRA. See WAC 182-12-146 for information on COBRA. The number of months the employee self-paid premiums during the appeal will count toward the total number of months allowed under COBRA.

(5) If the board, arbitrator, committee, or court sustains the employee in the appeal and directs reinstatement of employer paid PEBB insurance coverage retroactively, the employing agency must forward to HCA the full employer contribution for the period directed by the board, arbitrator, committee, or court and collect from the employee the employee's share of premiums due, if any.

(a) HCA will refund to the employee any premiums and applicable premium surcharges the employee paid that may be provided for as a result of the reinstatement of the employer contribution only if the employee makes retroactive payment of any employee contribution amounts associated with the PEBB insurance coverage. In the alternative, at the request of the employee, HCA may deduct the employee's contribution from the refund of any premiums and applicable premium surcharges self-paid by the employee during the appeal period.

(b) All optional life and optional ((~~long-term disability~~)) LTD insurance which was in force at the time of dismissal shall be reinstated retroactively only if the employee makes retroactive payment of premium for any such optional coverage which was not continued by self-payment during the appeal process. If the employee chooses not to pay the retroactive premium, evidence of insurability will be required to restore such optional coverage.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-171 When is a retiring employee eligible to enroll in public employees benefits board (PEBB)

retiree insurance coverage? A retiring employee is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) insurance coverage as a retiree if ((~~he or she~~)) they meet((~~s~~)) procedural and substantive eligibility requirements as described in subsections (1), (2), and (3) of this section. An elected ((~~state official or~~)) and full-time appointed ((~~state~~)) official of the legislative ((~~or~~)) and executive branch of state government is eligible as described in WAC 182-12-180.

(1) **Procedural requirements.** A retiring employee must enroll or defer enrollment in PEBB retiree insurance coverage as described in (a)((~~, (b), and (c)~~)) through (d) of this subsection:

(a) To enroll in PEBB retiree insurance coverage, the required form must be received by the PEBB program no later than sixty days after the employee's employer-paid coverage, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, or continuation coverage ends. The effective date of PEBB retiree insurance coverage is the first day of the month after the employee's employer-paid coverage, COBRA coverage, or continuation coverage ends;

(b) The employee's first premium payment and applicable premium surcharge is due to the health care authority (HCA) no later than forty-five days after the ((~~employee's election is received by the HCA~~)) election period ends as described in (a) of this subsection. Following the employee's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(((~~(b)~~))) (c); and

(c) If a retiring employee elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee;

Exception: If a retiring employee selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiring employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(d) To defer enrollment in a PEBB health plan, the employee must meet substantive eligibility requirements in subsection (2) of this section and defer enrollment as described in WAC 182-12-200 or 182-12-205.

(2) **Substantive eligibility requirements.**

(a) An employee as defined in WAC 182-12-109 who is eligible for PEBB benefits or an employee who is enrolled in basic benefits through a Washington state school district, educational service district as defined in RCW 28A.400.270, or a charter school and ends public employment after becoming vested in a Washington state-sponsored retirement plan may enroll or defer enrollment in PEBB retiree insurance coverage if ((~~he or she~~)) they meet((~~s~~)) procedural and substantive eligibility requirements.

To be eligible to continue enrollment or defer enrollment in PEBB insurance coverage as a retiree, the employee must be eligible to retire under a Washington state-sponsored retirement plan when the employee's employer-paid coverage, COBRA coverage, or continuation coverage ends.

(b) A retiring employee of a state agency must immediately begin to receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring employee who receives a ((~~lump-sum~~)) lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or

(ii) A retiring employee who is a member of a Plan 3 retirement plan, also called a separated employee (defined in RCW 41.05.011(((~~21~~))) (25)), must meet ((~~his or her~~)) their Plan 3 retirement eligibility criteria. The employee does not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage((~~;~~)).

(c) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan (HERP) must immediately begin to receive a monthly retirement plan payment, or meet ((~~his or her~~)) their HERP plan's retirement eligibility criteria, or be at least age fifty-five with ten years of state service;

(d) A retiring employee of an employer group participating in PEBB insurance coverage under contractual agreement with the authority must be eligible to retire as described in (i) or (ii) of this subsection to be eligible to continue PEBB insurance coverage as a retiree, except for a school district, educational service district, or charter school employee who must meet the requirements as described in subsection (2)(e) of this section.

(i) A retiring employee who is eligible to retire under a retirement plan sponsored by an employer group or tribal government that is not a Washington state-sponsored retirement plan must meet the same age and years of service requirements as if ((~~he or she was~~)) they were a member of public employees retirement system Plan 1 or Plan 2 during ((~~his or her~~)) their employment with that employer group or tribal government.

(ii) A retiring employee who is eligible to retire under a Washington state-sponsored retirement plan must immediately begin to receive a monthly retirement plan payment, with exceptions described in subsection (2)(b)(i) and (ii) of this section.

(iii) A retired employee of an employer group, except a Washington state school district, educational service district, or charter school that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage if ((~~he or she~~)) they enrolled after September 15, 1991. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

(iv) A retired employee of a tribal government employer that ends participation in PEBB insurance coverage is no longer eligible to continue enrollment in PEBB retiree insurance coverage. Any retiree who loses eligibility for this reason may continue health plan enrollment as described in WAC 182-12-146.

(e) A retiring employee of a Washington state school district, Washington state educational service district, or a Washington state charter school must immediately begin to

receive a monthly retirement plan payment, with exceptions described below:

(i) A retiring employee who ends employment before October 1, 1993; or

(ii) A retiring employee who receives a ((~~lump-sum~~)) lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan, or the employee enrolled before 1995; or

(iii) A retiring employee who is a member of a Plan 3 retirement system, also called a separated employee (defined in RCW 41.05.011((~~(21)~~)) (25)), must meet ((~~his or her~~)) their Plan 3 retirement eligibility criteria; or

(iv) An employee who retired as of September 30, 1993, and began receiving a monthly retirement plan payment from a Washington state-sponsored retirement system (as defined in chapters 41.32, 41.35 or 41.40 RCW) is eligible if ((~~he or she~~)) they enrolled in a PEBB health plan no later than the HCA's annual open enrollment period for the year beginning January 1, 1995.

(3) A retiring employee and ((~~his or her~~)) their enrolled dependents who are entitled to medicare must enroll and maintain enrollment in both medicare Parts A and B if the employee retired after July 1, 1991. If a retiree or an enrolled dependent becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, ((~~he or she~~)) they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree health plan. If an enrollee who is entitled to medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree ((~~insurance coverage~~)) health plan. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

(4) Washington state-sponsored retirement plans include:

(a) Higher education retirement plans;

(b) Law enforcement officers' and firefighters' retirement system;

(c) Public employees' retirement system;

(d) Public safety employees' retirement system;

(e) School employees' retirement system;

(f) State judges/judicial retirement system;

(g) Teachers' retirement system; and

(h) State patrol retirement system.

