WSR 19-20-002
PROPOSED RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Developmental Disabilities Administration)
[Filed September 18, 2019, 1:20 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-15-100.

Title of Rule and Other Identifying Information: The department is proposing to amend WAC 388-827-0105 Who is eligible for a state supplementary payment?

Hearing Location(s): On November 5, 2019, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than November 6, 2019.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., November 5, 2019.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by October 22, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The developmental disabilities administration is proposing to amend this rule about state supplementary payments (SSP) to clarify rule language and include a reference to the health care authority's regulations under WAC 182-512-0880 SSI-related medical —Special income disregards.

Reasons Supporting Proposal: These amendments to certain SSP eligibility criteria clarify that a client's supplemental security income had to be terminated due solely to the receipt of Title II disabled adult child benefits and the client must be categorically needy for medicaid due to a special income disregard.

Statutory Authority for Adoption: RCW 71A.12.030.

Statute Being Implemented: RCW 71A.12.030.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting: Chantelle Diaz, P.O. Box 45310, Olympia, WA 98504-5310, 360-407-1589; Implementation and Enforcement: Kari Freer, P.O. Box 45310, Olympia, WA 98504-5310, 360-407-1553.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed amendments clarify existing language and incorporate rules from another Washington state agency. Under RCW 34.05.328 (5)(b)(iii), these types of changes are exempt from the requirement to prepare a cost-benefit analysis.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4) because the rules do not affect small businesses.

Explanation of exemptions: The proposed amendments impose no new or disproportionate costs on small businesses so a small business economic impact statement is not required.

September 18, 2019
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-06-101, filed 3/7/18, effective 4/7/18)

WAC 388-827-0105 Who is eligible for a state supplementary payment? (1) The developmental disabilities administration (DDA) must not enroll you in state supplementary payments after the effective date of this section, unless you are eligible for a state supplementary payment for prevocational legacy.

(2) To be eligible for a state supplementary payment, you must meet all general eligibility requirements under subsection (3) of this section and any applicable program-specific requirements under subsections (4) through (8) of this section.

(3) To be eligible for a state supplementary payment, you must:

(a) Be determined DDA eligible under chapter 388-823 WAC;

(b) Complete an in-person interview and reassessment with DDA once every twelve months—or more often if DDA deems it necessary—to determine whether you continue to meet eligibility requirements; and

(c) Be financially eligible because:

(i) You receive ((~~supplementary~~)) supplemental security income ((~~cash assistance~~)) (SSI) benefits for the month in which the state supplementary payment is issued; or

(ii) You receive social security Title II benefits as a disabled adult child ((~~and you would be eligible for SSI if you did not receive these benefits~~)) (DAC), your SSI was terminated due solely to your receipt of DAC benefits, and you are eligible for categorically needy medicaid due to the special income disregard described in WAC 182-512-0880(3).

(4) To be eligible for children's legacy care state supplementary payments, you must live with your family as defined in WAC 388-832-0001.

(5) To be eligible for a state supplementary payment for waiver services, you must be enrolled in a home and community-based services waiver program as described in chapter 388-845 WAC.

(6) To be eligible for prevocational legacy state supplementary payments, you must:

(a) Have left prevocational services on or after September 1, 2015; and

(b) Not be enrolled in a DDA residential habilitation service.

(7) To be eligible for residential habilitation state supplementary payments, you must be receiving a residential habil-

itation service as described in chapter 388-845 WAC and as identified in your person-centered service plan.

(8) To be eligible for state supplementary payments in lieu of individual and family services you must be:

(a) At least three years old; and

(b) Living with your family as defined in WAC 388-832-0001.

WSR 19-20-017
PROPOSED RULES
DEPARTMENT OF HEALTH

[Filed September 20, 2019, 1:36 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-20-002.

Title of Rule and Other Identifying Information: Chapter 246-803 WAC, East Asian medicine practitioner, rules. The department of health proposes to clarify, streamline, and update regulations for licensed East Asian medicine practitioners in Washington state. The proposed rules amend WAC 246-803-010, 246-803-030, 246-803-130, and 246-803-300. In addition, the department proposed to create new rules for: Patient record content; patient abandonment; instrument sterilization procedure; preparing and maintaining a clean field; and expired license.

Hearing Location(s): On November 8, 2019, at 10:00 a.m., at the Department of Health, Town Center Three, 243 Israel Road S.E., Room 224, Tumwater, WA 98501.

Date of Intended Adoption: November 20, 2019.

Submit Written Comments to: Vicki Brown, East Asian Medicine Practitioner Program, P.O. Box 47852, Olympia, WA 98504-7852, email https://fortress.wa.gov/doh/policyreview, fax 360-236-2901, by November 8, 2019.

Assistance for Persons with Disabilities: Contact Vicki Brown, phone 360-236-4865, fax 360-236-2901, TTY 360-833-6388 or 711, email vicki.brown@doh.wa.gov, by November 1, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Chapter 246-803 WAC, East Asian medicine practitioner, was opened by the department of health (department) to clarify, streamline, and update regulations for licensed East Asian medicine practitioners in Washington state. A comprehensive review of the chapter had not been done since 2014, and the existing rules are outdated, conflict with current law and practice. The proposed rule amendments are necessary to provide clear, current, and enforceable regulations for regulating East Asian medicine practitioners.

These proposed changes include: Make general housekeeping and clarification changes; add updated and current definitions; and amend the patient notification of qualifications and scope of practice requirements.

In addition, the department is proposing new rules for: Patient record content; patient abandonment; instrument sterilization procedure; preparing and maintaining a clean field; and expired license.

Reasons Supporting Proposal: The department opened the chapter to revise the rules so they are clear, concise, and reflect current East Asian medicine practitioner practices. This revision is part of the five-year rule review process under RCW 43.70.041.

In addition, the department is proposing new rules to reflect current East Asian medicine practitioner practices including: Patient record content details the clinical information that is required to be included in a patient record, which must be in English and be legible, complete and accurate; patient abandonment establishes the requirement than an East Asian medicine practitioner shall respond to any reasonable request for services in the interest of public health and welfare; instrument sterilization procedure requires East Asian medicine practitioners to follow the 7th edition of "Best Practices for Acupuncture Needles Safety and Related Procedures" published by the Council of Colleges for Acupuncture and Oriental Medicine revised May 2017; preparing and maintaining a clean field for each patient. A clean field is the area that has been prepared to contain the equipment necessary for acupuncture in such a way as to reduce the possible contamination of sterile needles and other clean or sterile equipment; and expired license rule defines how an East Asian medicine practitioner with an expired license may return his or her license to an active license.

Statutory Authority for Adoption: RCW 18.06.160.

Statute Being Implemented: Chapter 18.06 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of health, East Asian medicine practitioner program, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Vicki Brown, 111 Israel Road S.E., Tumwater, WA 98501, 360-236-4865.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed rules don't impose costs of [on] businesses. The proposed rules amend and create new licensure regulations for licensure as an East Asian medicine practitioner.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The proposed rules don't impose costs of [on] businesses. The proposed rules amend and create new licensure regulations for licensure as an East Asian medicine practitioner.

September 19, 2019
John Wiesman, DrPH, MPH
Secretary

AMENDATORY SECTION (Amending WSR 11-17-105, filed 8/22/11, effective 9/22/11)

WAC 246-803-010 Definitions. The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Accredited school, college or program" ((~~is~~)) means:

(a) Accredited or has candidacy status as a United States postsecondary school, college or program; or

(b) Accredited by or has candidacy status with the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM).

(2) "Acupuncture needles" means solid filiform instruments intended to pierce the skin in the practice of acupuncture. Acupuncture needles used on a patient must be sterile and disposable, and may only be used once.

(3) "Approved school" ((~~is~~)) means a school, college or program approved by the secretary of the department of health that meets the requirements of WAC 246-803-500.

(((~~3~~))) (4) "Credit" means ten classroom contact hours on the quarter system or fifteen classroom contact hours on the semester or trimester system.

(((~~4~~))) (5) "Department" means the department of health.

(((~~5~~))) (6) "East Asian medicine apprenticeship" ((~~is~~)) means training in East Asian medicine administered by an apprenticeship trainer that satisfies the educational requirements set out in WAC 246-803-210, 246-803-220, and 246-803-230. An apprenticeship is of limited duration and ends at the time the parties to the apprenticeship agreement have completed their obligations.

(((~~6~~))) (7) "East Asian medicine practitioner" is a person licensed under chapter 18.06 RCW.

(((~~7~~))) (8) "East Asian medicine program" ((~~is~~)) means training in East Asian medicine offered by an academic institution that satisfies the education requirements set out in WAC 246-803-210, 246-803-220, and 246-803-230 and also offers training in other areas of study. A program is an established area of study offered on a continuing basis. An East Asian medicine program may be referred to as a program in acupuncture, acupuncture and Oriental medicine, or Oriental medicine.

(((~~8~~))) (9) "East Asian medicine school" ((~~is~~)) means an accredited academic institution which has the sole purpose of offering training in East Asian medicine that satisfies the education requirements set out in WAC 246-803-210, 246-803-220, and 246-803-230.

(((~~9~~))) (10) "East Asian medicine tutorial instruction" ((~~is~~)) means training in East Asian medicine which is offered by an academic institution or qualified instructor on the basis of a tutorial agreement between the school or instructor and the student and satisfies the education requirements set out in WAC 246-803-210, 246-803-220, and 246-803-230. A tutorial is of limited duration and ends at the time the parties to the tutorial agreement have performed their obligations under the agreement.

(((~~10~~))) (11) "Hypodermic needle" means a device intended to inject fluids into, or withdraw fluids from, parts of the body below the surface of the skin.

(12) "Primary health care provider" ((~~is~~)) means an individual licensed under:

(a) Chapter 18.36A RCW, Naturopathy;

(b) Chapter 18.57 RCW, Osteopathy—Osteopathic medicine and surgery;

(c) Chapter 18.57A RCW, Osteopathic physicians' assistants;

(d) Chapter 18.71 RCW, Physicians;

(e) Chapter 18.71A RCW, Physician assistants; or

(f) RCW 18.79.050, "Advanced registered nursing practice" defined—Exceptions.

AMENDATORY SECTION (Amending WSR 17-15-006, filed 7/5/17, effective 7/5/17)

WAC 246-803-030 East Asian medicine. East Asian medicine is a health care service using East Asian medicine diagnosis and treatment to promote health and treat organic or functional disorders. East Asian medicine includes the following:

(1) Acupuncture((~~. Acupuncture~~)), includes the use of acupuncture needles or lancets to directly or indirectly stimulate acupuncture points and meridians;

(2) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;

(3) Moxibustion;

(4) Acupressure;

(5) Cupping;

(6) Dermal friction technique;

(7) Infrared;

(8) Sonopuncture;

(9) Laserpuncture;

(10) Point injection therapy (aquapuncture):

(a) Is defined as meaning the subcutaneous, intramuscular and intradermal injection of substances consistent with the practice of East Asian medicine to stimulate acupuncture points, ((~~AHSHI~~)) ashi points, trigger points and meridians. Substances are limited to:

(i) Saline;

(ii) Sterile water;

(iii) Herbs specifically manufactured for injection by means of hypodermic needles;

(iv) Minerals specifically manufactured for injection by means of hypodermic needles;

(v) Vitamins in liquid form specifically manufactured for injection by means of hypodermic needles; and

(vi) Homeopathic and nutritional substances specifically manufactured for injection by means of hypodermic needles.

(b) For the purposes of this section, includes trigger points as a subset of acupuncture points and ((~~AHSHI~~)) ashi points as recognized in the current practice of East Asian medicine.

(c) Does not include injection of controlled substances contained in Schedules I through V of the Uniform Controlled Substances Act, chapter 69.50 RCW or steroids as defined in RCW 69.41.300.

(11) Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements.

Health education. Health education is educational information directed to the patient that attempts to improve, maintain, promote and safeguard the health care of the patient. Health education consists of educating the patient on how the mind, body and spirit connect in context of imbalances, emotional patterns and tendencies as defined by and treated in East Asian medicine. Health education does not include mental health counseling;

(12) Breathing, relaxation, and East Asian exercise techniques;

(13) Qi gong;

(14) East Asian massage. East Asian massage means manual techniques having originated in East Asia involving

the manipulation of the soft tissues of the body for therapeutic purposes.

(a) East Asian massage consists of:

(i) Applying fixed or movable pressure;

(ii) Passive, resistive, and assisted stretching of fascial and connective tissue;

(iii) Holding or causing movement of the body; or

(iv) Tapping, compressions or friction.

(b) East Asian massage may be performed with the use of tools common to the practice and aids of superficial heat, cold, water, lubricants, salts, minerals, liniments, poultices, and herbs.

(c) East Asian massage does not include attempts to adjust or manipulate any articulations of the body or spine or mobilization of these articulations by the use of a thrusting force.

(15) Tui na. Tui na is a method of East Asian bodywork, characterized by the kneading, pressing, rolling, shaking, and stretching of the body and does not include spinal manipulation; and

(16) Superficial heat and cold therapies.

AMENDATORY SECTION (Amending WSR 16-01-158, filed 12/21/15, effective 1/21/16)

WAC 246-803-130 Application requirements for applicants from foreign schools. (1) An applicant for an East Asian medicine practitioner license who has graduated from a foreign East Asian medicine practitioner program not accredited, or approved by the secretary must:

(a) Have at least a bachelor's or master's degree in East Asian medicine or acupuncture from an institution of higher learning which is approved by the foreign country's ministry of education/health, or other governmental entity;

(b) Have graduated from a program of East Asian medicine or acupuncture education with requirements substantially equal to those required of graduates of secretary-approved programs; and

(c) Demonstrate fluency in reading, speaking, and understanding the English language by taking the examinations required in WAC 246-803-240 (2)(a) through (c) in English or by passage of the test of English as a foreign language in WAC 246-803-240(3).

(2) An applicant for an East Asian medicine practitioner license must submit to the department:

(a) A completed application.

(b) The application fee required under WAC 246-803-990.

(c) Original copy of school transcripts from the East Asian medicine or acupuncture program showing degree and degree date.

(d) A credentialing evaluation report from the ((~~American Association of Collegiate Registrars and Admissions Officers (AACRAO). The report must be sent directly from the AACRAO to the department. Submit transcripts, fees, and other documentation to a credentialing service approved by the department and request the evaluation report be sent directly to the department. The department recognizes the AACRAO for credential evaluations~~)) International Consultants of Delaware (ICD).

(e) Verification of clinical training as required in WAC 246-803-230.

(f) Verification of successful completion of the examinations as required in WAC 246-803-240.

(g) Verification of all East Asian medicine practitioner or health care licenses held, submitted directly from the licensing agency. The ((~~certification~~)) verification shall include the license number, issue date, expiration date and whether the East Asian medicine practitioner has been the subject of final or pending disciplinary action.

(h) Verification of completion of seven clock hours of AIDS education as required in chapter 246-812 WAC, Part 8.

(i) Verification of current cardiopulmonary resuscitation (CPR) certification. The training in CPR shall consist of a minimum of one quarter credit or equivalent. Red Cross certification or documentation of equivalent training may be substituted for the one quarter credit.

(j) Any additional documents requested by the secretary.

(3) The department recognizes the ICD for credential evaluations. The applicant shall request that the ICD send their evaluation directly to the department. To obtain a credentialing evaluation report, the applicant shall submit to the ICD:

(a) Transcripts;

(b) Appropriate fees; and

(c) Other requested documentation.

AMENDATORY SECTION (Amending WSR 11-17-105, filed 8/22/11, effective 9/22/11)

WAC 246-803-300 Patient notification of qualifications and scope of practice. East Asian medicine practitioners in the state of Washington ((~~must~~)) shall provide to each patient prior to or at the time of the initial patient visit the qualifications and scope of practice form. The form must include:

(1) The East Asian medicine practitioner's education. The degree obtained or if the education was by apprenticeship, the dates and locations of the didactic and clinical training.

(2) License information, including state license number and date of licensure.

(3) A statement that the practice of East Asian medicine in the state of Washington includes the following:

(a) Acupuncture, including the use of acupuncture needles or lancets to directly and indirectly stimulate acupuncture points and meridians;

(b) Use of electrical, mechanical, or magnetic devices to stimulate acupuncture points and meridians;

(c) Moxibustion;

(d) Acupressure;

(e) Cupping;

(f) Dermal friction technique;

(g) Infrared;

(h) Sonopuncture;

(i) Laserpuncture;

(j) Point injection therapy (aquapuncture)((~~:~~)) is defined as meaning the subcutaneous, intramuscular and intradermal injection of substances consistent with the practice of East

Asian medicine to stimulate acupuncture points, ashi points, trigger points and meridians.

(i) For the purposes of this section, point injection therapy includes trigger points as a subset of acupuncture points and ahshi points as recognized in the current practice of East Asian medicine.

(ii) Does not include injection of controlled substances contained in Scheduled I through V of the Uniform Controlled Substance Act, chapter 69.50 RCW or steroids as defined in RCW 69.41.300.

(iii) Substances are limited to:

(A) Saline;

(B) Sterile water;

(C) Herbs specifically manufactured for injection by means of hypodermic needles;

(D) Minerals specifically manufactured for injection by means of hypodermic needles;

(E) Vitamins in liquid form specifically manufactured for injection by means of hypodermic needles; and

(F) Homeopathic and nutritional substances specifically manufactured for injection by means of hypodermic needles.

(k) Dietary advice and health education based on East Asian medical theory, including the recommendation and sale of herbs, vitamins, minerals, and dietary and nutritional supplements;

(l) Breathing, relaxation, and East Asian exercise techniques;

(m) Qi gong;

(n) East Asian massage and Tui na (which is a method of East Asian bodywork); and

(o) Superficial heat and cold therapies.

(4) A statement that side effects of the treatments listed above may include, but are not limited to, the following:

(a) Pain following treatment;

(b) Minor bruising;

(c) Infection;

(d) Needle sickness; and

(e) Broken needle.

(5) A statement that patients must inform the East Asian medicine practitioner if they have a severe bleeding disorder or pacemaker prior to any treatment.

NEW SECTION

WAC 246-803-305 Patient record content. (1) A licensed East Asian medicine practitioner shall:

(a) Make a complete, legible, and accurate record of each patient to whom an East Asian medicine treatment is given. The East Asian medicine practitioner shall ensure that a patient record is in English and includes:

(i) Name of the patient;

(ii) Patient history;

(iii) Dates of treatment;

(iv) Treatment given; and

(v) Progress made during treatment.

(b) Maintain a patient record for six years after the last treatment of the patient.

(c) Maintain a patient record for at least six years after the patient reaches eighteen years of age.

(2) A licensed East Asian medicine practitioner shall comply with chapter 70.02 RCW and the Health Insurance Portability and Accountability Act, 45 C.F.R. destruction and privacy regulations.

(3) For the purposes of this section "patient records" means all records maintained by a practitioner that includes all information related to the patient.

NEW SECTION

WAC 246-803-308 Patient abandonment. (1) An East Asian medicine practitioner may accept or reject a patient, but shall respond to any reasonable request for services in the interest of public health and welfare.

(2) The attending East Asian medicine practitioner, without reasonable cause, shall not neglect, ignore, abandon, or refuse to treat a patient. If the East Asian medicine practitioner chooses to withdraw responsibility for a patient of record, the East Asian medicine practitioner shall:

(a) Advise the patient in writing that treatment is being terminated and that another East Asian medicine practitioner should be sought for future care; and

(b) Advise the patient that the East Asian medicine practitioner shall remain reasonably available for up to fifteen calendar days from the date of such notice to address clinical concerns related to the care provided.

NEW SECTION

WAC 246-803-320 Instrument sterilization procedure. (1) An East Asian medicine practitioner shall use sterile instruments and follow proper instrument sterilization procedures and the keeping of accurate records of sterilization cycles and equipment service maintenance as described in the manufacturer's instruction manual and the 7th edition of "*Best Practices for Acupuncture Needle Safety and Related Procedures*" published by the Council of Colleges of Acupuncture and Oriental Medicine revised May 2017. This shall not apply to needles, which may not be reused or sterilized for a subsequent use on more than one patient under any circumstances.

(2) "Sterilization" means to kill all microbial life, including bacterial spores, for instruments which enter tissues. Sterilization is accomplished by subjecting clean items to steam pressure (autoclaving), ultraviolet-C, or to dry heat.

NEW SECTION

WAC 246-803-325 Preparing and maintaining a clean field. (1) A clean field is the area that has been prepared to contain the equipment necessary for acupuncture in such a way as to reduce the possible contamination of sterile needles and other clean or sterile equipment.

(2) An East Asian medicine practitioner must prepare and maintain a clean field for each patient.