(i) The two federal retirement systems, Civil Service Retirement System and Federal Employees' Retirement System, are considered Washington state-sponsored retirement systems for Washington State University Extension for an employee covered under PEBB insurance coverage at the time of retirement.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-180 When is an elected ((~~state official,~~)) and full-time appointed ((~~state~~)) official of the legislative ((~~or~~)) and executive branch of state government, or their survivor eligible to continue enrollment in public employees benefits board (PEBB) retiree insurance coverage? (1) ((~~The following officials are~~)) An elected and full-time appointed official of the legislative and executive branch of state government is eligible to continue enrollment or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage under the same terms as an outgoing legislator((~~s~~)), when they voluntarily or involuntarily leave public office((~~,~~)). The following officials are eligible if they meet the procedural requirements as described in subsection (3) of this section:

(a) A member of the state legislature;

(b) A statewide elected official of the executive branch;

(c) An executive official appointed directly by the governor as the single head of an executive branch agency; or

(d) An official appointed directly by a state legislative committee as the single head of a legislative branch agency or an official appointed to secretary of the senate or chief clerk of the house of representatives.

(2) The spouse, state registered domestic partner, or child of an official described in subsection (1) of this section who loses eligibility due to the death of the official may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage as described in (a) and (b) of this subsection and must meet procedural requirements as described in subsection (3)((~~(b) and (c)~~)) of this section.

(a) The official's spouse or state registered domestic partner may continue health plan enrollment until death.

(b) The official's child may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

(3) **Procedural requirements.** An official described in subsection (1) of this section or their survivor described in subsection (2) of this section must enroll or defer enrollment in PEBB retiree insurance coverage ((~~no later than sixty days after the official leaves public office or the death of the official~~)) as described in (a) through (d) of this subsection:

(a) For an official to enroll in PEBB retiree insurance coverage the required forms must be received by the PEBB program no later than sixty days after the official leaves public office ((~~or the death of the official~~)). The effective date of PEBB retiree insurance coverage is the first day of the month after the official leaves public office ((~~or the death of the official~~));

For a survivor to enroll in PEBB retiree insurance coverage, the required forms must be received by the PEBB program no later than sixty days after the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The effective date of PEBB retiree insurance coverage is the first day of the month after the date of the official's death or the first day of the month after the survivor's PEBB insurance coverage ends;

(b) The official's or survivor's first premium payment and applicable premium surcharge is due to the health care authority (HCA) no later than forty-five days after the official's or survivor's ((~~election is received by the PEBB program~~)) election period ends as described in (a) of this subsection. Following the official's or survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(((~~(b)~~))) (c);

(c) If an official or a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the official or survivor;

Exception: If an official or a survivor selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If an official or a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(d) To defer enrollment in a PEBB health plan the official or the survivor must meet deferral enrollment requirements as described in WAC 182-12-200 or 182-12-205.

(4) If the official, an enrolled dependent, or their survivor is entitled to medicare or becomes entitled to medicare after enrollment in PEBB retiree insurance coverage, ((~~he or she~~)) they must enroll and maintain enrollment in medicare Parts A and B to remain enrolled in a PEBB retiree ((~~insurance coverage~~)) health plan. If an enrollee who is entitled to medicare does not meet this procedural requirement, the enrollee is no longer eligible for enrollment in a PEBB retiree health plan. The enrollee may continue PEBB health plan enrollment as described in WAC 182-12-146.

(5) An official described in subsection (1) of this section shall be included in the term "retiree" or "retiring employee" as used in chapters 182-08, 182-12, and 182-16 WAC.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-12-200 ((~~How does a retiree who is~~)) May a retiring employee or a retiree enrolled as a dependent in a health plan sponsored by public employees benefits board (PEBB), a Washington state school district, a Washington state educational service district, or a Washington state charter school defer PEBB health plan enrollment under PEBB retiree insurance coverage? (1) A ((~~retiree~~)) retiring employee may defer enrollment in a public employees benefits board (PEBB) health plan ((~~during the period of time he or she is~~)) at retirement or after enrolling in PEBB retiree insurance coverage. Enrollment in a PEBB health plan may be deferred when they are enrolled as a dependent in a health plan sponsored by PEBB, a Washington state school district, a Washington state ((~~education~~)) educational service district, or a Washington state charter school, including such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continuation coverage. A retiring employee who defers enrollment at retirement must meet substantive eligibility requirements as described in WAC 182-12-171(2) or requirements as described in WAC 182-12-180(1).

(2) A retiree who defers enrollment in medical must defer enrollment in dental. Retirees must be enrolled in medical to enroll in dental. A retiree who defers enrollment in a PEBB health plan also defers enrollment for all eligible dependents.

(3) A retiree who defers ((~~coverage~~)) enrollment may later enroll in a PEBB health plan if ((~~he or she~~)) they provide((~~s~~)) evidence of continuous enrollment in a health plan sponsored by PEBB, a Washington state school district, a Washington state educational service district, or a Washington state charter school and submits the required form as described in (a) and (b) of this subsection:

(a) During the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(b) When enrollment in a health plan sponsored by PEBB, a Washington state school district, a Washington state educational service district, or a Washington state charter school ends, or such coverage under COBRA or continuation coverage ends. ((~~The retiree must submit the required form to enroll or defer enrollment as described in WAC 182-12-171 (1)(a).~~)) The required forms to enroll must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month following the date the other coverage ends. To continue in a deferred status, the retiree must defer enrollment as described in WAC 182-12-205.

(4) If a retiree elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical or PEBB dental plan as the retiree.

Exception: If a retiree selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiree selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-12-205 May a retiree((~~s~~)) or a survivor defer or voluntarily terminate public employees benefits board (PEBB) health plan enrollment under ((~~public employees benefits board (PEBB)~~)) PEBB retiree insurance coverage ((~~at or after retirement~~))? (1) The following ((~~provisions apply when retirees defer or voluntarily terminate enrollment under~~)) individuals may defer enrollment in a public employees benefits board (PEBB) ((~~retiree insurance coverage when enrolled in other coverage~~)) health plan:

((~~(1) Retirees~~)) (a) A retiring employee;

(b) A dependent becoming eligible as a survivor; or

(c) A retiree or a survivor enrolled in PEBB retiree insurance coverage.

(2) A subscriber described in subsection (1) of this section who defers enrollment in a PEBB health plan also defers enrollment for all eligible dependents, except as described in subsection ((~~(2)~~)) (3)(c) of this section.

((~~(2) Retirees may~~)) (3) A subscriber described in subsection (1) of this section who defers enrollment in a PEBB health plan ((~~at or after retirement if continuously enrolled~~)) must maintain continuous enrollment in other medical as described in this section or WAC 182-12-200. ((~~Retirees who~~)) A subscriber who defers enrollment in medical must defer enrollment in dental. ((~~Retirees~~)) A subscriber must be enrolled in medical to enroll in dental.

(a) Beginning January 1, 2001, ((~~retirees may defer~~)) enrollment in a PEBB health plan ((~~if they are~~)) may be deferred when the subscriber is enrolled in employer-based

group medical as an employee or the dependent of an employee, or such medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.

(b) Beginning January 1, 2001, ((~~retirees may defer~~)) enrollment in a PEBB health plan ((~~if they are~~)) may be deferred when the subscriber is enrolled as a retiree or the dependent of a retiree in a federal retiree medical plan.

(c) Beginning January 1, 2006, ((~~retirees may defer~~)) enrollment in a PEBB health plan ((~~if they are~~)) may be deferred when the subscriber is enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described in this chapter. ((~~The retiree's~~)) Dependents may continue their PEBB health plan enrollment if they meet PEBB eligibility criteria and are not eligible for creditable coverage under a medicaid program.

(d) Beginning January 1, 2014, ((~~retirees~~)) subscribers who are not eligible for Parts A and B of medicare may defer enrollment in a PEBB health plan ((~~if they are~~)) when the subscriber is enrolled in exchange coverage.

(((~~(3)~~))) (e) Beginning July 17, 2018, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled as a retiree or the dependent of a retiree in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

(4) To defer PEBB health plan enrollment, ((~~retiring employees or enrolled subscribers must submit~~)) the required forms must be submitted to the PEBB program.

(a) ((~~If~~)) For a retiring employee((~~s submit the required forms to defer enrollment in a PEBB health plan after their employer-paid coverage, COBRA coverage, or continuation coverage ends~~)) who meets the substantive eligibility requirements as described in WAC 182-12-171 (((~~(1)(b)~~))) (2), enrollment will be deferred the first of the month following the date their employer-paid coverage, COBRA coverage, or continuation coverage ends. The forms must be received by the PEBB program no later than sixty days after the employer-paid coverage, COBRA coverage, or continuation coverage ends.

(b) ((~~If enrolled subscribers~~)) For an official leaving public office who meets the requirements as described in WAC 182-12-180(1), enrollment will be deferred the first of the month following the date the official leaves public office. The forms must be received by the PEBB program no later than sixty days after the official leaves public office.

(c) For an employee determined to be retroactively eligible for disability retirement who meets the requirements as described in WAC 182-12-211 (1)(a) through (c), enrollment will be deferred as described in WAC 182-12-211 (2) or (3). The forms and formal determination letter must be received by the PEBB program no later than sixty days after the date on the determination letter.

(d) For an eligible survivor, the dependent must meet the requirements described below and the forms must be received by the PEBB program within the time described:

(i) For a survivor of an employee who meets the requirements as described in WAC 182-12-265 (1) or (3), enrollment will be deferred the first of the month following the later of the date of the employee's death or the date the survivor's PEBB insurance coverage, school district coverage, educational service district coverage, or charter school coverage ends. The forms must be received by the PEBB program no later than sixty days after the later of the date of the employee's death or the date the survivor's PEBB insurance coverage, school district coverage, educational service district coverage, or charter school coverage ends.

(ii) For a survivor of an official who meets the requirements as described in WAC 182-12-180(2), enrollment will be deferred the first of the month following the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends. The forms must be received by the PEBB program no later than sixty days after the later of the date of the official's death or the date the survivor's PEBB insurance coverage ends.

(iii) For a survivor of a retiree who meets the requirements as described in WAC 182-12-265(2), enrollment will be deferred the first of the month following the date of the retiree's death. The forms must be received by the PEBB program no later than sixty days after the retiree's death.

(iv) For a survivor of an emergency service personnel killed in the line of duty who meets the requirements as described in WAC 182-12-250, enrollment will be deferred the first of the month following the later of one of the events described in WAC 182-12-250 (5)(a) through (d). The forms must be received by the PEBB program no later than one hundred eighty days after the later of one of the events described in WAC 182-12-250 (5)(a) through (d).

(e) For an enrolled retiree or survivor who submits the required forms to defer enrollment in a PEBB health plan, enrollment will be deferred effective the first of the month following the date the required forms ((~~is~~)) are received by the PEBB program. If the forms ((~~is~~)) are received on the first day of the month, ((~~coverage will end on the last day of the previous month.~~

~~(4) Retirees who defer enrollment while enrolled in coverage as described in subsection (2)(a) through (d) of this section and lose such coverage must enroll in a PEBB retiree health plan as described in WAC 182-12-171 or defer enrollment as described in this section or WAC 182-12-200~~)) enrollment will be deferred effective that day.

Exception: When a subscriber or their dependent is enrolled in a medicare advantage plan, then enrollment in a PEBB health plan will be deferred effective the first of the month following the date the medicare advantage plan disenrollment form is received.

(5) A retiree((~~s~~)) who meets substantive eligibility requirements in WAC 182-12-171(2) and whose employer-paid coverage, COBRA coverage, or continuation coverage ended between January 1, 2001, and December 31, 2001, was not required to ((~~submit~~)) have submitted the deferral form at that time, but must ((~~have met~~)) meet all procedural requirements as stated in this section, WAC 182-12-171, and 182-12-200.

(6) ((~~Retirees who defer~~)) A subscriber described in subsection (1) of this section who defers enrollment while enrolled in qualifying coverage as described in subsection (3)(a) through (e) of this section may later enroll themselves and their dependents in a PEBB health plan ((~~as follows~~)) by submitting the required forms as described below and evidence of continuous enrollment in one or more qualifying

coverages as described in subsection (3)(a) through (e) of this section:

(a) ((~~Retirees~~)) A subscriber who defers enrollment while enrolled in employer-based group medical or such medical insurance continued under COBRA coverage or continuation coverage may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment ((~~in such coverage~~)) to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their employer-based group medical or such coverage under COBRA coverage or continuation coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after ((~~such~~)) coverage ends. PEBB health plan coverage begins the first day of the month after the employer-based group medical coverage, COBRA coverage, or continuation coverage ends.

(b) ((~~Retirees~~)) A subscriber who defers enrollment while enrolled as a retiree or dependent of a retiree in a federal retiree medical plan will have a one-time opportunity to enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment ((~~in such coverage~~)) to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When the federal retiree medical plan coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after ((~~such~~)) coverage ends. PEBB health plan coverage begins the first day of the month after coverage under the federal retiree medical plan ends.

(c) ((~~Retirees~~)) A subscriber who defers enrollment while enrolled in medicare Parts A and B and a medicaid program that provides creditable coverage as described in this chapter may enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment ((~~in such coverage~~)) to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When their medicaid coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after ((~~such~~)) coverage ends. PEBB health plan coverage begins the first day of the month after the medicaid coverage ends; or

(iii) No later than the end of the calendar year when their medicaid coverage ends if the retiree or survivor was also determined eligible under 42 U.S.C. § 1395w-114 and subsequently enrolled in a medicare Part D plan. Enrollment in the PEBB health plan will begin January 1st following the end of the calendar year when the medicaid coverage ends. The required forms must be received by the PEBB program no later than the last day of the calendar year in which the ((~~retiree's~~)) medicaid coverage ends.

(d) ((~~Retirees~~)) A subscriber who defers enrollment while enrolled in exchange coverage will have a one-time opportunity to enroll or reenroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment ((~~in such coverage~~)) to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When exchange coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after ((~~such~~)) coverage ends. PEBB health plan coverage begins the first day of the month after exchange coverage ends.

(e) ((~~Retirees~~)) A subscriber who defers enrollment while enrolled as a retiree or dependent of a retiree in CHAMPVA will have a one-time opportunity to enroll in a PEBB health plan by submitting the required forms and evidence of continuous enrollment to the PEBB program:

(i) During the PEBB annual open enrollment period. The required forms must be received by the PEBB program no later than the last day of the open enrollment period. PEBB health plan coverage begins January 1st of the following year; or

(ii) When CHAMPVA coverage ends. The required forms and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after coverage ends. PEBB health plan coverage begins the first day of the month after CHAMPVA coverage ends.