NEW SECTION

WAC 246-803-410 Expired license. An East Asian medicine practitioner with an expired license may return his or her license to an active license. During the time the license

is expired, an East Asian medicine practitioner cannot practice in Washington state.

(1) If an East Asian medicine practitioner's license has expired for one year or less, the East Asian medicine practitioner may return to active status by meeting the requirements of WAC 246-12-040 (3)(a)(i) through (v) and 246-803-990.

(2) If an East Asian medicine practitioner's license has expired for more than one year but less than three, the East Asian medicine practitioner may return to active status by meeting the requirements of WAC 246-12-040 (3)(b)(i) through (ix) and 246-803-990.

(3) If an East Asian medicine practitioner's license has expired for three years or more at the time of application and they have been engaged in practice in another state or United States jurisdiction, the East Asian medicine practitioner may return to active status by submitting proof to the department of:

(a) Verification of active practice from any other state or United States jurisdiction. For this purpose "active practice" means a minimum of five hundred sixty hours of practice in the preceding twenty-four months; and

(b) Having met the requirements of WAC 246-12-040 (3)(c)(i) through (xi) and 246-803-990.

(4) If an East Asian medicine practitioner's license has expired for three years or more at the time of application and they have not been engaged in practice in another state or United States jurisdiction, the East Asian medicine practitioner may return to active status by submitting proof to the department of:

(a) Having met the requirements of subsection (2) of this section; and

(b) In addition to these requirements, the practitioner has the choice of:

(i) Completion of extended course work preapproved by the department; or

(ii) Successfully retaking and passing the examinations as required in WAC 246-803-240.

WSR 19-20-018
PROPOSED RULES
ARTS COMMISSION

[Filed September 20, 2019, 3:53 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-16-003.

Title of Rule and Other Identifying Information: WAC 30-02-010 Definitions, the creative districts program is a new program that recently identified a need to make it clearer in the creative district definition that additional entities as approved may qualify as designees.

Hearing Location(s): On November 5, 2019, at 9:30 a.m, at 711 Capitol Way South, Suite 600, Olympia, WA 98504. Written comments are due by November 4, 2019.

Date of Intended Adoption: November 5, 2019.

Submit Written Comments to: Terry J. West, deputy director, 711 Capitol Way South, Suite 600, Olympia, WA 98504, email terry.west@arts.wa.gov, fax 360-586-5351, by November 4, 2019.

Assistance for Persons with Disabilities: Contact Terry J. West, deputy director, phone 360-586-5350, fax 360-586-5351, email terry.west@arts.wa.gov, by November 4, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Amend the definitions rule to make clear that under creative districts, a local government may include other entities as approved.

Reasons Supporting Proposal: This is a minor clarifying amendment.

Statutory Authority for Adoption: RCW 43.46.040.

Statute Being Implemented: RCW 43.46.090 through 43.46.095.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington state arts commission, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Terry J. West, 711 Capitol Way South, Suite 600, Olympia, 360-586-5350.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. A cost-benefit analysis is not required under RCW 34.05.328 as the Washington state arts commission is not listed under this statute as required to prepare a cost-benefit analysis. The rule being amended is not considered a significant rule change.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.030.

Explanation of exemptions: A small business economic impact statement is not required under RCW 19.85.030 because there are not more-than-minor costs to businesses in order to comply with this minor amendment.

September 20, 2019
Karen Hanan
Executive Director

AMENDATORY SECTION (Amending WSR 19-07-001, filed 3/6/19, effective 4/6/19)

WAC 30-02-010 Definitions. The following definitions shall apply throughout Title 30 WAC:

"Accession" means to formally acquire a work of art for the state art collection, including the action of assigning an accession or control number to the work of art.

"Appeal procedure" means the procedure as established in WAC 30-12-036 (Request for review of denied applications) whereby an applicant may request a review of a denied application.

"Application form" means printed, electronic, or web-based forms created and published by staff and used by the public to apply to commission program applications.

"Application guidelines" means the published document that provides the public with information on how to apply for commission programs, including eligibility requirements, review criteria used to evaluate and score applications, dead-

lines, timelines, and information on the appeal procedure. Published in print and/or electronic format, guidelines are accessible through the commission's web site.

"Art advisory committee" means a committee formed by staff and a partner agency to develop plans and overall project specifications, and to make funding allocation decisions related to the state art collection.

"Art in public places program" means the visual art program of the commission established by the legislature in RCW 43.46.090 to acquire works of art and to develop, administer, and manage the state art collection.

"Art selection committee" means a committee formed by a partner agency, and approved by staff, to review and select artists to create works of art for the state art collection, or to review and select works of art for or from the state art collection, through a process facilitated by staff.

"Artistic disciplines" means dance, design, folk and traditional arts, media arts, music, literature, theater, visual arts, and interdisciplinary arts.

"Artistic excellence" means evidence of some or all of the following: Mastery of skills and techniques, communication of unique vision or perspective, professional approaches to process and presentation. Additionally, for groups and organizations, includes the contribution the artistic work(s) make to the development of the artists involved, the art form and the arts generally; or for services delivered, the contribution the services make to the development of a vibrant arts and cultural community in the state.

"Arts professional" means an individual who has professional work experience in the arts or an arts-related field.

"Board" means the board of commissioners, consisting of nineteen members appointed by the governor and four members of the legislature appointed to the Washington state arts commission pursuant to RCW 43.46.015.

"Chair" means the chair of the board, elected pursuant to WAC 30-08-050 and fulfilling duties as established in Title 30 WAC.

"Collections management" means the ongoing care, preservation, and maintenance of the state art collection, including activities such as the management of conservation, restoration, deaccession, documentation, inventory, labeling, loans, and resiting of works of art.

"Commission" means the collective entity of the Washington state arts commission, including the board, executive director, and staff.

"Commissioner" means an individual appointed to the board of the Washington state arts commission.

"Conservation" means treatment of malfunctioning or damaged works of art for the purpose of bringing them to a stable condition so that future routine and special maintenance can be effective. Conservation-related activities may also include examination and documentation.

"Creative district" means a land area designated by a local government or other entity as approved, in accordance with RCW 43.46.105 that contains either a hub of cultural facilities, creative industries, or arts-related businesses, or multiple vacant properties in close proximity that would be suitable for redevelopment as a creative district.

"Curator" means a qualified visual arts professional with past curatorial experience selected to recommend works of art for acquisition to the state art collection.

"Deaccession" means board action to remove an accessioned work of art from the state art collection.

"Disability" is defined in RCW 49.60.040(7).

"Eligibility requirements" means published standards and/or minimum required qualifications which applicants and/or applications must meet in order for their application to be considered by the panel.

"Executive director" means that person employed pursuant to RCW 43.46.045 to carry out the functions of that chapter and Title 30 WAC.

"Grant" means a contract between the commission and an organization or individual, for arts or cultural services, awarded through a competitive application process and approved or ratified by the board.

"Inventory" means a periodic survey of the physical state and current location of works of art in the state art collection.

"Local government" means a local governing body, city, county, town, municipal county, tribal government, or other entity as approved.

"Nonprofit" means incorporation under the nonprofit laws of the state of Washington or another state, and determination by the Internal Revenue Service (IRS) that the incorporated entity is exempt from taxation under Section 501 (c)(3) of the IRS code.

"Panel" means a group of individuals convened by staff to review applications or nominations using published review criteria, and make recommendations to the board or executive director.

"Partner agency" means a state agency, K-12 public school, university, college, community or technical college, or other public entity working with the art in public places program.

"Pilot program" means a limited scale, flexible program that evaluates administrative needs and costs, adverse and favorable events, and improves upon the design prior to launch of a full program or integration of pilot into an existing program.

"Professional artist" means an individual who has a history of paid work as an artist.

"Public artist roster" means the board approved list of professional artists eligible to create visual works of art for the state art collection.

"Public benefit" means project outcomes that have an impact on a community, including some or all of the following: Broadening access to the arts or expanding and diversifying audiences for the arts; improving artistic, cultural, educational, or economic development within a community; and/or supporting specific community goals such as health and wellness, public safety, civic discourse, or other quality of life measures.

"Resiting" means the relocation of a work of art in the state art collection within the jurisdiction of a partner agency or between partner agencies.

"Restoration" means treatment that returns a malfunctioning or damaged work of art to a known or assumed state, often through the addition of nonoriginal material.

"Review criteria" means the standards used by panels to evaluate and score applications or nominations.

"Roster" means a list of approved arts professionals who have the skills and experience to address the needs of a specific commission program.

"Routine maintenance" means a regular procedure to preserve a work of art in the state art collection in proper condition: Clean, presentable, and in working order.

"Site responsive" means created, planned, or intended for a particular site. A site responsive work of art addresses both the physical characteristics of its location and the context of the community in which it is situated.

"Special maintenance" means anticipated but infrequent activities required to maintain aesthetic and/or structural aspects of the works of art in the state art collection, including integrity of the overall surface and/or individual elements.

"Staff" means employees of the Washington state arts commission, under the direction of the executive director, pursuant to RCW 43.46.045, employed to carry out the functions of that chapter, and Title 30 WAC.

"State art collection" means all works of art and select design models commissioned or purchased under RCW 43.17.200, 28A.58.055, 28A.335.210, 43.46.090, and 43.19.-455.

"State-certified creative district" means a creative district whose application for certification has been approved by the commission.

"Teaching artist" means a professional artist who is dedicated to arts education as an integral part of their professional practice, and who has cultivated skills as an educator in concert with skills as an artist.

"Under-resourced" means a lack of access to specialized, professional, financial, or institutional expertise and communal knowledge, and/or working with neglected or dated infrastructures and limited or absent assets and resources resulting in lack of recognition, competitiveness, and cyclical absent or diminished funding.

"Underserved" means populations whose opportunities to experience the arts are limited by geography, historical exclusion and marginalization due to race, ethnicity, sexual orientation, gender identity, economics, disability, or other social or institutionally imposed barriers.

((~~"Under-resourced" means a lack of access to specialized, professional, financial, or institutional expertise and communal knowledge, and/or working with neglected or dated infrastructures and limited or absent assets and resources resulting in lack of recognition, competitiveness, and cyclical absent or diminished funding.~~))

"Washington state arts commission" means the collective entity of the Washington state arts commission, including the board and staff.

WSR 19-20-023
PROPOSED RULES
EASTERN WASHINGTON UNIVERSITY
[Filed September 23, 2019, 9:26 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-16-106.

Title of Rule and Other Identifying Information: Revising WAC 172-122-310 Use of tobacco, electronic cigarettes, and related products.

Hearing Location(s): On November 26, 2019, at 10:00 a.m., at Eastern Washington University (EWU), Main Campus, 526 5th Street, Room 201, Showalter Hall, Cheney, WA 99004.

Date of Intended Adoption: December 6, 2019.

Submit Written Comments to: Joseph Fuxa, EWU, Main Campus, 526 5th Street, 314 Showalter Hall, Cheney, WA 99004, email jfuxa@ewu.edu, fax 509-359-2874, by November 26, 2019.

Assistance for Persons with Disabilities: Contact Joseph Fuxa, phone 509-359-7496, fax 509-359-2874, email jfuxa@ewu.edu, by November 25, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The revision to WAC 172-122-310 Use of tobacco, electronic cigarettes, and related products, adds stadiums to the list of prohibited locations owned or leased by EWU for the use of tobacco, electronic cigarettes and other related products.

Reasons Supporting Proposal: Modifications are being made to expand the locations where the use of tobacco, electronic cigarettes, and related products are prohibited.

Statutory Authority for Adoption: RCW 28B.35.120 (12).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: EWU, governmental.

Name of Agency Personnel Responsible for Drafting: Joseph Fuxa, 314 Showalter Hall, 509-359-7496; Implementation and Enforcement: Dr. Mary Cullinan, 214 Showalter Hall, 509-359-6362.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Pursuant to RCW 34.5.328 [34.05.328] (5)(a)(i), this agency is not an agency mandated to comply with RCW 34.05.328. Further, the agency does not voluntarily make that section applicable to the adoption of this rule pursuant to subsection (5)(a)(ii), and to date, the joint administrative rules review committee has not made the section applicable to the adoption of this rule.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4).

September 23, 2019
Joseph Fuxa
Labor Relations Manager

AMENDATORY SECTION (Amending WSR 18-06-023, filed 2/27/18, effective 3/30/18)

WAC 172-122-310 Use of tobacco, electronic cigarettes, and related products. Eastern Washington University is committed to providing a safe and healthy environment for its employees, students and visitors. In light of the

associated health risks, the use of tobacco, electronic cigarettes, and related products in or on university owned or leased property is restricted as described herein.

(1) The use of tobacco, electronic cigarettes, and related products is prohibited:

(a) Within any building, stadium, or vehicle owned or leased by EWU, to include residence halls and university apartments; and

(b) Within twenty-five feet of entrances, exits, windows that open, and ventilation intakes of any building owned, leased, or operated by EWU; and

(c) Anywhere within the boundaries of the Arévalo Student Mall. The Arévalo Student Mall is enclosed by a rectangle surrounded by the southwest elevation of Patterson Hall, the northwest elevation of Tawanka Hall, the northeast elevation of JFK Library and the southeast elevation of the Pence Union Building.

(2) For the purposes of this section, "tobacco, electronic cigarettes, and related products" includes any cigarette, cigar, pipe, bidi, clove cigarette, e-cigarette/cigar/pipe, waterpipe (hookah) and smokeless or spit tobacco, dissolvable tobacco, snuff or snoose.

(3) Distribution or sale of tobacco, electronic cigarettes, or related products in or on EWU owned or leased property is prohibited. Advertising or sponsorship of tobacco, electronic cigarettes or related products is prohibited on EWU property or at University-affiliated events, including the use of brand or corporate names, trademarks, logos, symbols or mottos. EWU will neither solicit nor accept any grant or gift from a manufacturer, distributor or retailer whose principal business is tobacco, electronic cigarettes, or related products.

(4) Any person intentionally violating this section may be subject to a civil fine of up to one hundred dollars. Local law enforcement agencies may enforce this section by issuing a notice of infraction, assessed in the same manner as traffic infractions, as described under chapter 70.160 RCW. Any student, staff or faculty member who violates this section may also be subject to disciplinary action by the university.

WSR 19-20-024
PROPOSED RULES
EASTERN WASHINGTON UNIVERSITY
[Filed September 23, 2019, 9:28 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-16-098.

Title of Rule and Other Identifying Information: Revising chapter 172-121 WAC, Student conduct code.

Hearing Location(s): On November 26, 2019, at 10:00 a.m., at Eastern Washington University, Main Campus, 526 5th Street, Room 201, Showalter Hall, Cheney, WA 99004.

Date of Intended Adoption: December 6, 2019.

Submit Written Comments to: Joseph Fuxa, Eastern Washington University, Main Campus, 526 5th Street, 314 Showalter Hall, Cheney, WA 99004, email jfuxa@ewu.edu, fax 509-359-2874, by November 26, 2019.

Assistance for Persons with Disabilities: Contact Joseph Fuxa, phone 509-359-7496, fax 509-359-2874, email jfuxa@ewu.edu, by November 25, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The revision[s] to chapter 172-121 WAC, Student conduct code, are needed to update university processes and procedures to better reflect current practices.

Reasons Supporting Proposal: Modifications are being made to chapter 172-121 WAC to update definitions, the investigative process, updating [update] interim restrictions, conduct review proceedings, brief hearings, the full hearing procedures, appeals, violations, and to repeal WAC 172-121-120.

Statutory Authority for Adoption: RCW 28B.35.120 (12).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Eastern Washington University, governmental.

Name of Agency Personnel Responsible for Drafting: Joseph Fuxa, 314 Showalter Hall, 509-359-7496; Implementation and Enforcement: Dr. Mary Cullinan, 214 Showalter Hall, 509-359-6362.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Pursuant to RCW 34.5.328 [34.05.328] (5)(a)(i), this agency is not an agency mandated to comply with RCW 34.05.328. Further, the agency does not voluntarily make that section applicable to the adoption of this rule pursuant to subsection (5)(a)(ii), and to date, the joint administrative rules review committee has not made the section applicable to the adoption of this rule.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4).

September 23, 2019
Joseph Fuxa
Labor Relations Manager

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-020 Definitions. For purposes of the student conduct code, chapter 172-121 WAC, the definitions in this section apply.

"Appeal authority" refers to the conduct review official presiding over an appeal under WAC 172-121-130.

"Appellant" refers to any respondent or complainant who appeals the decisions or sanctions of a hearing authority under WAC 172-121-130.

"Brief hearing" refers to a brief conduct review hearing before a conduct review officer or the student disciplinary council for allegations that, if substantiated by a preponderance of evidence, would result in a sanction less than a suspension or expulsion and that do not involve felony-level sexual misconduct.

"Business days" refers to the days and hours the university is open for business. Business days are Monday through Friday, from 8:00 a.m. to 5:00 p.m., excluding holidays as set forth in the university holiday schedule.

"Complainant" means the person who was subjected to the alleged misconduct. The complainant may or may not be the reporting party. If the person who was subjected to the alleged misconduct does not wish to pursue a student conduct case, the university may choose to fill the role of the complainant throughout the student conduct proceedings.

"Conduct review officer" or "CRO" refers to the person designated to serve as the decision maker for a brief or full hearing.

"Council" or "the council" refers to the student disciplinary council as described in WAC 172-121-070.

"Council hearing" refers to a brief conduct review hearing before the student disciplinary council.

"Dean of students" refers to the dean of students or designee.

"Director of SRR" refers to the director of student rights and responsibilities or designee.

"Filing" means to actually deliver documents. Documents required to be filed with a specific person under these rules shall be deemed filed upon actual receipt during office hours at EWU. Papers may be filed by delivering them to the dean of student's office, sending them via United States mail, properly addressed, postage prepaid, to 301 Pence Union Building, or emailing them to srr@ewu.edu.

"Full hearing" refers to a full conduct reviewing hearing before a conduct review officer (CRO) for allegations that, if substantiated by a preponderance of the evidence, could result in a sanction of a suspension or expulsion, or that constitute felony-level sexual misconduct.

"Hearing authority" refers to the university official or student disciplinary council who holds a conduct review hearing.

"Notify" means to provide notice to a person. A person may be notified in person, by telephone, by sending notice to the person's university email account, by leaving a message on his or her personal telephone, or by sending the notice in the United States mail, properly addressed, postage prepaid, to the person's last known address.

"Off-campus" refers to any location or facility that is not owned, leased, rented, or operated by Eastern Washington University.

"Party/parties" refers to the complainant and the respondent.

"Policies" or "university policy" refers to the written regulations of the university, including the standards of conduct for students, residence life handbook, university policies, and graduate/undergraduate catalogs and handbooks.

"Recognized student organizations" refers to clubs, organizations, societies or similarly organized groups recognized by the university or the associated students of Eastern Washington University (ASEWU).

"Reporting party" means the person who notifies student rights and responsibilities of alleged misconduct by a student or student organization. The reporting party may also be the complainant, but need not be the complainant.

"Respondent" refers to any student or student organization accused of violating the student conduct code under this chapter.

"Serve" means to post a document in the United States mail, properly addressed, postage prepaid, to a person's last known address, personal service, or electronic service to the person's university email account. Service by mail is complete upon deposit in the United States mail.

"Session council" refers to the student disciplinary council members selected for a specific hearing or appeal.

"Sexual misconduct" encompasses sexual harassment, domestic violence, dating violence, stalking, and acts of nonconsensual sexual activity for the purposes of WAC 172-121-030 through 172-121-140((~~. These terms are further defined~~)) and for trainings provided on campus. However, in the violations section in WAC 172-121-200 the violations are defined separately and the term sexual misconduct has the more limited definition of nonconsensual sexual activity.

"Student" includes all of the following:

(a) Any applicant who becomes enrolled, for violations of the code committed as part of the application process or committed following the applicant's submission of the application until the time of official enrollment;

(b) Any person currently enrolled at the university;

(c) Nonmatriculated, international students attending institutes or foreign study programs through the university; and

(d) Any person who was previously enrolled at the university for violations of the code committed while enrolled. A person who engaged in conduct in violation of the student conduct code while a student remains subject to action under this code even if the person has graduated, withdrawn, or is not currently enrolled for any reason.

"University" means Eastern Washington University.

"University official" includes any person employed or contracted by the university, performing assigned administrative or professional responsibilities.

"University premises" means buildings and/or property (including adjacent streets and sidewalks) which are owned, leased, rented or operated by the university, to include all satellite campuses affiliated with the university.

"University president" refers to the university president or designee.

"Vice president for student affairs" refers to the vice president for student affairs or designee.