(f) A subscriber who defers enrollment may enroll in a PEBB health plan if ((~~the retiree~~)) they receive((~~s~~)) formal notice that the authority has determined it is more cost-effective to enroll ((~~the retiree or the retiree's~~)) them or their eligible dependents in PEBB medical than a medical assistance program.

(g) If a subscriber elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the subscriber.

Exception: If a subscriber selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a subscriber selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(7) ((~~Retirees~~)) An enrolled retiree or a survivor who requests to voluntarily terminate their enrollment in a PEBB ((~~retiree insurance coverage~~)) health plan must do so in writing. The written termination request must be received by the PEBB program. A retiree((~~s~~)) or a survivor who voluntarily terminates their enrollment in a PEBB ((~~retiree insurance coverage~~)) health plan also terminates enrollment for all eligible dependents. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly eligible. Enrollment in a PEBB ((~~insurance coverage~~))

health plan will ((~~end~~)) terminate on the last day of the month in which the PEBB program receives the termination request. If the termination request is received on the first day of the month, enrollment in a PEBB ((~~insurance coverage~~)) health plan will ((~~end~~)) terminate on the last day of the previous month.

Exception: When a ((~~member~~)) subscriber or their dependent is enrolled in a medicare advantage plan, then enrollment in a PEBB ((~~insurance coverage will end~~)) health plan will terminate on the last day of the month when the medicare advantage plan disenrollment form is received.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-207 When can a retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage be ((~~canceled~~)) terminated by the health care authority (HCA)? A retiree or an eligible dependent's public employees benefits board (PEBB) insurance coverage can be terminated by the health care authority (HCA) for the following reasons:

(1) Failure to comply with the PEBB program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB program;

(2) Knowingly providing false information;

(3) Failure to pay the monthly premium or applicable premium surcharge when due as described in WAC 182-08-180 (1)(((~~b~~))) (c);

(4) Misconduct. If a retiree's PEBB insurance coverage is terminated for misconduct, PEBB insurance coverage will not be reinstated at a later date. Examples of such termination include, but are not limited to the following:

(a) Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium; or

(b) Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan or other HCA contracted vendor providing PEBB insurance coverage on behalf of the HCA, its employees, or other persons.

If a retiree's PEBB insurance coverage is terminated by HCA for the above reasons, PEBB insurance coverage for all of the retiree's eligible dependents is also terminated.

AMENDATORY SECTION (Amending WSR 16-20-080, filed 10/4/16, effective 1/1/17)

WAC 182-12-208 What are the requirements regarding enrollment in dental under public employees benefits board (PEBB) retiree insurance coverage? The following provisions apply to a subscriber and ((~~his or her~~)) their dependents enrolled under public employees benefits board (PEBB) retiree insurance coverage:

(1) A subscriber ((~~and his or her dependents~~)) enrolling in dental must meet procedural and eligibility requirements (((~~as described in WAC 182-12-171(1) and 182-12-262) and eligibility requirements (as described in WAC 182-12-171(2) and 182-12-260)~~))) under one of the following: WAC 182-12-171, 182-12-180, 182-12-200, 182-12-205, 182-12-211, 182-12-250, 182-12-262, or 182-12-265. The subscriber's dependents must meet eligibility criteria as described in WAC 182-12-250 or 182-12-260.

(2) A subscriber and ((~~his or her~~)) their dependents must be enrolled in medical to enroll in dental. If a subscriber elects to enroll dependents in PEBB dental coverage, the dependents must be enrolled in the same PEBB dental plan as the subscriber.

(3) A subscriber enrolling in dental must stay enrolled for at least two years before dental can be dropped unless ((~~he or she~~)) they defer((~~s~~)) or terminate medical and dental coverage as described in WAC 182-12-200 or 182-12-205, or drops dental as described in subsection (4) of this section.

(4) A subscriber enrolled in PEBB dental who becomes eligible for, and enrolls in, employer-based group dental as an employee or the dependent of an employee, or such coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), or continuation coverage may drop PEBB dental, before completing the two-year enrollment requirement. Coverage will end on the last day of the month in which the required form is received by the PEBB program. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(a) A subscriber may enroll, terminate, or change their election in PEBB dental during the PEBB annual open enrollment period. The required form must be received by the PEBB program no later than the last day of the open enrollment period. The change in PEBB dental begins January 1st of the following year.

(b) A subscriber may enroll in PEBB dental after ((~~his or her~~)) their employer-based group dental or such coverage under COBRA coverage or continuation coverage ends. The required form must be received by the PEBB program no later than sixty days after such coverage ends. PEBB dental begins the first day of the month after the employer-based group dental coverage or continuation coverage under COBRA ends.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-209 Who is eligible for retiree term life insurance? Eligible employees who participate in public employees benefits board (PEBB) life insurance as an employee and meet qualifications for PEBB retiree insurance coverage as provided in WAC 182-12-171 or 182-12-180 are eligible for ((~~PEBB~~)) retiree term life insurance. They must submit the required forms to the PEBB program. Forms for a retiring employee as described in WAC 182-12-171, must be received by the PEBB program no later than sixty days after the date their PEBB employee life insurance ends. Forms for an official leaving public office as described in WAC 182-12-180, must be received by the PEBB program no later than sixty days after the official leaves public office.

(1) Employees whose life insurance premiums are being waived under the terms of the life insurance contract are not eligible for retiree term life insurance until their waiver of premium benefit ends.

(2) Retirees may not defer enrollment in retiree term life insurance, except as allowed in subsection (3)(b) of this section.

(3) If a retiree returns to active employment status and becomes eligible for the employer contribution toward PEBB employee life insurance, ((~~he or she~~)) they may choose:

(a) To continue to self-pay premiums and keep retiree term life insurance, the employee must pay retiree term life insurance premiums directly to the contracted vendor during the period ((~~he or she is~~)) they are eligible for PEBB employee life insurance; or

(b) To stop self-paying retiree term life insurance premiums during the period ((~~he or she is~~)) they are eligible for PEBB employee life insurance and reelect retiree term life insurance when ((~~he or she is~~)) they are no longer eligible for the employer contribution toward PEBB employee life insurance.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-211 May an employee who is determined to be retroactively eligible for disability retirement enroll in public employees benefits board (PEBB) retiree insurance coverage? (1) An employee who is determined to be retroactively eligible for a disability retirement is eligible to enroll or defer enrollment (as described in WAC 182-12-200 or 182-12-205) in public employees benefits board (PEBB) retiree insurance coverage if:

(a) The employee submits the required form and a copy of the formal determination letter ((~~he or she~~)) they received from the Washington state department of retirement systems (DRS) or the appropriate higher education authority;

(b) The employee's form and a copy of ((~~his or her~~)) their Washington state-sponsored retirement system's formal determination letter are received by the PEBB program no later than sixty days after the date on the determination letter; and

(c) The employee immediately begins to receive a monthly pension benefit or a supplemental retirement plan benefit under ((~~his or her~~)) their higher education retirement plan (HERP), with exceptions described ((~~in~~)) below from WAC 182-12-171(2)((~~(a).~~)):

(i) A retiring employee of a state agency, Washington state school district, Washington state educational service district, Washington state charter school, or an employer group participating under a Washington state sponsored retirement plan, who receives a lump sum payment instead of a monthly retirement plan payment is only eligible if the department of retirement systems offered the employee the choice between a lump sum actuarially equivalent payment and the ongoing monthly payment, as allowed by the plan; or

(ii) A retiring employee of a state agency, Washington state school district, Washington state educational service district, Washington state charter school, or an employer group participating under a Washington state sponsored retirement plan, who is a member of a Plan 3 retirement plan, also called a separated employee (defined in RCW 41.05.011 (25)), must meet their Plan 3 retirement eligibility criteria. The employee does not have to receive a retirement plan payment to enroll in PEBB retiree insurance coverage; or

(iii) A retiring employee of a Washington higher education institution who is a member of a higher education retirement plan (HERP) must immediately begin to receive a monthly retirement plan payment, or meet their HERP plan's retirement eligibility criteria, or be at least age fifty-five with ten years of state service.