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-070 Conduct review officials. (1) The director of SRR or designee shall:

(a) Serve as the primary point of contact for all matters relating to student conduct code violations and proceedings;

(b) Manage the proceedings as described in this chapter;

(c) Maintain all records of conduct review proceedings as described in WAC 172-121-080;

(d) Ensure complaints are promptly investigated and resolved as required by federal and state laws; and

(e) Review off-campus incidents of alleged misconduct and make determinations as to whether the conduct involved

adversely affects the university community and/or the pursuit of its objectives and whether the conduct process should be initiated.

(2) Conduct review officer (CRO): The university president delegates to the vice president of student affairs the authority to designate one or more ((~~conduct review officers~~)) CRO(s). The director of SRR may be designated as a ((~~conduct review officer~~)) CRO. The ((~~conduct review officer(s)~~)) CRO(s) shall preside over brief hearings, council hearings, and full conduct hearings under this chapter and shall serve as the decision maker in such cases unless a brief hearing is held before the student disciplinary council.

As the presiding officer, in full hearings the ((~~conduct review officer~~)) CRO has authority to:

(a) Determine the order of presentation of evidence;

(b) Administer oaths and affirmations;

(c) Issue subpoenas pursuant to RCW 34.05.446;

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

(e) Rule on motions for summary judgment;

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

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

(h) Question witnesses in an impartial manner to develop any facts deemed necessary to fairly and adequately decide the matter;

(i) Call additional witnesses and request additional exhibits deemed necessary to complete the record and receive such evidence subject to each party's opportunity for cross-examination and rebuttal;

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

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

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

(m) Issue an order of default;

(n) Hold prehearing conferences; and

(o) Take any other action necessary and authorized by any applicable statute or rule.

(3) Student disciplinary council: All brief hearings are scheduled with a ((~~conduct review officer~~)) CRO unless one of the parties requests a brief hearing before the student disciplinary council. The council also serves as an appeal authority under WAC 172-121-130.

(a) Council pool: For each academic year, a pool of council members shall be established. All members of the council pool are appointed by the vice president for student affairs. Appointment of council pool members is as follows:

(i) Faculty and staff members are appointed for three-year terms. Student members are appointed for one-year terms;

(ii) Council chair: The director of SRR, or designee, shall serve as chair of council proceedings but will not have the right to vote, except in the case of a tie;

(iii) Vacancies: Council pool vacancies shall be filled as needed through appointment by the vice president for student affairs.

(b) Session council: When a student disciplinary council is needed for a brief hearing or an appeal, the director of SRR shall select available members from the council pool to serve as the session council. Each session council must include a quorum. A quorum is three voting members, which must include at least one student, one faculty/staff member, and one other member who could be a student or faculty/staff member.

(4) Investigator: In certain cases, the CRO may assign a complaint to an investigator to conduct an investigation. The investigator will provide a written investigative report to the CRO.

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-075 Conflicts of interest. (1) Individuals who play a role in receiving, investigating, advising, presiding over, and making decisions pertaining to individual student conduct cases shall not have any conflict of interest in the process. A conflict of interest exists if the investigator, advisor, presiding officer or decision maker is the respondent, complainant, or a witness; if the respondent, complainant, or witness is a family member or friend; if the individual has a personal interest or bias; or if the individual has previously served in an advisory capacity for any of the parties or witnesses. In the event such a conflict arises in the process, the person shall disclose such interest to the parties. Parties to the complaint who believe a university official involved in the process has a conflict of interest may report such concerns to the director of SRR or the dean of students. The director or dean shall determine whether a conflict of interest exists and take appropriate action.

(2) Challenges to council membership. Members of the student disciplinary council and the conduct review officer (CRO) are subject to the conflict of interest limitations set forth in subsection (1) of this section.

(a) If a member has such a conflict, the person shall recuse him/herself from further involvement in the case. In the event such a conflict arises after the council has been selected or during a proceeding, the member shall disclose the conflict to the parties.

(b) A member's or the ((~~conduct review officer's~~)) CRO's eligibility to participate in a case may be challenged by parties to the case or by other council members at any time by submitting a motion to disqualify to the ((~~conduct review officer~~)) CRO. When such a challenge is made, the session council, excluding the person alleged to have a conflict of interest, shall make a decision on the challenge.

(c) If a member is disqualified or disqualifies him/herself from a case, the director of SRR will appoint a replacement.

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-080 Administration and records. (1) Student conduct code.

(a) Interpretation: Any questions regarding the interpretation or application of this student conduct code are referred to the vice president for student affairs for final determination.

(b) Review: This student conduct code shall be reviewed at least every three years under the direction of the vice president for student affairs.

(2) Records of conduct review proceedings.

(a) Records of conduct review proceedings under this chapter shall be prepared by the conduct review official(s) involved and maintained by the director of SRR. As much as possible, records should include:

(i) A summary of the proceedings during a prehearing conference;

(ii) An audio recording of conduct review hearings;

(iii) All letters, statements, memoranda, decisions, orders, notices, and other documents related to conduct review proceedings;

(iv) Any images, articles, recordings, or other materials presented as evidence in a conduct review proceeding;

(v) A statement of matters officially noticed or considered by the council or conduct review officer (CRO);

(vi) Evidence submitted, whether or not accepted, any objections and rulings, any cross-examination questions submitted to the council and rulings on such questions;

(vii) Proposed findings, requested orders, and exceptions;

(viii) Recording of the hearing and subsequent transcript, if any;

(ix) Any staff memorandum to the extent required by RCW 34.05.476; and

(x) Matters placed on the record after any ex parte communication. "Ex parte" means when a member of the student discipline council or ((~~conduct review officer~~)) CRO communicates with a party about a nonprocedural matter regarding the hearing when the other party is not present.

(b) The director of SRR shall keep records of conduct review proceedings for seven years.

(c) Records of conduct review proceedings are the property of the university and are confidential to the extent provided in applicable law.

(d) Prior to the final disposition of a case, the respondent may review the records relative to their case. The respondent shall request to review the case records by contacting the ((~~conduct review officer~~)) CRO. The ((~~conduct review officer~~)) CRO shall make every reasonable effort to support the respondent's request.

(3) Student disciplinary records.

(a) Student disciplinary records are confidential and shall be treated consistently with the requirements of the Family Educational Rights and Privacy Act (FERPA) and applicable law. Disciplinary records shall be maintained in accordance with the university's records retention schedule.

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

(i) The student's parents or legal guardians may review these records as permitted by FERPA (20 U.S.C. Sec. 1232g; 34 C.F.R. Part 99).

(ii) Release to another educational institution, upon request, where the student seeks or intends to enroll, as allowed by FERPA (20 U.S.C. Sec. 1232g; 34 C.F.R. Part 99).

(iii) In response to a judicial order or a lawfully issued subpoena.

(iv) The university shall release information related to disciplinary records to complainants or other persons as required by Title IX of the Education Amendments of 1972, the Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act, and other state and federal laws.

(v) Disciplinary records will be made available to hearing councils and university personnel as needed for legitimate educational purposes.

(vi) A student may authorize release of their own disciplinary record to a third party in compliance with FERPA (20 U.S.C. Sec. 1232g; 34 C.F.R. Part 99) by providing a written consent to student rights and responsibilities.

(vii) Any student may review his/her own disciplinary records by contacting student rights and responsibilities.

(viii) A student may obtain a copy of their disciplinary record by making a written request to student rights and responsibilities. Student rights and responsibilities may charge the student a reasonable amount to cover copying expenses.

(ix) The university may disclose to a student's parents a violation of any federal, state, or local law, or of any university policy or rules regarding use or possession of alcohol or a controlled substance so long as the student is under the age of twenty-one at the time of the disclosure to the parent.

(c) When disciplinary records are released, personally identifiable information may be redacted to protect the privacy of others as permitted by law.

(4) Holds:

(a) Types of holds. Holds placed on a student's academic records may prevent admission, registration, graduation, or other academic activities. Holds may also restrict access to transcripts, grades, or other academic records.

(b) Discretionary holds: The ((~~conduct review officer~~)) CRO may place a hold on a student's academic records in either of the following situations:

(i) Pending the student's satisfactory completion of any sanctions imposed by a conduct review hearing; or

(ii) If the student fails to respond to any properly delivered notice from the ((~~conduct review officer~~)) CRO.

(c) Required holds: The ((~~conduct review officer~~)) CRO shall place a hold on a student's academic record if the student is the respondent to a violation of the conduct code and has withdrawn from the university, or if the student withdraws from the university after a complaint is filed against the student. A hold is also required if a student is subject to a pending student conduct complaint at the time of graduation. This hold shall remain in place until the allegation or complaint is resolved.

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-100 Complaints. (1) Filing of complaints.

(a) Any person may file a complaint against a student or student organization for violation of the student conduct code.

(b) A person wishing to file a complaint under the student conduct code must submit the complaint, in writing, to one of the following:

(i) Student rights and responsibilities; or

(ii) The office of the dean of students.

(c) Filing a complaint under the student conduct code does not prohibit or limit a person's right to file complaints or charges with other civil and/or criminal authorities for violations of local, county, state, or federal law.

(d) All student conduct code complaints will be forwarded to the director of SRR for further review and action.

(e) In cases where the university is acting as the complainant, an EWU employee shall initiate the complaint.

(2) Complaint review. Upon receipt of a complaint, the director of SRR shall review the complaint to determine whether it includes allegations of sexual misconduct and/or criminal conduct that will require special processing under subsection (3) of this section and whether appropriate law enforcement or other authorities should be notified. The director of SRR shall also review the complaint to determine whether the allegations may lead to a possible sanction of suspension, expulsion, or if the allegations rise to the level of a felony under Washington criminal law. All allegations that may lead to a possible suspension, expulsion, or that rise to the level of felony sexual misconduct under Washington criminal law shall be referred for a university investigation and full hearing under WAC 172-121-122.

(3) Sexual misconduct proceedings. Except where specifically stated, this section applies to all allegations the university receives of sexual misconduct regardless of the possible level of sanction or where the alleged acts occurred.

(a) Report to Title IX coordinator. The director of SRR shall report all complaints which may constitute any form of sexual misconduct to the university Title IX coordinator within twenty-four hours.

(b) Prompt resolution. The university shall investigate any complaint alleging sexual misconduct when it is legally required to do so to determine if the university will pursue the incident under this student conduct code and/or refer the incident to other departments or agencies for further criminal, civil, or disciplinary action. All allegations of sexual misconduct shall be promptly investigated and resolved. ((~~In the absence of extenuating circumstances, the university will seek to have the allegations resolved within sixty days from the date it is notified of the allegation.~~))

(c) Confidentiality. To facilitate the investigative process and protect the privacy of those involved, all information will be maintained in a confidential manner to the fullest extent permissible by law. During an investigation, complaint information will be disseminated on a need-to-know basis. If the complainant wishes to remain anonymous, the university will take all reasonable steps to investigate the allegation without disclosing the name of the complainant to the extent allowed by state and federal law. If the complainant wishes to remain anonymous, the university shall inform them that its ability to investigate and respond to the allegation will be limited. The university cannot ensure confidentiality, as its legal obligations under federal or state law may require investigation of the allegation and possible disclosure of the complainant's name. Reports of crimes to the campus community shall not include the names of the complainants. Files subject to public disclosure will be released to the extent required by law.

(d) Right to file a criminal report. Once the university is notified of an allegation of sexual misconduct, it will notify the potential complainant of their right to file a criminal complaint with campus or local law enforcement. If the complainant in such circumstances wishes to report the conduct to local law enforcement, the university will assist them in doing so. The university will also notify the complainant that he or she is not required to file a report with local law enforcement. The university will report allegations of sexual misconduct to law enforcement or other authorities consistent with federal, state, and local law.

(4) Interim measures and interim restrictions. During the complaint review, the director of SRR((~~, Title IX coordinator, or designee will evaluate the circumstances and recommend to the dean of students if any interim measures to assist or protect the parties during the conduct code process are needed. Interim measures may include, but are not limited to, safety planning with the EWU police department, no contact directives, academic or workplace modifications, providing counseling for the complainant and/or respondent, campus housing modifications, and/or an interim restriction for the respondent. The purpose of an interim measure is to provide an equitable process for both students that minimizes the possibility of a hostile environment on campus. The procedures and basis for imposing an interim restriction on the respondent is set forth~~)) will review whether any interim measures or interim restrictions are needed. Interim measures and interim restrictions are addressed in WAC 172-121-140.

(5) SRR will follow up with the parties as described below.

(a) For cases other than sexual misconduct, the director of SRR will contact the parties and provide them with the following information:

(i) The parties' rights under the student conduct code;

(ii) A summary of the allegations the complainant has against the respondent;

(iii) The potential conduct code violations related to the allegations; and

(iv) How to report any subsequent problems or retaliation, including intimidation, threats, coercion, or discrimination.

(b) In all cases alleging sexual misconduct, the director of SRR will, in addition to the information specified under (a) of this subsection, provide both parties with written information that will include, at a minimum:

(i) The student's rights and options, including options to avoid contact with the other party; a list of available university and community resources for counseling, health, mental health, victim advocacy, legal assistance, visa and immigration assistance, student financial aid, and other academic and

housing services at the university and in the community; and options for, available assistance in, and how to request changes to academic, living, transportation, and working situations or protective measures;

(ii) The importance of preserving evidence of the alleged incident and procedures to follow to preserve evidence of the alleged incident;

(iii) Who will receive a report of the allegation;

(iv) Their right to file or not file a criminal complaint as detailed above and the ability to be assisted by campus authorities in notifying law enforcement authorities if the complainant wishes to do so;

(v) A list of resources for obtaining protective, no contact, restraining, or similar orders, if applicable;

(vi) The procedures the university will follow when determining if discipline is appropriate;

(vii) Steps the university will take to ensure confidentiality of complainants and other necessary parties and the limits this may place on the university's ability to investigate and respond, as set forth above; and

(viii) Information regarding the university's policy against retaliation, steps the university will take to prevent and respond to any retaliation, and how the student should report retaliation or new incidents.

(6) Following the complaint review, the director of SRR will either dismiss the matter or arrange a preliminary conference.

(a) Dismiss the matter. If the director of SRR determines the allegations, even if true, would not rise to the level of a conduct violation, he/she may dismiss the matter. In such cases, the director of SRR will prepare a written record of the dismissal. The director of SRR will also notify the complainant of their decision, if such notification is permissible under FERPA. The dismissal letter, along with the original complaint and any other related documents, will be maintained as described in WAC 172-121-080. In cases of sexual misconduct, the complainant may request a review of the dismissal by the dean of students by filing a request for review with the director of SRR within ((~~ten~~)) seven business days of receiving notice of the dismissal.

(b) Preliminary conference. If the director of SRR does not dismiss the matter he/she will arrange a preliminary conference as described in WAC 172-121-110.

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-105 Conduct review proceedings. (1) General provisions:

(a) Conduct review proceedings in which the potential sanction is less than suspension, expulsion, or do not involve allegations of felony level sexual misconduct are brief hearings in accordance with WAC 172-108-050(3)((~~, and shall be conducted in an informal manner~~)). Conduct review proceedings in which the potential sanction is suspension, expulsion, or that involve allegations of felony level sexual misconduct are considered full hearings under the Administrative Procedure Act.

(b) Nonjudicial proceedings: Formal rules of process, procedure, and/or technical rules, such as are applied in criminal or civil courts, do not apply in student conduct code proceedings.

(2) Notification for student organizations: When a charge is directed towards a student organization, the conduct review officer (CRO) will communicate all matters relative to conduct review proceedings with the president of the organization or their designee.

(3) Advisors: The complainant and the respondent may be assisted by one advisor of their choice, subject to the following provisions:

(a) Any fees or expenses associated with the services of an advisor are the responsibility of the complainant or the respondent that employed the advisor;

(b) The advisor may be an attorney or any other person of the student's choosing;

(c) The advisor must provide the ((~~conduct review officer~~)) CRO with a FERPA release signed by the student they are assisting;

(d) If a complainant or the respondent is represented by an attorney, the attorney shall provide the ((~~conduct review officer~~)) CRO and other parties with the attorney's name, address, telephone number, and email address. The attorney must file a notice of appearance when hired to represent a person and a notice of withdrawal upon withdrawal of representation. A notice of appearance must be filed at least two business days prior to any conduct review proceeding.

(4) Review of evidence:

(a) In brief hearings, the respondent, and, in cases of sexual misconduct, the complainant may request to view material related to their case prior to a scheduled hearing by contacting the ((~~conduct review officer~~)) CRO. To facilitate this process, the party should contact the ((~~conduct review officer~~)) CRO as early as possible prior to the scheduled hearing. The ((~~conduct review officer~~)) CRO shall make a reasonable effort to support the request to the extent allowable by state and federal law.

(b) In council hearings, the parties may request to view material related to the case prior to the scheduled hearing by contacting the ((~~conduct review officer~~)) CRO. To facilitate this process, the party should contact the ((~~conduct review officer~~)) CRO as early as possible prior to the scheduled hearing. The ((~~conduct review officer~~)) CRO shall make a reasonable effort to support the request to the extent allowable by state and federal law.

(5) Continuances: Continuances, extensions of time, and adjournments may be ordered by the ((~~conduct review officer~~)) CRO. A party may file a timely request for a continuance if the party shows good cause for the continuance. A request for a continuance may be oral or written. Before granting a motion for a continuance, the ((~~conduct review officer~~)) CRO shall allow any other party to object to the request. The ((~~conduct review officer~~)) CRO will make a decision on the request and will communicate his/her decision in writing to the parties along with the reasons for granting or denying the request.

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-110 Notice of allegations and initial scheduling. (1) Scheduling. If, after reviewing a complaint, the director of SRR decides to initiate conduct review proceedings, the director shall, within ten business days of receiving the initial complaint, appoint a conduct review officer (CRO) to the case and notify the respondent. In cases alleging sexual misconduct, the CRO assigned must have completed training on issues relating to sexual misconduct, the Violence Against Women Reauthorization Act, and Title IX requirements. Notification of the allegations to the respondent must:

(a) Be made in writing;

(b) Include a written list of the allegations against the respondent; ((~~and~~

~~(c) Include~~)) (c) Indicate whether or not the allegation has been assigned to a university investigator and, if so, provide the contact information for the investigator; and

(d) In cases where an allegation is not assigned to an investigator, the information contained in subsection (2) of this section.

(2) After the conclusion of an investigation, or in cases where there is not an investigation, the director will provide written notice to the student the name of the ((~~conduct review officer~~)) CRO assigned to the case and the deadline for the respondent to contact the CRO in order to schedule a preliminary conference. Whenever possible, the deadline for the respondent to contact the CRO will be within five business days of the date the director of SRR sent notification to the respondent.

(((~~(2)~~))) (3) Failure to respond: If the respondent fails to respond to the notice of allegations, the director of SRR shall schedule the preliminary conference and notify the respondent. The notification shall be in writing and shall include a date, time, and location of the preliminary conference.

(((~~(3)~~))) (4) Follow up with complainant. In all cases alleging sexual misconduct or if there will be a full hearing, the SRR office shall notify the complainant(s) of the date, time, and location of the preliminary conference and of their right to attend the conference. The SRR office shall also follow up with the complainant(s)/respondent(s) to inform them of the process of reporting any retaliation or new incidents. If the complainant has experienced any type of retaliatory behavior, the university shall take immediate steps to protect the complainant from further harassment or retaliation.

(((~~(4)~~))) (5) The procedures for the preliminary conference for brief hearings is contained in WAC 172-121-121. The procedures for the preliminary and prehearing conference for full hearings is contained in WAC 172-121-122.

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-121 Brief hearings. Brief hearing procedures.

(1) The conduct review officer (CRO) may hold a brief hearing with the respondent if the proposed sanction is less than a suspension and the allegations do not involve felony level sexual misconduct. A respondent shall be informed of the option to have a brief hearing before a CRO or before the student discipline council. Unless the respondent affirmatively requests a council hearing, brief hearings shall be conducted with a ((~~conduct review officer~~)) CRO.

(2) General provisions.

(a) Hearing authority: The CRO exercises control over hearing proceedings. All procedural questions are subject to the final decision of the CRO.

(b) Closing hearings: All conduct review hearings will be closed. Admission of any person to a conduct review hearing shall be at the discretion of the hearing authority.

(c) Consolidation of hearings: In the event that one or more students are charged with the same misconduct arising from the same occurrence, the hearing authority may conduct separate hearings for each student or consolidate the hearings as practical, as long as consolidation does not impinge on the rights of any student.

(3) Appearance.

(a) Failure to appear: In cases where proper notice has been given but the respondent fails to attend a conduct review hearing, the hearing authority shall decide the case based on the information available, without the respondent's input.

(b) Appearance: The parties will be provided options for reasonable alternative arrangements if they do not wish to be present in the same room as the other student during the hearing. The parties may appear at the conduct review hearing in person, through telephone conference, or through any other practical means of communication, subject to the limits set forth below in (e) of this subsection. If a party does not appear at the hearing, the hearing authority will decide the case based on the information available.

(c) Advisors: The complainant and the respondent may be assisted by one advisor during conduct review hearings as described in WAC 172-121-105.

(d) Disruption of proceedings: Any person, including the respondent, who disrupts a hearing, may be excluded from the proceedings.

(e) Telephonic appearance. In the interest of fairness and expedience, the CRO may permit any person to appear by telephone, audio tape, written statement, or other means, as appropriate, if the rights of the parties will not be substantially prejudiced by a telephonic appearance as determined by the CRO.

(4) Standard of proof. The hearing authority shall determine whether the respondent violated the student conduct code, as charged, based on a preponderance of the evidence. A preponderance means, based on the evidence admitted, whether it is more probable than not that the respondent violated the student conduct code.

(5) Preliminary conference. The SRR office will schedule a preliminary conference with the respondent. Only the respondent and the respondent's advisor may appear at the preliminary conference, unless the case involves alleged sexual misconduct. In cases alleging sexual misconduct, the respondent and the complainant, along with their advisors, if they choose to have an advisor, may appear at the same or separate preliminary conferences. The purpose of the preliminary conference is to advise the parties regarding the student conduct process. During the preliminary conference, the ((~~conduct review officer~~)) CRO will:

(a) Review the written list of allegations with the respondent;

(b) Inform the respondent who is bringing the complaint against them;

(c) Provide the respondent with a copy of the student conduct code and any other relevant university policies;

(d) Explain the respondent's rights under the student code;

(e) Explain the conduct review procedures;

(f) Explain the respondent's and complainant's rights and responsibilities in the conduct review process; and

(g) Explain possible penalties under the student conduct code.

At the end of the preliminary conference, the ((~~conduct review officer~~)) CRO will either conduct or schedule a brief hearing with the respondent as set forth in this subsection. If proper notice was given of the preliminary conference and the respondent fails to attend the conference, the CRO may either proceed with the brief hearing and decide the case based on the information available, or place a hold on the respondent's academic records as described in WAC 172-121-080 until the respondent cooperates with the student conduct process.

((~~(3)~~)) (6) Scheduling. A brief hearing may take place immediately following the preliminary conference or it may be scheduled for a later date or time, except that, in cases of sexual misconduct, a brief hearing cannot take place without first notifying the complainant/respondent of the hearing. If the brief hearing will be held at a later date or time, the CRO shall schedule the hearing and notify the respondent and, in the case of sexual misconduct, the complainant of the date, time, and place of the hearing. The CRO may coordinate with the parties to facilitate scheduling, but is not required to do so.

((~~(4)~~)) (7) If the respondent fails to appear at the brief hearing, the CRO may conduct the hearing without the respondent present. The CRO may also place a hold on the respondent's academic records under WAC 172-121-080 until the respondent cooperates with the student conduct process.

((~~(5)~~)) (8) Deliberation. After the hearing, the CRO and/or council shall decide whether the respondent violated the student conduct code based on a preponderance of the evidence. For council hearings, the council shall meet in closed session and, within seven business days, determine by majority vote whether the respondent violated the student conduct code.

(a) If the CRO and/or council determines that there is not sufficient information to establish a violation by a preponderance of evidence, the CRO and/or council shall dismiss the complaint.

(b) If the CRO and/or council determines that the respondent violated the student conduct code, the CRO and/or council shall impose any number of sanctions as described in WAC 172-121-210, except suspension or expulsion.

((~~(6)~~)) (9) Sanctions. In determining what sanctions shall be imposed, the hearing authority may consider the evidence presented at the hearing as well as any information contained in the student's disciplinary and academic records. If a student fails to appear for a hearing, then the hearings authority shall review the evidence provided and may consider information available from the student's disciplinary and academic records in determining what sanction should be imposed.

(10) Notification. The CRO, and/or the presiding officer in cases of a council hearing, shall serve the respondent with a decision including its findings, conclusions, and rationale. The decision shall address credibility issues if credibility or witness demeanor was a substantial factor in the council's/CRO's decision. The findings shall be based exclusively on the evidence provided at the hearing. The decision must also identify the respondent's right to appeal.

In cases of sexual misconduct, the complainant shall be provided with written notice of:

(a) The university's determination as to whether such sexual misconduct occurred;

(b) The complainant's right to appeal;

(c) Any change to the results that occurs prior to the time that such results become final; and when such results become final (20 U.S.C. 1092(f)).

Information regarding the discipline of the respondent will not be released unless:

(i) The information contained in the record directly relates to the complainant, such as an order requiring the respondent to not contact the complainant; or

(ii) The misconduct involves a crime of violence or a sexual assault, including rape, dating violence, domestic violence or stalking as defined in 42 U.S.C. Sec. 13925(a).

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-122 Full hearing procedures. (1) Scheduling and notification. Full hearings are used for allegations which, if substantiated by a preponderance of the evidence, could result in a sanction of suspension or expulsion or that involve felony-level sexual misconduct. Following provision of the notice of allegations to the respondent, as set forth in WAC 172-121-110, the SRR office shall arrange for a preliminary conference.

(2) General provisions.

(a) Hearing authority: The CRO exercises control over hearing proceedings. All procedural questions are subject to the final decision of the CRO.

(b) Closed hearings: All conduct review hearings will be closed. Admission of any person to a conduct review hearing shall be at the discretion of the CRO.

(c) Consolidation of hearings: In the event that one or more students are charged with the same misconduct arising from the same occurrence, the CRO may conduct separate hearings for each student or consolidate the hearings as practical, as long as consolidation does not impinge on the rights of any student.

(3) Appearance.

(a) Failure to appear: In cases where proper notice has been given but the respondent fails to attend a conduct review hearing, the CRO shall decide the case based on the information available, without the respondent's input.

(b) Appearance: The parties will be provided options for reasonable alternative arrangements if they do not wish to be

present in the same room as the other student during the hearing. The parties may appear at the conduct review hearing in person, through telephone conference, or through any other practical means of communication, subject to the limits set forth below in (e) of this subsection. If a party does not appear at the hearing, the CRO will decide the case based on the information available.

(c) Advisors: The complainant and the respondent may be assisted by one advisor during conduct review hearings as described in WAC 172-121-105.

(d) Disruption of proceedings: Any person, including the respondent, who disrupts a hearing, may be excluded from the proceedings.

(e) Telephonic appearance. In the interest of fairness and expedience, the CRO may permit any person to appear by telephone, audio tape, written statement, or other means, as appropriate, if the rights of the parties will not be substantially prejudiced by a telephonic appearance as determined by the CRO.

(4) Standard of proof. The CRO shall determine whether the respondent violated the student conduct code, as charged, based on a preponderance of the evidence. A preponderance means, based on the evidence admitted, whether it is more probable than not that the respondent violated the student conduct code.

(5) Preliminary conference. The SRR office or designee will arrange for a preliminary conference with each of the parties separately to advise them about the student conduct process. During the preliminary conference, the SRR office or designee will:

(a) Review the written list of allegations with the respondent;

(b) Inform the respondent who is bringing the complaint against them;

(c) Provide the respondent with a copy of the student conduct code and any other relevant university policies;

(d) Explain the respondent's rights under the student code;

(e) Explain the conduct review procedures;

(f) Explain the respondent's and complainant's rights and responsibilities in the conduct review process; and

(g) Explain possible penalties under the student conduct code.

((~~(3)~~)) (6) Prehearing conference. Following the preliminary conference, the case will be referred to the CRO and the CRO will arrange for a prehearing conference with the parties. The purpose of the prehearing conference is for the CRO to explain what will occur for during the full hearing process, to schedule a date for the full hearing, and to address any preliminary matters or motions. Following the prehearing conference, the CRO shall schedule the hearing and notify the respondent with the date, time, and location of the hearing. The director of SRR shall also notify the complainant of the date, time, and location of the hearing in writing as well as any other details required by RCW 34.05.434. The notice will include information about how to request accommodations or interpreters for any parties or witnesses. The notice of hearing must be served on the respondent and complainant at least seven business days prior to the hearing. The CRO may coordinate with the parties to facilitate scheduling, but is not required to do so.

((~~(4)~~)) (7) Evidence.

(a) Evidence: Pertinent records, exhibits and written statements may be accepted as information for consideration by the ((~~conduct review officer~~)) CRO in accordance with RCW 34.05.452. Any investigation conducted by the university will be admitted into evidence. Evidence, including hearsay evidence, is admissible if in the judgment of the ((~~conduct review officer~~)) CRO it is the kind of evidence on which reasonably prudent persons are accustomed to rely in the conduct of their affairs. The ((~~conduct review officer~~)) CRO shall exclude evidence that is excludable on constitutional or statutory grounds or on the basis of evidentiary privilege recognized by Washington courts. The ((~~conduct review officer~~)) CRO may exclude incompetent, irrelevant, immaterial or unduly repetitious material. If not inconsistent with this section, the ((~~conduct review officer~~)) CRO shall refer to the Washington rules of evidence as guidelines for evidentiary rulings.

(b) The respondent and complainant have the right to view all material presented during the course of the hearing, except a respondent's previous disciplinary history which shall be used solely for the purpose of determining the appropriate sanction.

(c) All testimony of parties and witnesses shall be made under oath or affirmation. Any interpreter shall be proscribed the oath set forth in WAC 10-08-160.

(d) Documentary evidence may be received in the form of copies or excerpts, or by incorporation by reference.

(e) Official notice may be taken of (i) any easily verifiable facts such as dates or weather conditions, (ii) technical or scientific facts within EWU's specialized knowledge, such as enrollment status or class schedules, and (iii) codes or standards that have been adopted by an agency of the United States, of this state or of another state, or by a nationally recognized organization or association. Parties shall be notified either before or during hearing, or by reference in preliminary reports or otherwise, of the material so noticed and the sources thereof, including any staff memoranda and data, and they shall be afforded an opportunity to contest the facts and material so noticed. A party proposing that official notice be taken may be required to produce a copy of the material to be noticed.

(f) All rulings upon objections to the admissibility of evidence shall be made in accordance with the provisions of RCW 34.05.452.

((~~(5)~~)) (8) Discovery. Discovery is not permitted under the code, except for requests for documentary information from the university. Either party may request the university to produce relevant documents as long as such request is submitted at least five business days prior to the hearing, absent extenuating circumstances. If the CRO determines the request is not relevant to the present allegation, the CRO may deny the request. The university will provide the requested information prior to the hearing to the extent permitted by state and federal law.

(((~~(6)~~))) (9) Subpoenas.

(a) Subpoenas shall be issued and enforced, and witness fees paid, as provided in RCW 34.05.446 and 5.56.010.

(b) Every subpoena shall identify the party causing issuance of the subpoena and shall state EWU's name and the title of the proceeding and shall command the person to whom it is directed to attend and give testimony or produce designated books, documents, or things under his or her control.

(i) A subpoena to a person to provide testimony at a hearing shall specify the time and place set for hearing.

(ii) A subpoena duces tecum requesting a person to produce designated books, documents, or things under his or her control shall specify a time and place for producing the books, documents, or things. That time and place may be the time and place set for the hearing, or another reasonably convenient time and place in advance of the hearing.

(c) A subpoena may be served by any suitable person over eighteen years of age, by exhibiting and reading it to the witness, or by giving him or her a copy thereof, or by leaving such copy at the place of his or her abode. When service is made by any other person than an officer authorized to serve process, proof of service shall be made by affidavit or declaration under penalty of perjury.

(d) The CRO, upon motion ((~~made promptly and in any event at or before the time specified in the subpoena for compliance therewith,~~)) by a party or at his or her own discretion, may (i) quash or modify the subpoena if it is unreasonable and oppressive or (ii) condition denial of the motion upon advancement by the person in whose behalf the subpoena is issued of the reasonable cost of producing the books, papers, documents, or tangible things. Subpoenas may not be used to threaten or intimidate parties or witnesses.

(((~~(7)~~))) (10) Summary judgment. A motion for summary judgment may be granted and an order issued if the written record shows that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law.

(((~~(8)~~))) (11) Witnesses.

(a) The complainant, respondent, investigator, and CRO may present witnesses at full hearings.

(b) The party who wishes to call a witness is responsible for ensuring that the witness is available and present at the time of the hearing. An attorney may subpoena a witness to appear at the hearing. Nonattorneys may request the CRO to subpoena witnesses in accordance with subsection (4) of this section. The CRO has the discretion to deny a request to issue a subpoena or to quash a subpoena issued by an attorney if the subpoena is unreasonable and oppressive.

(c) The CRO may exclude witnesses from the hearing room when they are not testifying. The CRO is not required to take the testimony of all witnesses called by the parties if such testimony may be inappropriate, irrelevant, immaterial, or unduly repetitious.

(d) All parties have the right to hear all testimony provided by witnesses during the hearing.

(e) The parties should inform the CRO of any possible need for an interpreter or any accommodation requests at least five business days prior to the hearing. The CRO will comply with WAC 10-08-150.

(((~~(9)~~))) (12) Questioning:

(a) The complainant, the respondent, and their advisors may ask questions of each other or of any witnesses, except cross-examination questions for another party must be submitted in writing to the CRO. The CRO may ask such questions, but is not required to do so. The CRO may preclude any questions which he/she considers inappropriate, irrelevant, immaterial or unduly repetitious or may require that all questions be submitted to the CRO rather than allowing the parties to directly question witnesses. The CRO will explain to the parties the reason for rejecting any questions and will maintain a record of the questions submitted and rulings made.

(b) The CRO may ask their own questions of any witness called before them.

(((~~(10)~~))) (13) The CRO may accommodate concerns for personal safety, well-being, or fears of confrontation of any person appearing at the hearing by providing separate facilities, or by permitting participation by telephone, audio tape, video conferencing, or other means, as determined appropriate, subject to subsection (((~~(2)~~))) (3)(b) of this section.

(((~~(11)~~))) (14) Deliberations and sanctions. Following the hearing, the CRO will determine whether, by a preponderance of the evidence, the respondent violated the student conduct code based on the evidence presented at the hearing. If a student fails to appear, the CRO shall make a decision based on the information available. If the CRO determines the respondent violated the student conduct code, the CRO shall then decide what sanctions shall be imposed. The CRO may review the respondent's previous disciplinary history for purposes of determining the appropriate sanction. The ((~~CRO's~~)) CRO shall issue a decision including his/her findings, conclusions, and rationale. The decision shall address credibility issues if credibility or witness demeanor was a substantial factor in the CRO's decision. The findings shall be based exclusively on the evidence provided at the hearing. Such decisions should be issued within seven business days from the date of the hearing. The written decision shall also:

(a) Be correctly captioned identifying EWU and the name of the proceeding;

(b) Designate all parties and representatives participating in the proceeding;

(c) Contain appropriate numbered findings of fact meeting the requirements in RCW 34.05.461;

(d) Contain appropriate numbered conclusions of law, including citations of statutes and rules relied upon;

(e) Contain an initial or final order disposing of all contested issues;

(f) Contain a statement describing the available post-hearing remedies.

(((~~(12)~~))) (15) Notification to the respondent. The director of SRR shall serve the respondent with a copy of the decision and notice of the right to appeal.

(((~~(13)~~))) (16) Notification to the complainant. In cases of sexual misconduct, the complainant shall be provided with written notice of:

(a) The university's determination as to whether sexual misconduct occurred;

(b) The complainant's right to appeal;

(c) Any change to the results that occurs prior to the time that such results become final and when such results become final (20 U.S.C. 1092(f));

(d) Information regarding the discipline of the respondent will not be released unless:

(i) The information contained in the record directly relates to the complainant, such as an order requiring the student harasser to not contact the complainant; or

(ii) The misconduct involves a crime of violence or a sexual assault, including rape, relationship violence, domestic violence or stalking as defined in 42 U.S.C. Sec. 13925(a).

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-130 Appeals. (1) Basis: Appeals following a brief hearing, full hearing, or dismissal of a complaint may be filed by the respondent or the complainant under this section. Appeals of interim restrictions are governed by WAC 172-121-140. Appeals may be filed for one or more of the following reasons:

(a) To determine whether the hearing was conducted according to established procedures. A hearing may have deviated from established procedures if:

(i) The hearing was not conducted fairly in light of the notice of allegations and information presented;

(ii) The complainant was not given a reasonable opportunity to prepare and to present information as provided by the student conduct code;

(iii) The respondent was not given a reasonable opportunity to prepare and to present a response as provided by the student conduct code.

(b) The hearing authority misinterpreted the student conduct code.

(c) To determine whether the decision reached by the hearing authority, or the director of SRR's decision to not proceed with a hearing, was based on the information presented and that information was sufficient to reasonably establish that a violation of the conduct code did or did not occur based on a preponderance of the evidence.

(d) To determine whether the sanction(s) imposed were reasonable and appropriate for the associated conduct code violation(s).

(e) To consider newly discovered, material information which was not known to the appellant and could not reasonably have been discovered and presented by the appellant at the original hearing. It is the party's obligation to present all evidence at the time of the original hearing. The university is not obligated to grant an appeal and conduct a new hearing when parties do not take reasonable efforts to prepare their cases for the original hearing.

(2) Filing: Appeals may be filed following a brief hearing ((~~or~~)), full hearing, or dismissal of a complaint, subject to the following provisions:

(a) The appeal must be submitted to the director of student rights and responsibilities within ten ((~~calendar~~)) business days from service of the CRO's decision following a full hearing or dismissal of a complaint, or within twenty-one calendar days from service of a decision from a brief hearing conducted by the CRO or student disciplinary council;

(b) The appeal shall be in writing and shall include:

(i) The appellant's name;

(ii) The nature of the decision and sanctions reached by the hearing official;

(iii) The basis, as described in subsection (1) of this section, for the appeal; and

(iv) What remedy the appellant is seeking.

(c) In cases of sexual misconduct, the other party must be given a copy of the appeal and provided with an opportunity to provide his/her own written response to the appeal within three business days; and

(d) For dismissal of a complaint, appeals are determined by the dean of students.

(3) Appeal authorities:

(a) For brief hearings heard by the CRO, appeals are determined by the student disciplinary council.

(b) For brief hearings heard by the student disciplinary council, appeals are determined by the dean of students.

(c) For full hearings, appeals are determined by the vice president for student affairs.

(4) Forwarding of appeals: The director of SRR shall forward the appeal to the appropriate appeal authority. The submitted appeal will include, at a minimum, the appellant's written appeal and the written report of the case. The director of SRR may also forward any other written records related to the case.

(5) Review of appeals:

(a) Before rendering a decision, the appeal authority may request additional information or explanation from any of the parties to the proceedings.

(b) Except as required to explain the basis of new information, an appeal shall be limited to a review of the verbatim record of the conduct review hearing and supporting documents.

(c) In making its decision, the appeal authority will only consider the written record before it, the appellant's notice of appeal, the other party's response, and other information and/or explanation it has requested from the parties to the proceedings.

(6) Decisions: After reviewing the appeal, the appeal authority may affirm, reverse, or remand the decision(s) of the hearing authority. The appeal decision shall include an explanation of the appeal authority's decision and rationale. The appeal decision must be issued within thirty calendar days of the appeal authority receiving all necessary documentation.

(7) Remanded cases: In cases where the appeal authority remands the decision or sanction(s) of the hearing authority, the case will be returned to the hearing authority for reconsideration or other action as specified by the appeal authority. Following such reconsideration, the hearing authority will return the case to the appeal authority for further review/action. The appeal authority will then complete the appeal process or remand the case again. No appeal may, however, be remanded more than two times. After a case has been remanded twice, the appeal authority must affirm or reverse the decision and affirm, reverse, or modify the sanctions.

(8) Sanctions: The appeal authority may affirm, reverse, remand, or modify the sanctions assigned to the respondent. When determining sanctions, the appeal authority may con-

sider the complete record of the respondent's prior conduct and academic performance in addition to all other information associated with the case.

(9) Notification: Once the appeal authority has made a final decision to affirm or reverse and/or to modify the sanctions assigned, the appeal authority shall forward the decision to the director of SRR. The director of SRR shall serve the respondent, and, in cases of sexual misconduct, notify the complainant, with a brief written statement setting forth the outcome of the appeal. The notification shall also inform the recipient that judicial review of the decision may be available under chapter 34.05 RCW.

(10) Further proceedings. The appeal authority's decision is final and no further appeals may be made under the student conduct code. Judicial review of the university's decision may be available under chapter 34.05 RCW.