(2) Premiums and applicable premium surcharges are due from the effective date of enrollment in PEBB retiree insurance coverage. The employee, at ((~~his or her~~)) their option, must indicate the effective date of PEBB retiree insurance coverage on the form. The employee may choose from the following dates:

(a) The employee's retirement date as stated in the formal determination letter; or

(b) The first day of the month following the date the formal determination letter was written.

(3) The director may make an exception to the date PEBB retiree insurance coverage begins; however, such request must demonstrate extraordinary circumstances beyond the control of the retiree.

(4) If a retiring employee elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the retiring employee.

Exception: If a retiring employee selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a retiring employee selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-250 Public employees benefits board (PEBB) insurance coverage eligibility for survivors of emergency service personnel killed in the line of duty. Surviving spouses, state registered domestic partners, and dependent children of emergency service personnel who are killed in the line of duty are eligible to enroll or defer enrollment in public employees benefits board (PEBB) retiree insurance coverage.

(1) This section applies to the surviving spouse, the surviving state registered domestic partner, and dependent children of emergency service personnel "killed in the line of duty" as determined by the Washington state department of labor and industries.

(2) "Emergency service personnel" means law enforcement officers and firefighters as defined in RCW 41.26.030, members of the Washington state patrol retirement fund as defined in RCW 43.43.120, and reserve officers and firefighters as defined in RCW 41.24.010.

(3) "Surviving spouse, state registered domestic partner, and dependent children" means:

(a) A lawful spouse;

(b) An ex-spouse as defined in RCW 41.26.162;

(c) A state registered domestic partner as defined in RCW 26.60.020(1); and

(d) Children. The term "children" includes children of the emergency service worker up to age twenty-six. Children with disabilities as defined in RCW 41.26.030(6) are eligible at any age. "Children" is defined as:

(i) Biological children (including the emergency service worker's posthumous children);

(ii) Stepchildren or children of a state registered domestic partner;

(iii) Legally adopted children;

(iv) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(v) Children specified in a court order or divorce decree; or

(vi) Children as defined in RCW ((~~26.26.101~~)) 26.26A.-100.

(4) Surviving spouses, state registered domestic partners, and children who are entitled to medicare must enroll in both Parts A and B of medicare.

(5) The survivor (or agent acting on ((~~his or her~~)) their behalf) must submit the required forms to the PEBB program to either enroll or defer enrollment in PEBB retiree insurance coverage as described in subsection (7) of this section. The forms must be received by the PEBB program no later than one hundred eighty days after the later of:

(a) The death of the emergency service worker;

(b) The date on the letter from the department of retirement systems or the board for volunteer firefighters and reserve officers that informs the survivor that ((~~he or she is~~)) they are determined to be an eligible survivor;

(c) The last day the surviving spouse, state registered domestic partner, or child was covered under any health plan through the emergency service worker's employer; or

(d) The last day the surviving spouse, state registered domestic partner, or child was covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage from the emergency service worker's employer.

(6) Survivors who do not choose to defer enrollment in PEBB retiree insurance coverage may choose among the following options for when their enrollment in a PEBB health plan will begin:

(a) June 1, 2006, for survivors whose required forms are received by the PEBB program no later than September 1, 2006;

(b) The first of the month that is not earlier than sixty days before the date that the PEBB program receives the required forms (for example, if the PEBB program receives the required forms on August 29, the survivor may request health plan enrollment to begin on July 1st); or

(c) The first of the month after the date that the PEBB program receives the required forms.

For surviving spouses, state registered domestic partners, and children who enroll, monthly health plan premiums and applicable premium surcharges must be paid by the survivor as described in WAC 182-08-180 (1)(((~~(b)~~))) (c) except as provided in RCW 41.26.510(5) and 43.43.285 (2)(b).

(7) Survivors must choose one of the following two options to maintain eligibility for PEBB retiree insurance coverage:

(a) Enroll in a PEBB health plan:

(i) Enroll in medical; or

(ii) Enroll in medical and dental.

(iii) Survivors enrolling in dental must stay enrolled for at least two years before dental can be dropped, unless they defer medical and dental coverage as described in WAC 182-12-205, or drop dental as described in WAC 182-12-208(4).

(iv) Dental only is not an option.

(b) Defer enrollment:

(i) Survivors may defer enrollment in a PEBB health plan if continuously enrolled in ((~~other~~)) qualifying coverage as described in WAC 182-12-205(((~~(2)~~))) (3).

(ii) Survivors may enroll in a PEBB health plan as described in WAC 182-12-205(((~~(4)~~))) (6) when they lose other coverage. Survivors must provide evidence that they were continuously enrolled in ((~~other such coverage~~)) one or more qualifying coverages as described in WAC 182-12-205 (3)(a) through (e) when enrolling in a PEBB health plan. The required form and evidence of continuous enrollment must be received by the PEBB program no later than sixty days after such coverage ends.

(iii) PEBB health plan enrollment and premiums will begin the first day of the month following the day that the other coverage ended for eligible spouses and children who enroll.

(8) Survivors may change their health plan during the annual open enrollment. In addition to the annual open enrollment, survivors may change health plans as described in WAC 182-08-198.

(9) Survivors will lose their right to enroll in PEBB retiree insurance coverage if they:

(a) Do not apply to enroll or defer PEBB health plan enrollment within the timelines as described in subsection (5) of this section; or

(b) Do not maintain continuous enrollment in other qualifying coverage during the deferral period, as described in subsection (7)(b)(i) of this section.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-260 Who are eligible dependents? To be enrolled in a health plan, a dependent must be eligible under this section and the subscriber must comply with enrollment procedures outlined in WAC 182-12-262.

The public employees benefits board (PEBB) program verifies the eligibility of all dependents and will request documents from subscribers that provide evidence of a dependent's eligibility. The PEBB program reserves the right to review a dependent's eligibility at any time. The PEBB program will remove a subscriber's enrolled dependents from health plan enrollment if the PEBB program is unable to verify a dependent's eligibility. The PEBB program will not enroll or reenroll dependents into a health plan if the PEBB program is unable to verify a dependent's eligibility.

The subscriber must notify the PEBB program, in writing, when ((~~his or her~~)) their dependent is not eligible under this section. The notification must be received by the PEBB program no later than sixty days after the date ((~~his or her~~)) their dependent is no longer eligible under this section. See

WAC 182-12-262 (2)(a) for the consequences of not removing an ineligible dependent from PEBB insurance coverage.

The following are eligible as dependents:

(1) ((~~Lawful~~)) Legal spouse. Former spouses are not eligible dependents upon finalization of a divorce or annulment, even if a court order requires the subscriber to provide health insurance for the former spouse.