(11) Appeals standards:

(a) Appeal authorities must weigh all pertinent information presented to them in determining whether sufficient evidence exists to support reversal or modification of decisions or sanctions.

(b) For appeals based on a deviation from established procedures, such deviations will not be a basis for sustaining an appeal unless the alleged deviation materially changed the outcome of the case or the sanctions imposed.

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-140 Interim measures and restrictions. (1) Interim measures. During the complaint review, the director of SRR, Title IX coordinator, or designee will evaluate the circumstances and recommend to the dean of students if any interim measures to assist or protect the parties during the conduct code process are needed. Interim measures may include, but are not limited to, safety planning with the EWU police department, no contact directives, academic or workplace modifications, providing counseling for the complainant and/or respondent, campus housing modifications, and/or an interim restriction for the respondent. The purpose of an interim measure is to provide an equitable process for both students that minimizes the possibility of a hostile environment on campus.

(2) Interim restrictions. In situations where there is cause to believe that a student or a student organization poses an immediate danger to the health, safety, or welfare of themselves, the university community, or property of the university community, the dean of students may take immediate action(s) against the student or student organization without prior notice or hearing.

Simultaneous with such action(s), the dean of students will refer the allegations to the conduct review officer, who will process such allegations in accordance with the provisions of this student conduct code.

Interim restriction is subject to the following:

((~~(1)~~)) (a) Interim restriction actions may only be imposed in the following situations:

((~~(a)~~)) (i) When a student or student organization poses an immediate threat to:

((~~(i)~~)) (A) The health, safety or welfare of any part of the university community or public at large;

((~~(ii)~~)) (B) The student's own physical safety and well-being; or

((~~(iii)~~)) (C) Any property of the university community; or

((~~(b)~~)) (ii) When it is believed that the student's or student organization's continued attendance or presence may cause disorder, substantially interfere with or impede the lawful activities of others, or imperil the physical or mental health and safety of members of the university community.

((~~(2)~~)) (b) During the interim restriction period, a student may be restricted by any or all of the following means:

((~~(a)~~)) (i) Denial of access including, but not limited to: Assignment to alternate university housing or removal from university housing, limitation of access to university facilities, or restriction of communication with specific individuals or groups;

((~~(b)~~)) (ii) Interim suspension, including temporary total removal from the university or restriction of access to campus;

((~~(c)~~)) (iii) Mandatory medical/psychological assessment of the student's capability to remain in the university.

(3) The dean of students will determine what restriction(s) will be placed on a student.

(4) The dean of students will prepare a brief memorandum for record containing the reasons for the interim restriction. The dean of students will serve the memorandum on the restricted student and notify all other persons or offices bound by it. At a minimum, the memorandum will state:

(a) The alleged act(s) or behavior(s) of the student or student organization which prompted the interim restriction;

(b) How those alleged act(s) or behavior(s) could constitute a violation of the student conduct code;

(c) How the circumstances of the case necessitated the interim restriction action(s); and

(d) ((~~The date, time, and location for an~~)) An explanation of the process for emergency appeal ((~~hearing with the vice president for student affairs~~)) reviews.

(5) In cases alleging sexual misconduct, the complainant will be provided with notice of any interim restrictions that relate directly to the complainant. If the respondent appeals such interim restrictions, the complainant will be given notice of the respondent's appeal and an opportunity to submit a statement as to why the interim restriction should or should not be modified.

(6) Emergency appeal ((~~hearing~~)) review.

(a) If a student has been suspended on an interim basis, the student will automatically receive an emergency appeal ((~~hearing~~)) review with the vice president for student affairs, or designee((~~, within ten business days after the interim suspension is served~~)). If the interim restriction is something less than a suspension, the student or student organization subject to the interim restriction must file a written appeal with the vice president for student affairs within ((~~ten~~)) five business days after service of the interim restriction. In all cases, the student must submit any information the student wishes the vice president to consider submitted within ten business days after service of the interim restriction. The appealing party should outline the desired modification(s) to the interim

restriction as well as the specific challenge(s) to the interim restriction decision. Challenges to interim restriction decisions are limited to the criteria identified in WAC 172-121-140(1) upon which the interim restriction was imposed (threat to health or safety of the university community, potential for creating campus disorder, impeding the lawful activity of others, etc.). Appealing parties are limited to submitting their own written statements. Any other evidence should be submitted to the investigator or provided to the CRO under the regular hearing process.

(b) The vice president for student affairs, or designee, will conduct an emergency appeal((~~s hearing with the student or student organization subject to the interim restriction. The student may appear at the hearing telephonically and may be represented by counsel~~)) review. Emergency appeal reviews will address only the interim restriction decision of the dean of students and the basis on which the restriction modification or termination is requested by the appealing party. The emergency appeal review does not replace the regular hearing process. In the emergency appeal review, the vice president will only review materials available to and information considered by the dean of students at the time the interim restriction was imposed, written statements by the two parties, and information that becomes available as a part of the university's investigation that the vice president deems relevant.

(c) In cases alleging sexual misconduct, if ((~~an interim restriction is imposed, the student, the student organization, and~~)) a complainant believes the interim restriction does not adequately protect their health and safety, the complainant may appeal the interim restriction using the process outlined in this subsection. ((~~Also, in such cases, if an appeal is filed~~)) If the complainant files an appeal, all parties shall be given notice of the appeal and shall be provided the opportunity to ((~~participate in the appeal proceeding~~)) submit a written statement to the vice president.

(d) ((~~The vice president for student affairs may have the dean of students or any other person deemed relevant attend the meeting. The respondent and the complainant, if he/she has the right to be present under (b) of this subsection, may have an advisor present at the meeting.~~

~~(e)~~)) During the emergency appeal ((~~hearing~~)) review, the vice president for student affairs will review available materials and statements. ((~~After the meeting,~~)) The vice president for student affairs ((~~may uphold, modify, or terminate~~)) will issue a written decision upholding, modifying, or terminating the interim restriction action. The written decision shall include a rationale for the basis of the decision and be issued within fifteen business days of the date of service of an interim restriction.

(((~~f~~))) (e) The interim restriction does not replace the regular hearing process, which will proceed as quickly as feasible consistent with this chapter.

(((~~g~~))) (f) Duration. An interim restriction will remain in effect until terminated, in writing, by the student disciplinary council, CRO, or the vice president for student affairs.

AMENDATORY SECTION (Amending WSR 19-01-047, filed 12/13/18, effective 1/13/19)

WAC 172-121-200 Violations. The following are defined as offenses which are subject to disciplinary action by the university.

(1) **Acts of academic dishonesty.** University policy regarding academic dishonesty is governed by the university academic integrity policy.

(2) ((~~Acts of social misconduct.~~)) **Abuse, threats and harassment.**

(a) Abuse. Assault and other forms of physical abuse((~~, verbal abuse, and/or other conduct which threatens or~~)).

(b) Threats. Any conduct or statement that, when viewed objectively, threatens bodily harm to another person or that endangers the health or safety of ((~~any~~)) another person.

(((~~b~~))) (c) Bullying. Bullying is behavior that is:

(i) Intentional;

(ii) Targeted at an individual or group;

(iii) Repeated;

(iv) Hostile or offensive; and

(v) Creates an intimidating and/or threatening environment that is so severe or pervasive, and objectively offensive, that it substantially interferes with another's ability to work, study, participate in, or benefit from the university's programs and activities.

(((~~c~~))) (d) Discriminatory harassment. Physical, verbal, electronic, or other conduct based on an individual's race, color, religion, national origin, sex, age, pregnancy, marital status, sexual orientation, gender identity or expression, disability, or veteran status when one of the conditions outlined in subsection (1) or (2) of this section are present:

(i) Submission to, or rejection of such conduct is made implicitly or explicitly a term or condition of a person's instruction, academic standing, employment, or participation in any university program, activity, or benefit, or is used as a basis for evaluation in making academic or personnel decisions; or

(ii) Such conduct creates a hostile environment. A hostile environment is created when the conduct is sufficiently severe or pervasive, and objectively offensive, that it unreasonably interferes with an individual's academic or work performance, ability to participate in or benefit from the university's programs, services, opportunities, or activities. Unreasonable interference is viewed from both a subjective and objective standard.

(e) Domestic violence and dating violence.

(i) Domestic violence means:

(A) Physical harm, bodily injury, assault, or the infliction of fear of imminent physical harm, bodily injury or assault, between family or household members;

(B) Sexual assault of one family or household member by another; or

(C) Stalking of one family or household member by another family or household member.

(ii) Dating violence is a type of domestic violence, except the acts specified above are committed by a person who is or has been in a social relationship of a romantic or intimate nature with the complainant. In determining whether such a relationship exists, the following factors are considered:

(A) The length of time the relationship has existed;

(B) The nature of the relationship; and

(C) The frequency of interaction between the parties involved in the relationship.

(((~~(d) Harassment is conduct by any means that is sufficiently severe, pervasive, or persistent, and objectively offensive so as to threaten an individual or limit the individual's ability to work, study, participate in, or benefit from the university's programs or activities. Harassment based on someone's actual or perceived membership in a protected class, as defined by university policy, is also discrimination.~~

~~(e)~~)) (f) Sexual and gender-based harassment. Sexual harassment is defined by the Office of Civil Rights as unwelcome conduct of a sexual nature and may include unwelcome sexual advances, requests for sexual favors, and other verbal, nonverbal, or physical conduct of a sexual nature. Sexual harassment violates this code when it is sufficiently severe or pervasive such that it denies or limits another's ability to work, study, participate in, or benefit from the university's programs or activities.

In determining whether conduct is severe or pervasive, the university shall consider all relevant circumstances from both an objective and subjective perspective, including the type of harassment (verbal or physical); the frequency and severity of the conduct; the age, sex, and relationship of the individuals involved; the degree to which the conduct affected the complainant; the setting and context in which the harassment occurred; whether other incidents have occurred at the university; and other relevant factors.

Gender-based harassment includes nonsexual acts of verbal, nonverbal, or physical aggression, intimidation, or hostility based on a person's gender or nonconformity with gender stereotypes. Gender-based harassment violates this code when it is sufficiently severe or pervasive, such that it denies or limits another's ability to work, study, participate in, or benefit from the university's programs or activities.

(((~~(f)~~))) (g) Retaliation. Any actual or threatened retaliation or any act of intimidation intended to prevent or otherwise obstruct the reporting of a violation of this code is prohibited and is a separate violation of this code. Any actual or threatened retaliation or act of intimidation directed towards a person who participates in an investigation or disciplinary process under this code is prohibited and is a separate violation of this code.

(((~~(g)~~))) (3) **Sexual misconduct.** Sexual misconduct includes, but is not limited to:

(((~~(i)~~))) (a) Nonconsensual sexual activity. Nonconsensual sexual activity is sexual contact or sexual intercourse without consent. Sexual contact is intentional contact with a person's intimate body parts without their consent. Intimate body parts include, but are not limited to, breasts, genitalia, thighs, and buttocks. Nonconsensual sexual intercourse is penetration, no matter how slight, of the vagina, or anus, with any body part or object, without consent; or, oral penetration by a sex organ of another person without consent. Consent means actual words or conduct indicating freely given agreement to the sexual act. Consent cannot be inferred from silence, passivity, or lack of active resistance. There is no consent where there is a threat of force or violence or any other form of coercion or intimidation, physical or psychological. Sexual activity is nonconsensual when one person is incapable of consent by reason of mental incapacity, drug/alcohol use, illness, unconsciousness, or physical condition. Incapacitation due to drugs or alcohol refers to an individual who is in a state of intoxication such that the individual is incapable of making rational, reasonable decisions because the person lacks the capacity to give knowing consent.

(((~~(ii)~~))) (b) Other forms of sexual misconduct. Other forms of sexual misconduct include indecent liberties; indecent exposure; sexual exhibitionism; sex-based cyber harassment; prostitution or the solicitation of a prostitute; peeping or other voyeurism; or going beyond the boundaries of consent, such as by allowing others to view consensual sex or the nonconsensual recording of sexual activity.

(((~~(h)~~))) (4) **Stalking.** Stalking is engaging in a course of conduct directed at a specific person that would cause a reasonable person to:

(((~~(i)~~))) (a) Fear for their health and/or safety or the health/safety of others; or

(((~~(ii)~~))) (b) Suffer substantial emotional distress.

(((~~(i)~~))) (5) **Unauthorized use of electronic or other devices**((~~:~~))**.** Making an audio or video recording of any person while on university premises without the person's prior knowledge or without their effective consent, when such a recording is of a private conversation or of images taken of a person(s) at a time and place where the person would reasonably expect privacy and where such recordings are likely to cause injury or distress. This includes, but is not limited to, surreptitiously taking pictures of another person in a gym, locker room, or restroom, but does not include taking pictures of persons in areas which are considered by the reasonable person to be open to public view.

(((~~(3)~~))) (6) **Property violations.** Theft of, damage to, or misuse of another person's or entity's property. This also includes any conduct or statement that, when viewed objectively, threatens to damage another's property.

(((~~(4)~~))) (7) **Weapons.** Possession, carrying, discharge or other use of any weapon is prohibited on property owned or controlled by Eastern Washington University, except as permitted in (a) through (d) of this subsection. Examples of weapons under this section include, but are not limited to: Explosives, chemical weapons, shotguns, rifles, pistols, air guns, BB guns, pellet guns, longbows, hunting bows, throwing weapons, stun guns, electroshock weapons, and any item that can be used as an object of intimidation and/or threat, such as replica or look-a-like weapons.

(a) Commissioned law enforcement officers may carry weapons, which have been issued by their respective law enforcement agencies, while on campus or other university controlled property, including residence halls. Law enforcement officers must inform the university police of their presence on campus upon arrival.

(b) A person may possess a personal protection spray device, as authorized by RCW 9.91.160, while on property owned or controlled by Eastern Washington University.

(c) A person may bring a weapon onto campus for display or demonstration purposes directly related to a class or other educational activity, provided that they obtain prior authorization from the university police department. The uni-

versity police department shall review any such request and may establish conditions to the authorization.

(d) Weapons that are owned by the institution for use in organized recreational activities or by special groups, such as EWU ROTC or university-sponsored clubs or teams, must be stored in a location approved by the university police department. These weapons must be checked out by the advisor or coach and are to be used only in organized recreational activities or by legitimate members of the club or team in the normal course of the club or team's related activity.

(((~~5~~))) (8) **Failure to comply.**

(a) Failure to comply with lawful and/or reasonable directions of university officials or law enforcement officers acting in performance of their duties on campus or affecting conduct on campus;

(b) Failure to identify oneself to university officials in their course of duty, refusal or failure to appear before university officials or disciplinary bodies when directed to do so;

(c) Failure to attend any medical treatment or evaluation program when directed to do so by the dean of students or other authorized university official.

(((~~6~~))) (9) **Trespassing/unauthorized use of keys.**

(a) Trespass. Entering or remaining on university property without authorization.

(b) Unauthorized use of keys. Unauthorized possession, duplication, or use of university keys or access cards.

(((~~7~~))) (10) **Deception, forgery, fraud, unauthorized representation.**

(a) Knowingly furnishing false information to the university.

(b) Forgery, alteration, or misuse of university documents, records, or instruments of identification. This includes situations of identity theft where a person knowingly uses or transfers another person's identification for any purpose.

(c) Forgery or issuing a bad check with intent to defraud.

(d) Unauthorized representation. The unauthorized use of the name of the university or the names of members or organizations in the university community.

(((~~8~~))) (11) **Safety.**

(a) Intentionally activating a false fire alarm.

(b) Making a bomb threat.

(c) Tampering with fire extinguishers, alarms, or safety equipment.

(d) Tampering with elevator controls and/or equipment.

(e) Failure to evacuate during a fire, fire drill, or false alarm.

(((~~9~~))) (12) **Alcohol, drugs, and controlled substances.**

(a) Alcohol and substance violations. Use, possession, distribution, or sale of alcoholic beverages (except as permitted by university policy and state law) is prohibited. Under no circumstances may individuals under the age of twenty-one use, possess, distribute, manufacture or sell alcoholic beverages. Public intoxication is prohibited.

(b) Drugs and paraphernalia.

(i) Use, possession, distribution, manufacture, or sale of illegal drugs, paraphernalia, narcotics or controlled substances, is prohibited.

(ii) Use, possession, distribution, manufacture, or sale of marijuana is prohibited except for reasons permitted under EWU Policy 602-01 (drug and alcohol abuse prevention).

(iii) Being under the influence of marijuana or an illegal substance, while on property owned or operated by the university, is prohibited. Being under the influence of a controlled substance, except when legally prescribed by a licensed medical practitioner, is also prohibited while on property owned or operated by the university.

(((~~10~~))) (13) **Hazing.** Any act which, for the purpose of initiation, admission into, affiliation with, or as a condition for continued membership in, a group or organization:

(a) Endangers the mental or physical health or safety of any student or other person;

(b) Destroys or removes public or private property; or

(c) Compels an individual to participate in any activity which is illegal or contrary to university rules, regulations or policies.

The express or implied consent of any participant is not a defense. A person who is apathetic or acquiesces in the presence of hazing violates this rule.

(((~~11~~))) (14) **Disruptive conduct/obstruction.**

(a) Disruptive conduct. Conduct which unreasonably interferes with any person's ability to work or study, or obstructs university operations or campus activities.

(b) Disorderly conduct. Conduct that is disorderly, lewd, indecent or a breach of peace.

(c) Obstruction. Obstruction of the free flow of pedestrian or vehicular traffic on university premises or at university-sponsored or university-supervised events.

(((~~12~~))) (15) **Violations of other laws, regulations and policies.**

(a) Violation of a local, county, state, or federal law.

(b) Violation of other university policies, regulations, or handbook provisions.

(((~~13~~))) (16) **Assisting/attempts.** Soliciting, aiding, abetting, concealing, or attempting conduct in violation of this code.

(((~~14~~))) (17) **Acts against the administration of this code.**

(a) Initiation of a complaint or charge knowing that the charge was false or with reckless disregard of its truth.

(b) Interference with or attempt to interfere with the enforcement of this code including, but not limited to, intimidation or bribery of hearing participants, acceptance of bribes, dishonesty, or disruption of proceedings and hearings held under this code.

(c) Knowing violation of the terms of any disciplinary sanction or attached conditions imposed in accordance with this code.

(((~~15~~))) (18) **Other responsibilities((~~:~~)).**

(a) Guests. A student, student group or student organization is responsible for the conduct of guests on or in university property and at functions sponsored by the university or sponsored by any recognized university organization.

(b) Students studying abroad. Students who participate in any university sponsored or sanctioned foreign country study program shall observe the following rules and regulations:

(i) The laws of the host country;

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

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

(iv) The student conduct code.

((~~(16)~~)) (19) **Student organization and/or group offenses.** Clubs, organizations, societies or similarly organized groups in or recognized by the university and/or ASEWU are subject to the same standards as are individuals in the university community. The commission of any of the offenses in this section by such groups or the knowing failure of any organized group to exercise preventive measures relative to violations of the code by their members shall constitute a group offense.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 172-121-120 Hearing procedures.

WSR 19-20-028
PROPOSED RULES
DEPARTMENT OF HEALTH

[Filed September 23, 2019, 1:16 p.m.]

Original Notice.

Proposal is exempt under RCW 34.05.310(4) or 34.05.-330(1).

Title of Rule and Other Identifying Information: WAC 246-247-035 National standards adopted by reference for sources of radionuclide emissions.

Hearing Location(s): On November 5, 2019, at 10:00 a.m., at the Department of Health, Town Center 2, Room 139, 111 Israel Road S.E., Tumwater, WA 98501.

Date of Intended Adoption: November 12, 2019.

Submit Written Comments to: Theresa Phillips, Department of Health, P.O. Box 47820, Olympia, WA 98504-7820, email https://fortress.wa.gov/doh/policyreview, by November 5, 2019.

Assistance for Persons with Disabilities: Contact Theresa Phillips, phone 360-236-3147, TTY 360-833-6388 or 711, email theresa.phillips@doh.wa.gov, by October 29, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This rule making is necessary to update the publication date of rules previously adopted by reference in WAC 246-247-035 National standards adopted by reference for sources of radionuclide emissions. The amendment makes no changes to any requirements previously adopted, but is required for the department of health (department) to receive full delegation of the radionuclide air emissions program from the United States Environmental Protection Agency (EPA).

Reasons Supporting Proposal: The intent of RCW 70.98.050 is to safely regulate the possession and use of radioactive material within the state of Washington. The intent of RCW 70.98.080(5) is to reduce redundant licensing requirements. The rule meets the intent of the statutes by adopting requirements as-stringent-as the federal requirements in order for the department to have full delegation authority from EPA.

Statutory Authority for Adoption: RCW 70.98.050 and 70.98.080(5).

Statute Being Implemented: RCW 70.98.050 and 70.98.080(5).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of health, governmental.

Name of Agency Personnel Responsible for Drafting: Theresa Phillips, 111 Israel Road S.E., Tumwater, WA 98501, 360-236-3147; Implementation and Enforcement: John Martell, 309 Bradley Boulevard, Suite 201, Richland, WA 99352, 509-946-3798.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The agency did not complete a cost-benefit analysis under RCW 34.05.328. RCW 34.05.328 (5)(b)(iii) exempts rules that adopt or incorporate by reference without material change federal statutes or regulations, Washington state law, the rules of other Washington state agencies, or national consensus codes that generally establish industry standards.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Citation of the specific federal statute or regulation and description of the consequences to the state if the rule is not adopted: The proposed changes are necessary for consistency between federal and state rules and as a primary condition for delegation of the national emission standard for hazardous air pollutants authority from EPA to the department. If Washington does not adopt the proposed changes, the department would not receive full delegation as required by EPA.

Is exempt under RCW 19.85.025(3) as the rules are adopting or incorporating by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule.

Explanation of exemptions: The agency did not complete a cost-benefit analysis under RCW 34.05.328. RCW 34.05.328 (5)(b)(iii) exempts rules that adopt or incorporate by reference without material change federal statutes or regulations, Washington state law, the rules of other Washington state agencies, or national consensus codes that generally establish industry standards.

September 19, 2019
Clark Halvorson
Assistant Secretary

AMENDATORY SECTION (Amending WSR 19-04-042, filed 1/29/19, effective 3/1/19)

WAC 246-247-035 National standards adopted by reference for sources of radionuclide emissions. (1) In addition to other requirements of this chapter, the following federal standards, as in effect on July 1, ((~~2018~~)) 2019, are adopted by reference except as provided in subsection (2) of this section.

(a) For federal facilities:

(i) 40 C.F.R. Part 61, Subpart A - General Provisions.

(ii) 40 C.F.R. Part 61, Subpart H - National Emission Standards for Emissions of Radionuclides Other Than Radon From Department of Energy Facilities.

(iii) 40 C.F.R. Part 61, Subpart I - National Emission Standards for Radionuclide Emissions From Federal Facilities Other Than Nuclear Regulatory Commission Licensees and Not Covered by Subpart H.

(iv) 40 C.F.R. Part 61, Subpart Q - National Emission Standards for Radon Emissions From Department of Energy Facilities.

(b) For nonfederal facilities:

(i) 40 C.F.R. Part 61, Subpart A - General Provisions.

(ii) 40 C.F.R. Part 61, Subpart B - National Emission Standards for Radon Emissions From Underground Uranium Mines.

(iii) 40 C.F.R. Part 61, Subpart K - National Emission Standards for Radionuclide Emissions From Elemental Phosphorus Plants.

(iv) 40 C.F.R. Part 61, Subpart R - National Emissions Standards for Radon from Phosphogypsum Stacks.

(v) 40 C.F.R. Part 61, Subpart T - National Emission Standards for Radon Emissions From the Disposal of Uranium Mill Tailings.

(vi) 40 C.F.R. Part 61, Subpart W - National Emission Standards for Radon Emissions From Operating Mill Tailings.

(2) References to "Administrator" or "EPA" in 40 C.F.R. Part 61 include the department of health except in any section of 40 C.F.R. Part 61 for which a federal rule or delegation indicates that the authority will not be delegated to the state.

WSR 19-20-037
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Economic Services Administration)
[Filed September 25, 2019, 11:48 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-13-102.

Title of Rule and Other Identifying Information: The department is proposing amendments to WAC 388-478-0015 Need standards for cash assistance.

Hearing Location(s): On November 5, 2019, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than November 6, 2019.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., November 5, 2019.

Assistance for Persons with Disabilities: Contact Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by October 22, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The department is proposing amendments to WAC 388-478-0015 Need standards for cash assistance, to revise the basic need standards for cash assistance.

Reasons Supporting Proposal: As required by RCW 74.04.770, the department must establish standards of need for cash assistance programs on an annual basis.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.770, 74.08.090.

Statute Being Implemented: RCW 74.04.770.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Sarah Garcia, P.O. Box 45470, Olympia, WA 98504-5470, 360-522-2214.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. This amendment is exempt as allowed under RCW 34.05.328 (5)(b)(vii) which states in part, "[t]his section does not apply to … rules of the department of social and health services relating only to client medical or financial eligibility and rules concerning liability for care of dependents."

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rule content is explicitly and specifically dictated by statute.

Is exempt under RCW 74.04.770.

September 23, 2019
Katherine I. Vasquez
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-22-021, filed 10/26/18, effective 1/1/19)

WAC 388-478-0015 Need standards for cash assistance. The need standards for cash assistance units are:

(1) For assistance units with an obligation to pay shelter costs:

Assistance unit size	Need standard
1	$ ((~~1,460~~)) 1,520
2	((~~1,848~~)) 1,923
3	((~~2,281~~)) 2,374
4	((~~2,692~~)) 2,801
5	((~~3,102~~)) 3,229
6	((~~3,513~~)) 3,656
7	((~~4,060~~)) 4,226
8	((~~4,494~~)) 4,677
9	((~~4,927~~)) 5,128
10 or more	((~~5,360~~)) 5,579

(2) For assistance units with shelter provided at no cost:

Assistance unit size	Need standard
1	$ ((~~659~~)) 695
2	((~~833~~)) 880
3	((~~1,029~~)) 1,086
4	((~~1,214~~)) 1,281
5	((~~1,399~~)) 1,477
6	((~~1,585~~)) 1,672
7	((~~1,832~~)) 1,933
8	((~~2,027~~)) 2,139
9	((~~2,223~~)) 2,346
10 or more	((~~2,418~~)) 2,552

WSR 19-20-040
PROPOSED RULES
HEALTH CARE AUTHORITY
(School Employees Benefits Board)

[Admin #2019-02—Filed September 25, 2019, 12:59 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-16-142.

Title of Rule and Other Identifying Information: The following sections in chapter 182-30 WAC are revised: WAC 182-30-090 When may a subscriber change health plans? and 182-30-100 When may a subscriber enroll 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)?

Hearing Location(s): On November 5, 2019, at 10:00 a.m., at the Health Care Authority (HCA), Cherry Street Plaza, Sue Crystal Conference Room 106A, 626 8th Avenue, Olympia, WA 98504. Metered public parking is available street side around building. A map is available at https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: Not sooner than November 6, 2019.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by November 5, 2019.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication relay services 711, email amber.lougheed@hca.wa.gov, by October 22, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA continues to develop rules to implement legislation that created the new school employees' benefits board (SEBB) program. The purpose of this proposal is to amend some of the special open enrollment (SOE) rules.

Making technical amendments to:

- Amended WAC 182-30-090 to add a SOE that allows a subscriber who is changing employment from a SEBB organization to a school district that straddles county lines or is in a county that borders Idaho or Oregon to be able to make new elections. Also added another SOE that states 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;
- Amended WAC 182-30-100 to add a new SOE that allows a subscriber who is changing employment from a SEBB organization to a school district that straddles county lines or is in a county that borders Idaho or Oregon they may be able to make new elections.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: ESSB 6241.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Rob Parkman, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0883; Implementation: Barbara Scott, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0880; and Enforcement: Scott Palafox, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1858.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. These rules do not apply to small businesses.

September 25, 2019
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-090 When may a subscriber change health plans? A subscriber may change health plans at the following times:

(1) **During the annual open enrollment:** A subscriber may change health plans during the school employees benefits board (SEBB) annual open enrollment period. The subscriber must submit the required enrollment forms to change their health plan. A school employee submits the enrollment forms to their SEBB organization. A subscriber on continuation coverage submits the enrollment forms to the SEBB 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:** A subscriber may revoke their health plan election and make a new election outside of the annual open enrollment if a special open enrollment event occurs. A special open enrollment event must be an event other than an employee gaining initial eligibility for SEBB benefits. 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. The forms must be received no later than sixty days after the event occurs. A school employee submits the enrollment forms to their SEBB organization. A subscriber on continuation coverage submits the enrollment forms to the SEBB program. In addition to the required forms, a subscriber 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. 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 state registered 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 the employer contribution toward their employer-based group health plan;

(d) Subscriber has a change in employment from a SEBB organization to a public school that straddles county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available. The subscriber may change their election if the change in employment causes:

(i) The subscriber's current medical plan to no longer be available, in this case the subscriber may select from any available medical plan; or

(ii) The subscriber has one or more new medical plans available, in this case the subscriber may select to enroll in a newly available plan.

(iii) As used in this subsection the term "public school" shall be interpreted to not include charter schools and educational service districts.

(e) The subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

Note: As used in (d) of this subsection 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~~))) (f) 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, otherwise there will be limited network providers and covered services;

Exception: A dental plan is considered available if a provider is available within 50 miles of the new address.

(((~~f~~))) (g) A court order 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~~))) (h) 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~~))) (i) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from medicaid or CHIP;

(((~~i~~))) (j) 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. 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 182-30-085(1);

(k) 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 authority may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

(((~~j~~))) (l) Subscriber or a subscriber's dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the sub-

scriber or the subscriber's dependent. 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 SEBB program determines that a continuity of care issue exists. The SEBB program will consider but not limit its consideration to the following:

(i) Active cancer treatment such as chemotherapy or radiation therapy;

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period; or

(v) Treatment for a high-risk pregnancy.

(3) If the school 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 19-14-093, filed 7/1/19, effective 8/1/19)

WAC 182-30-100 When may a school employee enroll 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)? A school employee who is eligible to participate in the salary reduction plan as described in WAC 182-31-060 may enroll, 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 182-31-040 and enrolling as described in WAC 182-30-080(1).

(2) **During annual open enrollment:** An eligible school employee may elect to enroll in or opt out of participation under the premium payment plan during the annual open enrollment by submitting the required form to their school employees benefits board (SEBB) organization. An eligible school employee may elect to enroll or reenroll in the medical FSA, DCAP, or both during the annual open enrollment by submitting the required forms to their SEBB organization, the HCA or applicable contracted vendor as instructed. 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: School employees enrolled in a high deductible health plan (HDHP) with a health savings account (HSA) cannot also enroll in a medical FSA in the same plan year. School employees who elect both will only be enrolled in the HDHP with a HSA.

(3) **During a special open enrollment:** A school employee who is eligible to participate in the salary reduction plan may enroll or revoke their election and make a new election under the 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 school employee must submit the required form to their SEBB organization. The SEBB organization must receive the required form and evidence of the event that created the special open enrollment no later than sixty days after the event occurs.

For purposes of this section, an eligible dependent includes any person who qualifies as a dependent of the school 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 state registered domestic partner otherwise qualifies as a dependent for tax purposes under IRC 26 U.S.C. Sec. 152.

(a) **Premium payment plan.** A school employee may enroll or 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 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) School employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the school employee;

• Birth, adoption, or when the school employee 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) School employee's dependent no longer meets SEBB eligibility criteria because:

• School employee has a change in marital status;

• School 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) School employee or a school employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by Health Insurance Portability and Accountability Act (HIPAA);

(iv) School employee has a change in employment status that affects the school employee's eligibility for their employer contribution toward their employer-based group health plan;

(v) The school employee's dependent has a change in their own employment status that affects their eligibility for the employer contribution toward 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) School employee or a school 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 SEBB annual open enrollment;

(vii) School employee or a school employee's dependent has a change in residence that affects health plan availability;

(viii) School 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, and that change in residence resulted in the dependent losing their health insurance;

(ix) A court order requires the school employee or any other individual to provide insurance coverage for an eligible dependent of the school employee (a former spouse or former state registered domestic partner is not an eligible dependent);

(x) School employee or a school employee's dependent becomes entitled to coverage under medicaid or a state children's health insurance program (CHIP), or the school employee or a school employee's dependent loses eligibility for coverage under medicaid or CHIP;

(xi) School employee or a school employee's dependent becomes eligible for state premium assistance subsidy for SEBB health plan coverage from medicaid or CHIP;

(xii) School employee or a school employee's dependent becomes entitled to coverage under medicare or the school employee or a school employee's dependent loses eligibility for coverage under medicare;

(xiii) School employee or a school employee's dependent's current health plan becomes unavailable because the school employee or enrolled dependent is no longer eligible for a HSA. The HCA may require evidence that the school employee or a school employee's dependent is no longer eligible for a HSA;

(xiv) School employee or a school employee's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the school employee or a school employee's dependent. The school employee may not change their health plan election if the school employee's or dependent's physician stops participation with the school employee's health plan unless the SEBB program determines that a continuity of care issue exists. The SEBB program will consider but not limit its consideration to the following:

• Active cancer treatment such as chemotherapy or radiation therapy;

• Treatment following a recent organ transplant;

• A scheduled surgery;

• Recent major surgery still within the postoperative period; or

• Treatment for a high-risk pregnancy.

(xv) School employee or school employee's dependent becomes eligible and enrolls in a TRICARE plan, or loses eligibility for a TRICARE plan.

(xvi) Subscriber has a change in employment from a SEBB organization to a public school that straddles county lines or is in a county that borders Idaho or Oregon, which results in the subscriber having different medical plans available. The subscriber may change their election if the change in employment causes:

• The subscriber's current medical plan to no longer be available, in this case the subscriber may select from any available medical plan; or

• The subscriber has one or more new medical plans available, in this case the subscriber may select to enroll in a newly available plan.

• As used in this subsection the term "public school" shall be interpreted to not include charter schools and educational service districts.

If the subscriber 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 FSA.** A school employee may enroll or 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 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 SEBB organization. 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) School employee acquires a new dependent due to:

• Marriage;

• Registering a state registered domestic partnership when the dependent is a tax dependent of the school employee;

• Birth, adoption, or when the school employee 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) School employee's dependent no longer meets SEBB eligibility criteria because:

• School employee has a change in marital status;

• School 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) School employee or a school employee's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by HIPAA;

(iv) School employee or a school employee's dependent has a change in employment status that affects the school employee's or a dependent's eligibility for the medical FSA;

(v) A court order requires the school employee or any other individual to provide insurance coverage for an eligible dependent of the school employee (a former spouse or former state registered domestic partner is not an eligible dependent);

(vi) School employee or a school employee's dependent becomes entitled to coverage under medicaid or CHIP, or the school employee or a school employee's dependent loses eligibility for coverage under medicaid or CHIP;

(vii) School employee or a school employee's dependent becomes entitled to coverage under medicare.

(c) **DCAP.** A school employee may enroll or 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 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 SEBB organization. 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) School employee acquires a new dependent due to:

• Marriage;

• Registering a domestic partnership if the state registered domestic partner qualifies as a tax dependent of the school employee;

• Birth, adoption, or when the school employee 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) School employee or a school employee's dependent has a change in employment status that affects the school employee's or a dependent's eligibility for DCAP;

(iii) School employee or school 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 SEBB annual open enrollment;

(iv) School employee changes dependent care provider; the change to the DCAP election amount can reflect the cost of the new provider;

(v) School employee or school 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) School employee's dependent care provider imposes a change in the cost of dependent care; school 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 school employee as defined in IRC 26 U.S.C. Sec. 152.

WSR 19-20-069
PROPOSED RULES
SEATTLE COLLEGES

[Filed September 26, 2019, 4:44 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-12-018.

Title of Rule and Other Identifying Information: Required and emergency medical leaves of absence.

Hearing Location(s): On November 22, 2019, at 1:00-2:30 p.m., at the Siegal Center, 1st Floor District Boardroom, 1500 Harvard Avenue, Seattle, WA 98122.

Date of Intended Adoption: January 9, 2020.

Submit Written Comments to: Jennie Chen, 1500 Harvard Avenue, Seattle, WA 98122, email jennie.chen@seattlecolleges.edu, fax 206-934-3894.

Assistance for Persons with Disabilities: Contact Jennie Chen, phone 206-934-3873, email jennie.chen@seattlecolleges.edu, by November 8, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This proposed rule addresses a need for the colleges to issue medical withdrawals to students who exhibit self-harm and cannot otherwise be accommodated through the interactive process while attending college.

Reasons Supporting Proposal: The Department of Education's Office for Civil Rights recommends that colleges separate emergency medical leave procedures from the disciplinary procedures.

Statutory Authority for Adoption: RCW 28B.50.140, 28B.50.090(3).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Seattle Colleges, public.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Kurt Buttleman, Siegal Center, 206-934-4111.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 34.05.328.

Explanation of exemptions: Pursuant to RCW 34.05.328 (5)(a)(i), this agency is not an agency mandated to comply with RCW 34.05.328. Further, the agency does not voluntarily make that section applicable to the adoption of this rule pursuant to subsection (5)(a)(ii), and to date, the joint administrative rules review committee has not made the section applicable to the adoption of this rule.

September 26, 2019
Kurt R. Buttleman
Vice Chancellor of
Academic and Student Success

Chapter 132F-126 WAC

REQUIRED AND EMERGENCY MEDICAL LEAVES OF ABSENCE

NEW SECTION

WAC 132F-126-010 Issuing a required medical leave of absence. (1) The vice president of student services, or the vice president's designee, (hereinafter collectively referred to as the "vice president") may require a student to take a medical leave of absence if a student has a physical illness or a mental, emotional, or psychological condition and as a result of the condition:

(a) Is engaging in, or is threatening to engage in, behavior that poses a significant danger of causing substantial harm to the health, safety, or welfare of the student or others;

(b) The student's behavior has resulted in substantial harm to the health, safety, or welfare of the student or others and the behavior continues, or there is a risk the behavior will continue, posing a significant danger of causing substantial harm to the health, safety, or welfare of the student or others; or

(c) The student's behavior has resulted in significant disruption of the teaching, learning or administrative activities of other members of the campus community and the behavior continues, or there is a risk the behavior will continue, with the likely result of such behavior substantially impeding the education processes or proper activities or functions of the college and its personnel.

(2) In determining whether to require a student to take a medical leave of absence, the vice president shall consult with counseling faculty and, where possible, other persons who can provide relevant information about a student's condition.

(3) Prior to the vice president requiring a student to take a medical leave of absence, the student shall be provided an opportunity to present information about his or her circumstances, where reasonably possible, to the vice president. A student waives their opportunity to provide information if he or she is unwilling or unable to meet with the vice president upon request.

(4) The vice president shall issue the required medical leave of absence in writing to the student. The written notice shall include the effective date of the leave, the reasons for requiring the leave, the conditions for reenrollment, and any restrictions imposed on the student's access to the campus or college-sponsored activities.

(5) The required medical leave of absence shall be effective twenty-one days after it is served on the student, unless the student files an appeal.

NEW SECTION

WAC 132F-126-020 Appealing a required medical leave of absence. A student may appeal the vice president's decision imposing a required medical leave of absence to the medical leave of absence review board (review board). The appeal must be filed in writing with the vice president of student services within twenty days of service of the vice president's decision. Service of the vice president's decision shall be complete upon deposit in the United States mail to the student, postage prepaid and properly addressed to the student at the last known address on file with the registrar's office, or by personal service on the student.

NEW SECTION

WAC 132F-126-030 Hearing an appeal of a required medical leave of absence. (1) Upon receipt of a timely appeal by a student of the vice president's decision imposing a required medical leave of absence, the vice president of student services, or the vice president's designee, shall convene the review board to hear the appeal. The review board may:

(a) Affirm the vice president's decision;

(b) Affirm the vice president's decision but alter the disposition from imposition of a required medical leave of absence to conditional enrollment under specified directives; or

(c) Reverse the vice president's decision allowing the student to remain enrolled without restriction.

(2) The review board's decision shall be in writing and served on the student within seven business days of the hearing. Service of the decision shall be effective upon deposit in the United States mail to the student, postage prepaid and properly addressed to the student at the last known address on file with the registrar's office, or by personal service on the student.

(3) The review board shall be composed of at least three members drawn from a pool of academic deans and staff members not reporting to the vice president who have been identified by the president. The president shall select one of the members to act as the chair at the hearing.

(4) The vice president shall notify the student in writing of the time, date, and location of the hearing.

(5) The review board shall conduct the hearing according to the Administrative Procedure Act, chapter 34.05 RCW.

(6) The chair of the review board may order the hearing closed to public observation as necessary to protect from disclosure medical or educational records held to be confidential under state or federal law.

NEW SECTION

WAC 132F-126-040 President's review and final college order. (1) The college president shall review the record and enter the final college order, in accordance with RCW 34.05.461(2) and 34.05.464.