(2) State registered domestic partner. State registered domestic partner as defined in RCW 26.60.020(1) and substantially equivalent legal unions from other jurisdictions as defined in RCW 26.60.090. Former state registered domestic partners are not eligible dependents upon dissolution or termination of a partnership, even if a court order requires the subscriber to provide health insurance for the former partner.

(3) Children. Children are eligible through the last day of the month in which their twenty-sixth birthday occurred except as described in ((~~(i)~~)) (h) of this subsection. Children are defined as the subscriber's:

(a) Children based on establishment of a parent-child relationship as described in RCW ((~~26.26.101~~)) 26.26A.100, except when parental rights have been terminated;

(b) ((~~Biological children, where parental rights have not been terminated;~~

~~(c) Stepchildren.~~)) Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to a subscriber (and eligibility as a ((~~PEBB~~)) dependent) ends((~~, for purposes of this rule,~~)) on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;

(((~~(d) Legally adopted~~)) (c) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of the child;

(((~~(e)~~))) (d) Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;

(((~~(f)~~))) (e) Children of the subscriber's state registered domestic partner, based on the state registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a ((~~PEBB~~)) dependent) ends((~~, for purposes of this rule,~~)) on the same date the subscriber's legal relationship with the state registered domestic partner ((~~as defined in RCW 26.60.020(1)~~)) ends through divorce, annulment, dissolution, termination, or death;

(((~~(g)~~))) (f) Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;

(((~~(h)~~))) (g) Extended dependent((~~s~~)) in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. ((~~"Children"~~)) Extended dependent child does not include a foster ((~~children for whom support payments are made to the subscriber through the state department of social and health services foster care program~~)) child unless the subscriber, the subscriber's spouse, or the subscriber's state registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and

(((~~(i)~~))) (h) Children of any age with a developmental ((~~disability~~)) or physical ((~~handicap~~)) disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age twenty-six:

(i) The subscriber must provide ((~~evidence~~)) proof of the disability ((~~and evidence that the condition occurred before~~)) and dependency within sixty days of the child's attainment of age twenty-six;

(ii) The subscriber must agree to notify the PEBB program, in writing, ((~~when his or her dependent is not eligible under this section. The notification must be received by the PEBB program~~)) no later than sixty days after the date that ((~~a~~)) the child ((~~age twenty-six or older~~)) is no longer ((~~qualifies~~)) eligible under this subsection;

(iii) A child with a developmental ((~~disability~~)) or physical ((~~handicap~~)) disability who becomes self-supporting is not eligible under this subsection as of the last day of the month in which ((~~he or she~~)) they become((~~s~~)) capable of self-support;

(iv) A child with a developmental ((~~disability~~)) or physical ((~~handicap~~)) disability age twenty-six and older who becomes capable of self-support does not regain eligibility under (i) of this subsection if ((~~he or she~~)) they later become((~~s~~)) incapable of self-support;

(v) The PEBB program with input from the applicable contracted vendor will periodically ((~~certify~~)) verify the eligibility of a dependent child with a disability beginning at age twenty-six, but no more frequently than annually after the two-year period following the child's twenty-sixth birthday, which may require renewed proof from the subscriber.

(4) Parents.

(a) Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:

(i) The parent maintains continuous enrollment in PEBB medical;

(ii) The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;

(iii) The subscriber continues enrollment in PEBB insurance coverage; and

(iv) The parent is not covered by any other group medical plan.

(b) Parents eligible under this subsection may be enrolled with a different health plan than that selected by the subscriber. Parents may not add additional dependents to their PEBB insurance coverage.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-262 When may subscribers enroll or remove eligible dependents? (1) **Enrolling dependents in public employees benefits board (PEBB) benefits.** A dependent must be enrolled in the same health plan coverage as the subscriber, and the subscriber must be enrolled to enroll ((~~his or her~~)) their dependent except as provided in WAC 182-12-205 ((~~(2)~~)) (3)(c). Subscribers must satisfy the enrollment requirements as described in subsection (4) of this

section and may enroll eligible dependents at the following times:

(a) **When the subscriber becomes eligible** and enrolls in public employees benefits board (PEBB) benefits. If eligibility is verified and the dependent is enrolled, the dependent's effective date will be the same as the subscriber's effective date, except if the employee enrolls a newborn child in optional dependent life insurance. The newborn child's dependent life insurance coverage will be effective on the date the child becomes fourteen days old.

(b) **During the annual open enrollment.** PEBB health plan coverage begins January 1st of the following year.

(c) **During special open enrollment.** Subscribers may enroll dependents during a special open enrollment as described in subsection (3) of this section. ((~~The subscriber must satisfy the enrollment requirements as described in subsection (4) of this section.~~))

(2) **Removing dependents from a subscriber's health plan coverage.**

(a) **A dependent's eligibility for enrollment in health plan coverage ends the last day of the month the dependent** meets the eligibility criteria as described in WAC 182-12-250 or 182-12-260. Employees must notify their employing agency when a dependent is no longer eligible. All other subscribers must notify the PEBB program when a dependent is no longer eligible. Consequences for not submitting notice within sixty days of the last day of the month the dependent loses eligibility for health plan coverage may include, but are not limited to:

(i) The dependent may lose eligibility to continue health plan coverage under one of the continuation coverage options described in WAC 182-12-270;

(ii) The subscriber may be billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;

(iii) The subscriber may not be able to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and

(iv) The subscriber may be responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

(b) **Employees have the opportunity to remove dependents:**

(i) During the annual open enrollment. The dependent will be removed the last day of December; or

(ii) During a special open enrollment as described in subsections (3) and (4)(f) of this section.

(c) **Retirees, survivors, and enrollees with PEBB continuation coverage as described in WAC 182-12-133, 182-12-141, 182-12-142, 182-12-146, or 182-12-148 may remove dependents** from their PEBB insurance coverage outside of the annual open enrollment or a special open enrollment by providing written notice to the PEBB program. ((~~Unless otherwise approved by the PEBB program,~~)) The dependent will be removed from the subscriber's PEBB insurance coverage prospectively. PEBB insurance coverage will end on the last day of the month in which the written notice is received by the PEBB program. If the written notice is received on the first day of the month, coverage will end on the last day of the previous month.

(3) **Special open enrollment.**

(a) Subscribers may enroll or remove their dependents outside of the annual open enrollment if a special open enrollment event occurs. The change in enrollment must be allowable under the Internal Revenue Code (IRC) and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependents, or both.

(i) Health plan coverage will begin the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment begins on that day.

(ii) Enrollment of an extended dependent or a dependent with a disability will be the first day of the month following eligibility certification.

(iii) The dependent will be removed from the subscriber's health plan coverage the last day of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(iv) If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin or end as follows:

• For the newly born child, health plan coverage will begin the date of birth;

• For a newly adopted child, health plan coverage will begin on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier;

• For a spouse or state registered domestic partner of a subscriber, health plan coverage will begin the first day of the month in which the event occurs. The spouse or state registered domestic partner will be removed from health plan coverage the last day of the month in which the event occurred;

A newly born child must be at least fourteen days old before optional dependent life insurance coverage purchased by the employee becomes effective.