(2) If either the respondent or the vice president for student services wishes to file written argument with the president, she/he must file that argument and serve a copy on the other within fifteen days after service of the review board's order. Within seven days after service of any such argument, the other party may file and serve a written response. The president shall have discretion to modify these deadlines and/or to allow oral arguments. However no new evidence, not already part of the record, may be introduced in any argument, except as expressly authorized by the president upon a showing of compelling legal justification and after any appropriate fact-finding.

(3) The president shall personally consider the whole record or such portions of it as may be cited by the parties. A

party's failure to present any argument shall mean that the party is citing "none" of the record.

(4) Within ninety days following the later of the conclusion of the hearing or the review board's receipt of closing arguments, the president shall either remand the matter for further proceedings, with instructions to the review board, or enter a final order in the matter. The president shall have all of the decision-making power that he/she would have had if presiding over the hearing, including the power to affirm, reverse, or modify the review board's decision.

(5) The president's final order shall include, or incorporate by reference to the review board's initial order, all matters required by RCW 34.05.461, and in accordance with RCW 34.05.464. It shall also include notice to the respondent of his/her right to seek judicial review under RCW 34.05.510 et seq.

(6) Copies of the final order shall be served on the respondent, the vice president, any legal counsel who have appeared, and the review board's chair.

(7) The decision of the president shall be the final district action in the matter.

NEW SECTION

WAC 132F-126-050 Emergency medical leave of absence. (1) The vice president may immediately require a student to take an emergency medical leave of absence if the student has a medical, mental, emotional, or psychological condition and as a result of the condition:

(a) The student is engaging in, or threatening to engage in, behavior that poses a significant danger of causing imminent and substantial harm to the health, safety, or welfare of the student or others; or

(b) The student's behavior has resulted in substantial harm to the health, safety, or welfare of the student or others and the behavior continues, or there is a risk the behavior will continue, posing a significant danger of causing imminent and substantial harm to the health, safety, or welfare of the student or others; or

(c) The student's behavior has resulted in significant disruption of the teaching, learning or administrative activities of other members of the campus community and the behavior continues, or there is a risk the behavior will continue, with the likely result of such behavior imminently and substantially impeding the education processes or proper activities or functions of the college and its personnel.

(2) A decision by the vice president requiring a student to take an emergency medical leave of absence shall be in writing and served on the student. The decision shall set forth the reasons for requiring the leave and, as appropriate, any restrictions imposed on the student's access to the campus or college-sponsored activities. Service of the decision shall be effective upon deposit in the United States mail to the student, postage prepaid and properly addressed to the student at the last known address on file with the registrar's office, or by personal service on the student.

(3) A student subject to an emergency medical leave of absence shall be provided a hearing before a presiding officer appointed by the college president to review the vice president's decision. The hearing shall occur within three business days of the student being served with the vice president's decision imposing the emergency medical leave of absence unless a student elects to waive his or her right to a hearing. Except as otherwise provided herein, the process for conducting the emergency medical leave hearing shall be pursuant to the Administrative Procedure Act, chapter 34.05 RCW.

(4) An emergency medical leave of absence shall take effect immediately and remain in effect until the review board or president reinstate the student. The vice president may at any time decide to reinstate the student under an emergency medical leave when the vice president determines that the reasons for the emergency medical leave of absence no longer exist.

NEW SECTION

WAC 132F-126-060 Returning from a required or emergency leave of absence. (1) A student wishing to be considered for reenrollment to the college shall submit an application for reenrollment to the vice president at least one month prior to the start of the quarter in which the student wishes to reenroll. The student shall provide appropriate documentation with any conditions for reenrollment set forth in the vice president's decision. If a student files an appeal of the vice president's decision, and the conditions for reenrollment are modified by the review board, the student shall provide evidence that the conditions set forth in the review board's order have been met. A student must also meet all other admission or enrollment requirements of the college for reenrollment.

(2) The vice president shall consult with counseling faculty and, where possible, other persons who can provide relevant information about a student's condition prior to determining if the student may reenroll.

(3) The vice president shall notify the student in writing of the decision and the conditions associated with the approval or denial for reenrollment.

WSR 19-20-083
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed September 30, 2019, 9:14 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-13-059.

Title of Rule and Other Identifying Information: WAC 182-511-1000 Health care for workers with disabilities (HWD)—Program description, 182-511-1050 HWD—Program requirements, 182-511-1060 HWD—Income standard based on the federal poverty guidelines, 182-511-1100 HWD—Retroactive coverage, 182-511-1150 HWD—Disability requirements, 182-511-1200 HWD—Employment requirements, 182-511-1250 HWD—Premium payments, and 182-512-0550 SSI-related medical—All other excluded resources.

Hearing Location(s): On November 5, 2019, at 10:00 a.m., at the Health Care Authority (HCA), Cherry Street Plaza, Sue Crystal Room 106A, 626 8th Avenue, Olympia,

WA 98504. Metered public parking is available street side around building. A map is available at https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: Not sooner than November 6, 2019.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by November 5, 2019.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication relay services 711, email amber.lougheed@hca.wa.gov, by October 25, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is revising these rules to comply with the requirements of SHB 1199. Specifically, the following changes are being made:

WAC 182-511-1000, this rule is being amended to clarify that HWD coverage may provide access to long-term services and supports (LTSS), and that approval for LTSS also includes a determination of functional eligibility. If an enrollee is approved for both, then they may choose between paying a monthly premium for HWD or participating in the cost of care according to rules that apply to the specific LTSS program.

WAC 182-511-1050, this rule is being amended to remove the income and age limit.

WAC 182-511-1060, this rule is being repealed as it is no longer applicable. Effective January 1, 2020, there is no income limit.

WAC 182-511-1100, this rule is being amended to allow for the approval of any one month of retroactive coverage for which the full premium amount is paid in advance.

WAC 182-511-1150, this rule is being amended to clarify the disability determination for HWD coverage, including requirements that apply to people who are sixty-five years or older. Statutory authority of the Balanced Budget Act of 1997 is added, which allows people who are sixty-five years or older to enroll, if they meet all program requirements that include having blindness or a disability.

WAC 182-511-1200, this rule is being amended to clarify work activity that meets program requirements for people who are self-employed.

WAC 182-511-1250, this rule is being amended to clarify that the monthly premium amount shall not exceed 7.5 percent of countable income. Also, to allow payment for retroactive coverage, if paid separately, to be applied before payment for a current coverage month.

WAC 182-512-0550, this rule is being amended to exclude as a resource the funds held in a separate account that include only the income of a client earned during the time of enrollment in HWD. If the account is maintained separately, its value shall be excluded as a resource when determining the client's subsequent eligibility for another medical assistance program.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; SHB 1199 (chapter 70, Laws of 2019).

Statute Being Implemented: RCW 41.05.021, 41.05.160; SHB 1199 (chapter 70, Laws of 2019).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Valerie Smith, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1344; Implementation and Enforcement: Stephen Kozak, P.O. Box 45534, Olympia, WA 98504-5534, 360-725-1343.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The proposed rule pertains to clients and therefore does not impose any costs on businesses.

September 30, 2019
Wendy Barcus
Rules Coordinator

Chapter 182-511 WAC

((~~HEALTH CARE~~)) APPLE HEALTH FOR WORKERS WITH DISABILITIES (HWD)

AMENDATORY SECTION (Amending WSR 15-14-080, filed 6/29/15, effective 7/30/15)

WAC 182-511-1000 Apple health ((~~care~~)) for workers with disabilities (HWD)—Program description. This section describes the apple health ((~~care~~)) for workers with disabilities (HWD) program.

(1) The HWD program provides categorically needy (CN) scope of care as described in WAC 182-501-0060.

(2) The HWD program also provides long-term services and supports described in chapters 182-513 and 182-515 WAC for a client who meets the functional requirements for those programs, are approved for those services, and choose to enroll in HWD.

(3) The medicaid agency approves HWD coverage for twelve months effective the first of the month in which a person applies and meets program requirements. See WAC 182-511-1100 for ((")retroactive((")) coverage for months before the month of application.

(((~~(3)~~))) (4) A person who is eligible for another medicaid program may choose not to participate in the HWD program.

(((~~(4)~~))) (5) A person is not eligible for HWD coverage for a month in which the person received medicaid benefits under the medically needy (MN) program.

(((~~(5) The HWD program does not provide long-term care (LTC) services described in chapters 182-513 and 182-515 WAC. LTC services include institutional, waivered, and hospice services. To receive LTC services, a person must qualify and participate in the cost of care according to the rules of those programs.~~)))

AMENDATORY SECTION (Amending WSR 15-14-080, filed 6/29/15, effective 7/30/15)

WAC 182-511-1050 Apple health ((~~care~~)) for workers with disabilities (HWD)—Program requirements. This section describes requirements a person must meet to be eligible for the apple health ((~~care~~)) for workers with disabilities (HWD) program.

(1) To qualify for the HWD program, a person must:

(a) Meet the general requirements for a medical program described in WAC 182-503-0505 (3)(a) through (f);

(b) Be at least age sixteen ((~~through sixty-four~~));

(c) Meet the federal disability requirements described in WAC 182-511-1150; and

(d) ((~~Have net income at or below two hundred twenty percent of the federal poverty level (FPL) (see WAC 182-511-1060 for FPL amounts for medical programs); and~~

~~(e)~~)) Be employed full or part time (including self-employment) as described in WAC 182-511-1200.

(2) ((~~To determine net income, the medicaid agency applies the following rules to total gross household income in this order:~~

~~(a) Deduct income exclusions described in WAC 182-512-0800, 182-512-0820, 182-512-0840, and 182-512-0860; and~~

~~(b) Follow the CN income rules described in:~~

~~(i) WAC 182-512-0600, SSI-related medical—Definition of income;~~

~~(ii) WAC 182-512-0650, SSI-related medical—Available income;~~

~~(iii) WAC 182-512-0700 (1) through (5), SSI related medical—Income eligibility;~~

~~(iv) WAC 182-512-0750, SSI-related medical—Countable unearned income; and~~

~~(v) WAC 182-512-0960, SSI related medical clients.~~

~~(3)~~)) The HWD program does not require ((~~an asset~~)) a resource test.

(((~~(4)~~))) (3) Once approved for HWD coverage, a person must pay the monthly premium in ((~~the following manner to continue to qualify for the program:~~)) order to continue to qualify.

(a) The agency calculates the premium for HWD coverage according to WAC 182-511-1250((~~;~~)).

(b) If a person does not pay four consecutive monthly premiums, the person is not eligible for HWD coverage for the next four months and must pay all premium amounts owed before HWD coverage can be approved again((~~; and~~)).

(c) Once approved for HWD coverage, a person who experiences a job loss can choose to continue HWD coverage through the original twelve months of eligibility, if the following requirements are met:

(i) The job loss results from an involuntary dismissal or health crisis; and

(ii) The person continues to pay the monthly premium.

AMENDATORY SECTION (Amending WSR 15-14-080, filed 6/29/15, effective 7/30/15)

WAC 182-511-1100 Apple health ((~~care~~)) for workers with disabilities (HWD)—Retroactive coverage. This section describes requirements for retroactive coverage provided under the apple health ((~~care~~)) for workers with disabilities (HWD) program.

(1) Retroactive coverage refers to the period of up to three months before the month in which a person applies for the HWD program. ((~~The medicaid agency cannot approve HWD coverage for a month that precedes January 1, 2002.~~))

(2) To qualify for retroactive coverage under the HWD program, a person must first:

(a) Meet all program requirements described in WAC 182-511-1050 for each month of the retroactive period; and

(b) Pay the premium amount for each month requested within one hundred twenty days of being billed for such coverage.

(3) ((~~If a person does not pay premiums in full as described in subsection (2)(b) for all months requested in the retroactive period, the agency denies retroactive coverage and refunds any payment received for those months.~~)) Payment must be received for each month requested of retroactive coverage before such coverage is approved.

AMENDATORY SECTION (Amending WSR 19-08-025, filed 3/27/19, effective 4/27/19)

WAC 182-511-1150 Apple health ((~~care~~)) for workers with disabilities (HWD)—Disability requirements. This section describes the disability requirements for the ((~~two~~)) following groups of individuals ((~~that~~)) who may qualify for the apple health ((~~care~~)) for workers with disabilities (HWD) program.

(1) ((~~To qualify for the HWD program,~~)) A person age sixteen through age sixty-four must meet the requirements of the Social Security Act in section 1902 (a)(10)(A)(ii):

(a) (XV) for the basic coverage group (BCG); or

(b) (XVI) for the medical improvement group (MIG).

(2) The BCG consists of individuals who:

(a) Meet federal disability requirements for the supplemental security income (SSI) or Social Security Disability Insurance (SSDI) program; or

(b) Are determined by the department of social and health services (DSHS), division of disability determination services (DDDS), to meet federal disability requirements for the HWD program.

(3) The MIG consists of individuals who:

(a) Were previously eligible and approved for the HWD program as a member of the BCG; and

(b) Are determined by DDDS to have a medically improved disability. The term "medically improved disability" refers to the particular status granted to persons described in subsection (1)(b). For these people, a continuation of HWD coverage is provided to help them maintain their employment.

(4) A person age sixty-five or older, must meet federal disability requirements as determined by the DSHS DDDS. Coverage under the MIG is not available under federal law for persons age sixty-five or older. Coverage for this age group is authorized under the Balanced Budget Act of 1997 as described under section 1902 (a)(10)(A)(ii)(XIII).

(5) When completing a disability determination for the HWD program, DDDS will not ((~~deny disability status because of employment~~)) determine a person not disabled

based only on earnings or the performance of substantial gainful activity (SGA). (See SSA POMS Section DI 10501.001, https://secure.ssa.gov/apps10/poms.nsf/lnx/0410501001).

AMENDATORY SECTION (Amending WSR 11-24-018, filed 11/29/11, effective 12/1/11)

WAC 182-511-1200 Apple health ((~~care~~)) for workers with disabilities (HWD)—Employment requirements. This section describes the employment requirements for the basic coverage group (BCG) and the medical improvement group (MIG) for the apple health ((~~care~~)) for workers with disabilities (HWD) program.

(1) For the purpose of the HWD program, employment means a person:

(a) Gets paid for working;

(b) Has earnings that are subject to federal income tax; and

(c) Has payroll taxes taken out of earnings received, unless self-employed.

(2) To qualify for HWD coverage as a member of the BCG, a person must be employed full or part time.

(3) To qualify for HWD coverage as a member of the MIG, a person must be:

(a) Working at least forty hours per month; and

(b) Earning at least the local minimum wage as described under section 6 of the Fair Labor Standards Act (29 U.S.C. 206).

(4) For a person who is self-employed, the examples described in the *Social Security Administration Program Operations Manual System (POMS)* provide guidance when determining whether someone meets the HWD work requirements. (See SSA POMS Section SI 00820.200, http://secure.ssa.gov/poms.nsf/lnx/0500820200). The guidelines described in POMS for determining the existence of a trade or business may also be used when making this determination. (See SSA POMS Section RS 01802.010, https://secure.ssa.gov/apps10/poms.nsf/lnx/0301802010).

AMENDATORY SECTION (Amending WSR 15-14-080, filed 6/29/15, effective 7/30/15)

WAC 182-511-1250 Apple health ((~~care~~)) for workers with disabilities (HWD)—Premium payments. This section describes how the medicaid agency calculates the premium amount a person must pay for apple health ((~~care~~)) for workers with disabilities (HWD) coverage. This section also describes program requirements regarding the billing and payment of HWD premiums.

(1) When determining the HWD premium amount, the agency counts only the income of the person approved for the program. It does not count the income of another household member.

(2) When determining countable income used to calculate the HWD premium, the agency applies the following rules:

(a) Income is considered available and owned when it is:

(i) Received; and

(ii) Can be used to meet the person's needs for food, clothing, and shelter, except as described in WAC 182-512-0600(5), 182-512-0650, and 182-512-0700(1).

(b) ((~~Loans and certain other~~)) Certain receipts are not ((~~considered to be~~)) income as described in 20 C.F.R. Sec. 416.1103((~~, e.g., direct payment by anyone of a person's medical insurance premium or a tax refund on income taxes already paid~~)).

(3) The HWD premium amount equals the lesser of the two following amounts:

(a) A total of the following (rounded down to the nearest whole dollar):

(((~~(a)~~))) (i) Fifty percent of unearned income above the medically needy income level (MNIL) described in WAC 182-519-0050; plus

(((~~(b)~~))) (ii) Five percent of total unearned income; plus

(((~~(c)~~))) (iii) Two ((~~point five~~)) and one-half percent of earned income after first deducting sixty-five dollars; or

(b) Seven and one-half percent of countable income described in subsection (2) of this section, including both earned and unearned income.

(4) When determining the premium amount, the agency will use the ((~~current~~)) currently verified income amount until a change in income is reported and processed, unless good cause for delay in verifying changes exists.

(5) A change in the premium amount is effective the month after the change in income is reported and processed.

(6) For current and ongoing coverage, the agency will bill for HWD premiums during the month following the benefit month ((~~in which coverage is approved~~)).

(7) For retroactive coverage, the agency will bill the HWD premiums during the month following the month in which coverage is requested and necessary information ((~~is received~~)) that establishes eligibility is received by the agency.

(8) If initial coverage for the HWD program is approved in a month that follows the month of application, the first monthly premium includes the costs for both the month of application and any following ((~~month(s)~~)) months that have passed during determination of eligibility.

(9) As described in WAC 182-511-1050 (4)(b), the agency will close HWD coverage ((~~after four consecutive months for which premiums are not paid in full.~~

~~(10) If a person makes only a partial payment toward the cost of HWD coverage for any one month, the person remains one full month behind in the payment schedule.~~

~~(11) The agency first applies payment for current and ongoing coverage to any amount owed for such coverage in an earlier month. Then it applies payment to the current month and then to any unpaid amount for retroactive coverage~~)) if premiums are not paid in full for four consecutive months.

(10) The person must pay the monthly premium in full to avoid losing HWD coverage. If a person makes a partial payment, the payment does not count as a full payment toward the premium.

(11) Payments received are applied to premiums owed in the following order:

(a) If retroactive coverage is requested, the retroactive coverage month(s);

(b) Past due months, beginning with the most delinquent month;

(c) The current coverage month that has been invoiced; then

(d) Future coverage months.

(12) A person must pay a premium for any month that HWD coverage is provided. This includes months when a redetermination of coverage is made, and months when continued coverage that is requested, pending the outcome of an administrative hearing.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-511-1060	Washington apple health—Health care for workers with disabilities (HWD)—Income standard based on the federal poverty guidelines.

AMENDATORY SECTION (Amending WSR 19-13-010, filed 6/6/19, effective 7/7/19)

WAC 182-512-0550 SSI-related medical—All other excluded resources. All resources described in this section are excluded resources for SSI-related medical programs. Unless otherwise stated, interest earned on the resource amount is counted as unearned income.

(1) Resources necessary for a person who is blind or disabled to fulfill a self-sufficiency plan approved by the agency.

(2) Retroactive payments from SSI or old age, survivors, and disability insurance (OASDI), including benefits a person receives under the interim assistance reimbursement agreement with the Social Security Administration, are excluded for nine months following the month of receipt. This exclusion applies to:

(a) Payments received by the person, the person's spouse, or any other person financially responsible for the person;

(b) SSI payments for benefits due for the month(s) before the month of continuing payment;

(c) OASDI payments for benefits due for a month that is two or more months before the month of continuing payment; and

(d) Proceeds from these payments as long as they are held as cash, or in a checking or savings account. The funds may be commingled with other funds, but must remain identifiable from the other funds for this exclusion to apply. This exclusion does not apply once the payments have been converted to any other type of resource.

(3) All resources specifically excluded by federal law, such as those described in subsections (4) through (11) of this section as long as such funds are identifiable.

(4) Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

(5) The excluded resources described in WAC 182-512-0770 and other resources of American Indians/Alaska Natives that are excluded by federal law.

(6) Restitution payment and any interest earned from this payment to persons of Japanese or Aleut ancestry who were relocated and interned during war time under the Civil Liberties Act of 1988 and the Aleutian and Pribilof Islands Restitution Act.

(7) Funds received from the Agent Orange Settlement Fund or any other funds established to settle Agent Orange liability claims.

(8) Payments or interest accrued on payments received under the Radiation Exposure Compensation Act received by the injured person, the surviving spouse, children, grandchildren, or grandparents.

(9) Payments or interest accrued on payments received under the Energy Employees Occupational Illness Compensation Act of 2000 (EEOICA) received by the injured person, the surviving spouse, children, grandchildren, or grandparents.

(10) Payments from:

(a) The Dutch government under the Netherlands' Act on Benefits for Victims of Persecution (WUV).

(b) The Victims of Nazi Persecution Act of 1994 to survivors of the Holocaust.