Any one of the following events may create a special open enrollment:

(b) Subscriber acquires a new dependent due to:

(i) Marriage or registering for a state domestic partnership;

(ii) Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

(c) Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(d) Subscriber has a change in employment status that affects the subscriber's eligibility for ((~~his or her~~)) their employer contribution toward ((~~his or her~~)) their employer-based group health plan;

(e) The subscriber's dependent has a change in ((~~his or her~~)) their own employment status that affects ((~~his or her~~)) their eligibility for the employer contribution under ((~~his or her~~)) their employer-based group health plan;

Exception: For the purposes of special open enrollment "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 54.9801-6.

(f) Subscriber or a subscriber's dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB program's annual open enrollment;

(g) Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States;

(h) A court order ((~~or national medical support notice (see also WAC 182-12-263)~~)) requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(i) Subscriber or a subscriber's dependent becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(j) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or a state children's health insurance program (CHIP).

(4) **Enrollment requirements. A subscriber must submit the required forms within the time frames described in this subsection.** Employees submit the required forms to their employing agency. All other subscribers submit the required forms to the PEBB program. In addition to the required forms indicating dependent enrollment, the subscriber must provide the required documents as evidence of the dependent's eligibility; or as evidence of the event that created the special open enrollment.

(a) If a subscriber wants to enroll ((~~his or her~~)) their eligible dependents when the subscriber becomes eligible to enroll in PEBB benefits, the subscriber must include the dependent's enrollment information on the required forms that the subscriber submits within the relevant time frame described in WAC 182-08-197, 182-08-187, 182-12-171, or 182-12-250.

(b) If a subscriber wants to enroll eligible dependents during the PEBB annual open enrollment period, the required forms must be received no later than the last day of the annual open enrollment.

(c) If a subscriber wants to enroll newly eligible dependents, the required forms must be received no later than sixty days after the dependent becomes eligible except as provided in (d) of this subsection.

(d) If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB program by submitting the required form as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required form must be received no later than twelve months after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

(e) If the subscriber wants to enroll a child age twenty-six or older as a child with a disability, the required forms must be received no later than sixty days after the last day of the month in which the child reaches age twenty-six or within the relevant time frame described in WAC 182-12-262 (4)(a), (b), and (f). To recertify an enrolled child with a disability, the required forms must be received by the PEBB program or contracted vendor by the child's scheduled PEBB coverage termination date.

(f) If the subscriber wants to change a dependent's enrollment status during a special open enrollment, required forms must be received no later than sixty days after the event that creates the special open enrollment.

AMENDATORY SECTION (Amending WSR 15-22-099, filed 11/4/15, effective 1/1/16)

WAC 182-12-263 National Medical Support Notice (NMSN). When a National Medical Support Notice (NMSN) requires a subscriber to provide health plan coverage for a dependent child the following provisions apply:

(1) The subscriber may enroll ((~~his or her~~)) their dependent child and request changes to ((~~his or her~~)) their health plan coverage as described under subsection (3) of this section. Employees submit the required forms to their employing agency. All other subscribers submit the required forms to the public employees benefits board (PEBB) program.

(2) If the subscriber fails to request enrollment or health plan coverage changes as directed by the NMSN, the employing agency or the PEBB program may make enrollment or health plan coverage changes according to subsection (3) of this section upon request of:

(a) The child's other parent; or

(b) Child support enforcement program.

(3) Changes to health plan coverage or enrollment are allowed as directed by the NMSN:

(a) The dependent will be enrolled under the subscriber's health plan coverage as directed by the NMSN;

(b) An employee who has waived PEBB medical under WAC 182-12-128 will be enrolled in medical as directed by the NMSN, in order to enroll the dependent;

(c) The subscriber's selected health plan will be changed if directed by the NMSN;

(d) If the dependent is already enrolled under another PEBB subscriber, the dependent will be removed from the other health plan coverage and enrolled as directed by the NMSN.

(e) If the subscriber is eligible for and elects COBRA or other continuation coverage, the NMSN will be enforced and the dependent must be covered in accordance with the NMSN.

(4) Changes to health plan coverage or enrollment as described in subsection (3)(a) through (c) of this section will begin the first day of the month following receipt of the NMSN. If the NMSN is received on the first day of the month, the change to health plan coverage or enrollment begins on that day. A dependent will be removed from the subscriber's health plan coverage as described in subsection (3)(d) of this section the last day of the month the NMSN is

received. If that day is the first of the month, the change in enrollment will be made the last day of the previous month.

(5) The subscriber may be eligible to make changes to ((~~his or her~~)) their health plan enrollment and salary reduction elections ((~~during a special open enrollment~~)) related to the NMSN as described in WAC 182-08-198(2), 182-08-199(3), 182-12-128(4), or 182-12-262(3).

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-265 What options for continuing health plan enrollment are available to ((~~widows, widowers and dependent children~~)) a surviving spouse, state registered domestic partner, or child, if the employee or retiree dies? The ((~~dependent~~)) survivor of an eligible employee or retiree who meets the eligibility criteria and submits the required forms as described in subsection (1), (2), or (3) of this section is eligible to enroll or defer enrollment as a survivor under public employees benefits board (PEBB) retiree insurance coverage. ((~~An eligible survivor must submit the required forms to enroll or defer enrollment in PEBB retiree insurance coverage. The forms must be received by the PEBB program no later than sixty days after the date of the employee's or retiree's death. The dependent's~~)) If enrolling in PEBB retiree insurance coverage, the survivor's first premium payment and applicable premium surcharge is due to the health care authority (HCA) no later than forty-five days after the ((~~dependent's election is received by the HCA~~)) election period ends as described in subsection (1), (2), or (3) of this section. Following the ((~~dependent's~~)) survivor's first premium payment, premiums and applicable premium surcharges must be paid as described in WAC 182-08-180 (1)(((~~(b)~~))) (c).

(1) An employee's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible employee may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system. To satisfy the requirement to immediately receive a monthly retirement benefit they must begin receiving monthly benefit payments no later than one hundred twenty days from the date of death of the employee. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the employee's death or the date the survivor's PEBB insurance coverage ends.

(a) The employee's spouse or state registered domestic partner may continue health plan enrollment until death.

(b) The employee's children may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

Notes: If a spouse, state registered domestic partner, or child of an eligible employee is not eligible for a monthly retirement benefit, ((~~the dependent is~~)) they are not eligible to enroll as a survivor under PEBB retiree insurance coverage. However, ((~~the dependent~~)) they may continue health plan enrollment as described in WAC 182-12-146.

Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an employee of a participating employer group will cease at the end of the month in which the group's contract with the authority ends unless the employer group is a school district, educational service district, or charter school.

Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an elected ((~~or~~)) and full-time appointed official of the legislative ((~~or~~)) and executive branches of state government is described in WAC 182-12-180.

(2) A retiree's spouse, state registered domestic partner, or child who loses eligibility due to the death of an eligible retiree may enroll or defer enrollment as a survivor under PEBB retiree insurance coverage. The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the retiree's death.

(a) The retiree's spouse or state registered domestic partner may continue health plan enrollment until death.

(b) The retiree's children may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

(c) If a spouse, state registered domestic partner, or child of an eligible retiree is not enrolled in a PEBB health plan at the time of the retiree's death, the ((~~dependent~~)) survivor is eligible to enroll or defer enrollment as a survivor under PEBB retiree insurance coverage. ((~~The dependent must submit the required form(s) to enroll or defer PEBB health plan enrollment.~~)) The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the retiree's death. To enroll in a PEBB health plan, the ((~~dependent~~)) survivor must provide evidence of continuous enrollment in medical coverage from the most recent open enrollment for which the ((~~dependent~~)) survivor was not enrolled in a PEBB medical plan prior to the retiree's death.

Note: Eligibility for the surviving spouse, surviving state registered domestic partner, or surviving child of an employer group retiree will cease at the end of the month in which the group's contract with the authority ends unless the employer group is a school district, educational service district, or charter school.

(3) The spouse, state registered domestic partner, or child of a deceased school district, educational service district, or a charter school employee is eligible to enroll or defer enrollment as a survivor under PEBB retiree insurance coverage at the time of the employee's death provided the employee died on or after October 1, 1993. The ((~~dependent~~)) survivor must immediately begin receiving a retirement benefit allowance under chapter 41.32, 41.35 or 41.40 RCW ((~~and submit the required form to enroll or defer enrollment in PEBB retiree insurance coverage~~)). The required forms to enroll or defer enrollment must be received by the PEBB program no later than sixty days after the later of the date of the employee's death or the date the survivor's school district coverage, educational service district coverage, or charter school coverage ends.

(a) The employee's spouse or state registered domestic partner may continue health plan enrollment until death.

(b) The employee's children may continue health plan enrollment until they lose eligibility as described in WAC 182-12-260.

(4) If a premium and applicable premium surcharge received by the ((~~authority~~)) HCA is sufficient as described in WAC 182-08-180 (1)(((~~c~~))) (d)(ii) to maintain PEBB health plan enrollment after the employee's or retiree's death, the PEBB program will consider the payment as notice of the survivor's intent to continue enrollment.

If the ((~~dependent's~~)) survivor's enrollment ended due to the death of the employee or retiree, the PEBB program will reinstate the survivor's enrollment without a gap subject to payment of premium and applicable premium surcharge.

(5) If a survivor elects to enroll a dependent in PEBB health plan coverage, the dependent must be enrolled in the same PEBB medical and PEBB dental plan as the survivor.

Exception: If a survivor selects a medicare supplement plan, nonmedicare enrollees will be enrolled in the Uniform Medical Plan (UMP) Classic. If a survivor selects any other medicare plan, they must also select a nonmedicare plan with the same contracted vendor available to nonmedicare enrollees.

(6) In order to avoid duplication of group medical coverage, ((~~surviving dependents~~)) a survivor may defer enrollment in a PEBB health plan as described in WAC 182-12-200 and 182-12-205.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-270 What options for continuation coverage are available to dependents who cease to meet the eligibility criteria as described in WAC 182-12-260? If eligible, dependents may continue health plan enrollment under one of the continuation coverage options in subsection (1) or (2) of this section by self-paying the premiums and applicable premium surcharges set by the health care authority (HCA), with no contribution from the employer, following their loss of eligibility under the subscriber's health plan coverage. The dependent's first premium payment and applicable premium surcharge is due to the HCA no later than forty-five days after the ((~~dependent's election is received by the HCA~~)) election period ends as described in WAC 182-12-146, 182-12-180, 182-12-250, or 182-12-265, whichever applies. Following the employee's first premium payment, the dependent must pay premium and applicable premium surcharge amounts associated with PEBB insurance coverage as premiums and applicable premium surcharges become due. If the monthly premium or applicable premium surcharge remain unpaid for sixty days from the original due date, PEBB insurance coverage will be terminated retroactive to the last day of the month for which the monthly premium and applicable premium surcharge was paid as described in WAC 182-08-180 (1)(((~~b~~))) (c). The ((~~public employees benefits board (PEBB)~~)) PEBB program must receive the required forms as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*. Options for continuing health plan enrollment are based on the reason that eligibility was lost.

(1) Spouses, state registered domestic partners, or children who lose eligibility due to the death of an employee or retiree may be eligible to continue health plan enrollment as described in WAC 182-12-180, 182-12-250, or 182-12-265; or

(2) Dependents who lose eligibility because they no longer meet the eligibility criteria as described in WAC 182-12-260 are eligible to continue health plan enrollment under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA). See WAC 182-12-146 for more information on COBRA.

((~~**Exception:** A dependent who loses eligibility because a state registered domestic partnership is dissolved may continue health plan enrollment under PEBB continuation coverage for a maximum of thirty-six months.~~))

Note: Based on RCW 26.60.015 and public employees benefits board policy resolution that extended PEBB coverage for dependents not otherwise eligible for COBRA, an employee's state registered domestic partner and the state registered partner's children may continue PEBB insurance coverage on the same terms and conditions as spouses and other eligible dependents under COBRA.

No ((~~PEBB~~)) continuation coverage will be offered unless the PEBB program is notified through hand-delivery or United States Postal Service mail of the qualifying event as outlined in the *PEBB Initial Notice of COBRA and Continuation Coverage Rights*.

AMENDATORY SECTION (Amending WSR 17-19-077, filed 9/15/17, effective 1/1/18)

WAC 182-12-300 Public employees benefits board (PEBB) wellness incentive program eligibility and procedural requirements. The public employees benefits board (PEBB) annually determines the design of the PEBB wellness incentive program.

(1) All subscribers, except PEBB subscribers who are enrolled in both medicare Parts A and B, and in the medicare risk pool, are eligible to participate in the PEBB wellness incentive program.

(2) Effective January 1, 2016, to receive the PEBB wellness incentive of a reduction to the subscriber's medical plan deductible or a deposit to the subscriber's health savings account for the following plan year, eligible subscribers must complete PEBB wellness incentive program requirements during the current plan year by the latest date below:

(a) For subscribers continuing enrollment in PEBB medical and subscribers enrolling in PEBB medical with an effective date in January, February, March, April, May, or June the deadline is September 30th; or

(b) For subscribers enrolling in PEBB medical with an effective date in July or August, the deadline is one hundred twenty days from the subscriber's PEBB medical effective date; or

(c) For subscribers enrolling in PEBB medical with an effective date in September, October, November, or December, the deadline is December 31st.

(3) Subscribers who do not complete the requirements according to subsection (2) of this section, except as noted, within the time frame described are not eligible to receive a PEBB wellness incentive the following plan year.

Note: All eligible subscribers can earn a wellness incentive. Subscribers who cannot complete the wellness incentive program requirements may be able to earn the same incentive by different means. The PEBB program will work with enrollees (and their physician, if they wish) to define an individual wellness program that provides the opportunity to qualify for the same incentive in light of the enrollee's health status.

(4) Effective January 1, 2018, an eligible subscriber will receive a separate PEBB wellness incentive for completing the SmartHealth well-being assessment on or before December 31st, of the current plan year. An eligible subscriber may only earn this separate PEBB wellness incentive once per plan year. Once earned, subscribers must claim the incentive on or before December 31st of the same calendar year it was earned.

(5) PEBB wellness incentive will be provided only if:

(a) For the wellness incentive described in subsection (2) of this section the subscriber is still eligible for the PEBB wellness incentive program in the year the incentive applies;

(b) The funding rate provided by the legislature is designed to provide a PEBB wellness incentive program or a PEBB wellness incentive, or both; or

(c) Specific appropriations are provided for wellness incentives.