(c) Susan Walker vs. Bayer Corporation, et al., 96-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds.

(d) Ricky Ray Hemophilia Relief Fund Act of 1998 P.L. 105-369.

(11) The unspent social insurance payments received due to wage credits granted under sections 500 through 506 of the Austrian General Social Insurance Act.

(12) Tax refunds and earned income tax credit refunds and payments are excluded as resources for twelve months after the month of receipt.

(13) Payments from a state administered victim's compensation program for a period of nine calendar months after the month of receipt.

(14) Cash or in-kind items received as a settlement for the purpose of repairing or replacing a specific excluded resource are excluded:

(a) For nine months. This includes relocation assistance provided by state or local government.

(b) Up to a maximum of thirty months, when:

(i) The person intends to repair or replace the excluded resource; and

(ii) Circumstances beyond the control of the settlement recipient prevented the repair or replacement of the excluded resource within the first or second nine months of receipt of the settlement.

(c) For an indefinite period, if the settlement is from federal relocation assistance.

(d) Permanently, if the settlement is assistance received under the Disaster Relief and Emergency Assistance Act or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States, or is comparable assistance

received from a state or local government or from a disaster assistance organization. Interest earned on this assistance is also excluded from resources. Any cash or in-kind items received as a settlement and excluded under this subsection are available resources when not used within the allowable time periods.

(15) Insurance proceeds or other assets recovered by a Holocaust survivor.

(16) Pension funds owned by an ineligible spouse. Pension funds are defined as funds held in a(n):

(a) Individual retirement account (IRA) as described by the IRS code; or

(b) Work-related pension plan (including plans for self-employed persons, known as Keogh plans).

(17) Cash payments received from a medical or social service agency to pay for medical or social services are excluded for one calendar month following the month of receipt.

(18) SSA- or division of vocational rehabilitation (DVR)-approved plans for achieving self-support (PASS) accounts, allowing blind or disabled persons to set aside resources necessary for the achievement of the plan's goals, are excluded.

(19) Food and nutrition programs with federal involvement. This includes Washington Basic Food, school reduced and free meals and milk programs and WIC.

(20) Gifts to, or for the benefit of, a person under eighteen years old who has a life-threatening condition, from an organization described in section 501 (c)(3) of the Internal Revenue Code of 1986 which is exempt from taxation under section 501(a) of that code, as follows:

(a) In-kind gifts that are not converted to cash; or

(b) Cash gifts up to a total of two thousand dollars in a calendar year.

(21) Veteran's payments made to, or on behalf of, natural children of Vietnam veterans regardless of their age or marital status, for any disability resulting from spina bifida suffered by these children.

(22) The following are among assets that are not resources and as such are neither excluded nor counted:

(a) Home energy assistance/support and maintenance assistance;

(b) Retroactive in-home supportive services payments to ineligible spouses and parents; and

(c) Gifts of domestic travel tickets.

(23) ((~~For a more complete list, please see the program operations manual system (POMS) at http://policy.ssa.gov/poms.nsf/lnx/0501130050.~~)) Resources accumulated in a separate account, designated by the client, that result from work activity during the client's enrollment in apple health for workers with disabilities (HWD) program under chapter 182-511 WAC.

(24) Resources listed in the program operations manual system (POMS), not otherwise excluded under this section, are excluded (see SSA POMS Section SI 01130.050 http://secure.ssa.gov/apps10/poms.nsf/lnx/0501130050).

WSR 19-20-093
PROPOSED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Aging and Long-Term Support Administration)

[Filed October 1, 2019, 8:59 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-15-104.

Title of Rule and Other Identifying Information: The department is proposing to create WAC 388-101-3120 Certification fees, to establish rules for the collection and enforcement of annual certification fees as authorized by SB 5359 (chapter 458, Laws of 2019).

Hearing Location(s): On November 5, 2019, at 10:00 a.m., at Office Building 2, Department of Social and Health Services (DSHS) Headquarters, 1115 Washington, Olympia, WA 98504. Public parking at 11th and Jefferson. A map is available at https://www.dshs.wa.gov/sesa/rules-and-policies-assistance-unit/driving-directions-office-bldg-2.

Date of Intended Adoption: Not earlier than November 6, 2019.

Submit Written Comments to: DSHS Rules Coordinator, P.O. Box 45850, Olympia, WA 98504, email DSHSRPAU RulesCoordinator@dshs.wa.gov, fax 360-664-6185, by 5:00 p.m., November 5, 2019.

Assistance for Persons with Disabilities: Jeff Kildahl, DSHS rules consultant, phone 360-664-6092, fax 360-664-6185, TTY 711 relay service, email Kildaja@dshs.wa.gov, by October 22, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: SB 5359 was enacted during the 2019 legislative session. The bill authorizes the department to collect an annual certification fee from certified community residential services and supports providers. The proposed rule would outline the collection and enforcement of the fees. There are currently no existing rules addressing the collection of certification fees.

Reasons Supporting Proposal: See purpose statement above.

Statutory Authority for Adoption: Chapter 71A.12 RCW; RCW 71A.12.030.

Statute Being Implemented: Chapter 71A.12 RCW; RCW 71A.12.030.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: DSHS, governmental.

Name of Agency Personnel Responsible for Drafting: Antonietta Lettieri-Parkin, P.O. Box 45600, Olympia, WA 98504, 509-227-2474; Implementation: Candace Goehring, P.O. Box 45600, Olympia, WA 98504, 360-725-2401; and Enforcement: Loida Baniqued, P.O. Box 45600, Olympia, WA 98504, 360-725-2405.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The rule does not meet the definition of significant legislative rule under RCW 34.05.328.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rule content is explicitly and specifically dictated by statute.

Is exempt under SB 5359 (chapter 458, Laws of 2019).

September 26, 2019
Katherine I. Vasquez
Rules Coordinator

NEW SECTION

WAC 388-101-3120 Certification fees. The certified community residential services and supports provider must submit an annual certification fee. If the provider fails to pay the annual certification fee, the department may impose remedies outlined in WAC 388-101-4175.

WSR 19-20-094
PROPOSED RULES
DEPARTMENT OF HEALTH
(Occupational Therapy Practice Board)
[Filed October 1, 2019, 10:07 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-22-117.

Title of Rule and Other Identifying Information: WAC 246-847-067, the occupational therapy practice board (board) proposes to create a new section to establish licensing requirements for applicants with a license that has expired in another state.

Hearing Location(s): On November 8, 2019, at 9:10 a.m., at the Department of Health, Town Center 2, Room 145, 111 Israel Road S.E., Tumwater, WA 98501.

Date of Intended Adoption: November 8, 2019.

Submit Written Comments to: Kathy Weed, P.O. Box 47852, Olympia, WA 9854-7852 [98504-7852], email https://fortress.wa.gov/doh/policyreview, fax 360-236-2901, by November 7, 2019.

Assistance for Persons with Disabilities: Contact Kathy Weed, phone 360-236-4883, fax 360-236-2901, TTY 360-833-6388 or 711, email kathy.weed@doh.wa.gov, by November 1, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rule creates requirements for applicant[s] with expired credentials in another state that seek Washington licensure. Proposed rule language is clear and will assist the board in quickly evaluating individual portfolios and expedite the application process.

Reasons Supporting Proposal: This route to licensure was inadvertently deleted during previous rule making in August 2018 under WSR 18-09-032. To ensure this route to licensure is still available, rule making is required. Rule making establishes enforceable licensing requirements and a safety mechanism for patients receiving occupational therapy services. These mechanisms ensure competence, appropriate education, and training for applicants that have not been actively practicing for an extended period of time.

Statutory Authority for Adoption: RCW 18.59.130.

Statute Being Implemented: RCW 18.59.130.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of health, occupational therapy practice board, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Kathy Weed, 111 Israel Road S.E., Tumwater, WA 98504, 360-236-4883.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Kathy Weed, P.O. Box 47852, Olympia, WA 98501, phone 360-236-4883, fax 360-236-2901, TTY 360-833-6388 or 711, email kathy.weed@doh.wa.gov.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The proposed rule does not impose costs on businesses.

October 1, 2019
Sheryl Zylstra, OT, Chair
Occupational Therapy Practice Board

NEW SECTION

WAC 246-847-067 Initial application for individuals who have an expired license in a different state and are seeking Washington licensure. (1) An initial applicant with an expired license in a different state who has not practiced for less than three years must comply with the requirements for licensure as specified in chapter 18.59 RCW and this chapter.

(2) An initial applicant with an expired license in a different state who has not practiced for three or more years but less than five years from date of application must comply with the requirements for licensure as specified in chapter 18.59 RCW and this chapter and submit proof to the department of:

(a) Completion of thirty hours of continued competency as described in WAC 246-847-065 for the previous two-year period; and

(b) Completion of any additional requirements as required by the board.

(3) An initial applicant with an expired license in a different state who has not practiced for five or more years from date of application must comply with the requirements for licensure as specified in chapter 18.59 RCW and this chapter and submit proof to the department of:

(a) Completion of thirty hours of continued competency as described in WAC 246-847-065 for the previous two-year period;

(b) Completion of a board-approved reentry program; and

(c) In addition to these requirements, the applicant has the choice of:

(i) Completion of extended course work preapproved by the board; or

(ii) Successfully retaking and passing the examinations specified in WAC 246-847-080.

(d) Completion of any additional requirements as required by the board.

(4) The applicant may be required to appear before the board for oral interview.

WSR 19-20-109
PROPOSED RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. 2016-05—Filed October 2, 2019, 9:37 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 16-07-083.

Title of Rule and Other Identifying Information: Title insurance agent escrow practices and accounts.

Hearing Location(s): On November 15, 2019, at 9:00 a.m., at the Office of the Insurance Commissioner (OIC), 5000 Capitol Boulevard S.E., Tumwater, WA 98501.

Date of Intended Adoption: November 27, 2019.

Submit Written Comments to: Tabba Alam, P.O. Box 40260, Olympia, WA 98504-0260, email rulescoordinator@oic.wa.gov, fax 360-586-3109.

Assistance for Persons with Disabilities: Melanie Watness, phone 360-725-7013, fax 360-586-2023, TTY 360-586-0241.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Independent escrow agents are currently licensed by the department of financial institutions (DFI) and are subject to extensive rules and regulations by DFI, from which title insurance companies are exempt. The commissioner seeks to adopt similar rules regulating the escrow practices of title insurance agents.

Reasons Supporting Proposal: Title insurance agents and independent escrow agents, who perform the same duties as escrow agents, should be subject to the same regulatory oversight by state agencies.

Statutory Authority for Adoption: RCW 48.02.060 and 48.29.005.

Statute Being Implemented: RCW 48.29.005 and 48.29.015.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Tabba Alam, P.O. Box 40260, Olympia, WA 98504-0260, 360-725-7170; Implementation: Jeff Baughman, P.O. Box 40260, Olympia, WA 98504-0260, 360-725-7156; and Enforcement: Melanie Anderson, P.O. Box 40260, Olympia, WA 98504-0260, 360-725-7000.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Tabba Alam, P.O. Box 40260, Olympia, WA, 98504-0260, phone 360-725-7170, email tabbaa@oic.wa.gov.

The proposed rule does impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. Based on its cost-benefit analysis, OIC determined that there were not more-than-minor costs associated with adopting these rules.

A copy of the statement may be obtained by contacting Tabba Alam, P.O. Box 45378, Olympia, WA 98504, phone 360-725-7170, email tabbaa@oic.wa.gov.

October 2, 2019
Mike Kreidler
Insurance Commissioner

NEW SECTION

WAC 284-29-300 Definitions. For purposes of WAC 284-29-300 through 284-29-340:

(1) "Closing" means the process of completing a real estate transaction in accordance with the written escrow instructions of the principle parties during which: Deeds, deeds of trust, mortgages, leases, and other required documents are either executed or delivered, or both; an accounting between the parties is made; the funds are disbursed; and the appropriate documents are recorded.

(2) "Escrow" has the meaning set forth in RCW 18.44.011(7).

(3) "Escrow agent" has the meaning set forth in RCW 18.44.011(8).

(4) "Escrow instructions" are the instructions, signed by the principal parties to the transaction, that identify the duties and responsibilities of the title insurance agent in carrying out the escrow, that identify the thing or things of value held by the title insurance agent, and the specified condition or set of conditions under which the thing or things of value are to be transferred.

(5) "Escrow trust account" means an account to hold funds in trust for third parties.

(6) "Federally insured financial institution" means a financial institution that has its deposits insured by an instrumentality of the federal government, including the Federal Deposit Insurance Corporation (FDIC), Federal Savings and Loan Insurance Corporation (FSLIC) and National Credit Union Administration (NCUA).

(7) "Positive pay" or "reverse positive pay" means any system by which the authenticity of a check is determined before payment is made by the financial institution against which the check is drawn.

(8) "Trial balance" means a list of all open individual escrow ledger record balances at the end of the reconciliation period.

(9) "Three-way reconciliation" means a method for discovering shortages (intentional or otherwise), charges that must be reimbursed or any type of errors or omissions that must be corrected in relation to an escrow trust account.

(10) "Unclaimed fund" means any fund that is abandoned under the Uniform Unclaimed Property Act, chapter 63.29 RCW.

NEW SECTION

WAC 284-29-310 Title insurance agent employment restrictions. A title insurance agent must not, without the written consent of the commissioner, employ any person that has been convicted of, or plead no contest to either:

(1) A felony involving dishonesty or a breach of trust within the last ten years; or

(2) A gross misdemeanor involving theft, fraud, forgery, embezzlement or the mishandling of funds, within the last year.

NEW SECTION

WAC 284-29-320 Title insurance agent escrow records. Under RCW 48.29.190 title insurance agents are required to keep adequate records of all transactions handled by the title insurance agent. These records must be in an organized form and must include and conform with the following requirements:

(1) An individual ledger for each escrow trust account for which funds are received. All of the transactions in the individual ledger must be accurate, posted, and kept current to the date of the most recent activity.

(2) All receipts and disbursements must be posted in the individual ledger, including:

(a) Credit entries that show the date of the deposit, amount, and name of the remitter;

(b) Debit entries that show the date of payment, amount of payment, name of the payee, wire transfer reference number, electronic payment reference number, or check number; and

(c) A monthly trial balance of each individual ledger.

(3) All documents pertinent to all individual trust account transaction activity must be retained, including:

(a) Original or imaged copies of checks clearing the bank (both front and back of the check);

(b) Bank debit memos when funds are disbursed via wire transfer and a copy of the instructions signed by the owner of the funds to be wire transferred identifying the receiving entity and account number;

(c) ACH confirmation or a copy of the confirmation screen. This retained documentation must, at a minimum, include payee, payment date, escrow account number debited, and the confirmation number assigned to the ACH transaction;

(d) Voided items and documents supporting all adjustments. All voided transactions must be posted or reflected in the individual client ledger and the receipts and disbursements ledger; and

(e) Bank statements.

(4) Transaction files containing all escrow instructions, closing statements, correspondence for each transaction, agreements, contracts, leases, and any other pertinent supporting documents necessary to validate the transaction.

(5) A computerized accounting system must:

(a) Provide a capability to back-up all data files; and

(b) At least monthly the receipt and check registers, bank reconciliation, client trial balance and transaction activity must be printed out or imaged and retained as a permanent record.

(6) At least quarterly, do the following:

(a) Conduct a review of all open client escrows and ensure that all outstanding payments are made for the purpose of resolving client escrow accounts and identifying unclaimed funds; and

(b) Contact the department of revenue for disposition instructions under chapter 63.29 RCW in the event that the title agent finds unclaimed funds. All correspondence related to unclaimed funds must be retained for five years.

NEW SECTION

WAC 284-29-330 Controls for escrow trust accounts. (1) All escrow trust account funds received by a title insurance agent must be deposited in the account not later than the first banking day following the receipt thereof.

(2) A title insurance agent must not make any disbursement from an escrow trust account unless it is in compliance with RCW 48.29.190 (1)(c).

(3) Escrow trust accounts and operating accounts of the title insurance agent must be separately maintained and not commingled with the title insurance agent's operating account or an employee or manager's personal account.

(4) On at least a monthly basis, the title insurance agent must prepare trial balances for all escrow trust accounts using a three-way reconciliation method which requires that the escrow trial balance, the book balance, and the reconciled bank balance be verified on all open escrow balances. If all three parts of the three-way reconciliation do not agree, the title insurance agent must identify and reconcile the difference within a commercially reasonable period of time.

(5) On at least a daily basis, reconciliation of the receipts and disbursements of the escrow trust account must be performed.

(6) Segregation of duties must be in place to ensure the reliability of the reconciliation and reconciliations must be conducted by someone other than those with signing authority.

(7) Results of the reconciliation must be reviewed and approved by management.

(8) Appropriate identification must appear on all account-related documentation including bank statements, bank agreements, disbursement checks, and deposit tickets to identify the account as an escrow trust account.

(9) Outstanding escrow trust account file balances must be documented.

(10) Appropriate authorization levels must be set by the title insurance agent and reviewed annually for updates. Former employees must immediately be deleted as listed signatories on all bank accounts of the title insurance agent.

(11) Unless directed by the beneficial owner, all escrow trust accounts must be maintained in federally insured financial institutions.

(12) The title insurance agent must use positive pay or reverse positive pay, automated clearing house blocks and international wire blocks, if available.

NEW SECTION

WAC 284-29-340 Retention of records after closure of business—Notice. (1) Every title insurance agent provid-

ing escrow services must retain and preserve business and accounting records for five years after each transaction as required by RCW 48.29.190, 48.17.470, WAC 284-12-080, and 284-29-265 and must continue to do so after the business is closed.

(2) Every title insurance agent must provide the commissioner thirty days' advance written notice of its intent to close the business. This notice must provide the following:

(a) The most recently completed reconciliation of the escrow fund account to the trial balance and all supporting accounting records, including the escrow bank statement;

(b) A valid contact name, address, phone number, and email address;

(c) The location of the business records and how they are being retained; and

(d) A description how the records will be made available for inspection by the commissioner for five years after the date of completion of the escrow transactions as required by RCW 48.17.470.

WSR 19-20-110
PROPOSED RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2019-06—Filed October 2, 2019, 9:39 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-14-112.

Title of Rule and Other Identifying Information: Revise WAC concerning system for electronic rate and form filing (SERFF) general filing instructions.

Hearing Location(s): On November 6, 2019, at 1:30 p.m., at the Office of the Insurance Commissioner (OIC), 5000 Capitol Boulevard S.E., Tumwater, WA 98501.

Date of Intended Adoption: December 8, 2019.

Submit Written Comments to: Meg L. Jones, P.O. Box 40260, Olympia, WA 98504-0260, email rulescoordinator@oic.wa.gov, fax 360-586-3109, by November 5, 2019.

Assistance for Persons with Disabilities: Melanie Watness, phone 360-725-7013, fax 360-586-2023, TTY 360-586-0241, email MelanieW@oic.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The commissioner proposes amending the four WAC chapters identifying the applicable SERFF filing instructions for charitable gift annuity, health coverage and life and disability filers. A recent rates and forms division project revised and renamed the filing instructions, necessitating an update to the WAC chapters used by filers as references. The anticipated effect of the proposed rule is providing the correct reference in WAC, and confirming that the names of documents in the WAC match documents posted in SERFF and on the OIC's web site.

Reasons Supporting Proposal: In order to correctly submit documents in SERFF for review and approval by OIC, filers must understand which sets of instructions govern their filing. Because the requirement to use SERFF is found in the WAC, the references must be correct in terms of the applicable sets of instructions.

Statutory Authority for Adoption: RCW 48.02.060, 48.18.030, 48.19.035, 48.20.025, 48.20.550, 48.38.075, 48.43.730, 48.43.733, 48.44.050, 48.46.030.

Statute Being Implemented: RCW 18.18.100, 48.19.040, 48.20.012, 48.20.025, 48.20.028, 48.20.029, 48.20.042, 48.38.010, 48.38.020, 48.38.030, 48.43.730, 48.43.733, 48.44.017, 48.44.020, 48.44.022, 48.44.023, 48.44.080, 48.44.120, 48.46.060, 48.46.062, 48.46.064, 48.46.066.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Meg Jones, P.O. Box 40260, Olympia, WA, 360-725-7169; Implementation: Molly Nollette, P.O. Box 40255, Tumwater, WA, 360-725-7117; and Enforcement: Toni Hood, P.O. Box 40255, Tumwater, WA, 360-725-7050.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The rule is a procedural rule pursuant to RCW 34.05.328 (5)(c)(i).

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules relate only to internal governmental operations that are not subject to violation by a nongovernment party.

Is exempt under RCW 34.05.328 (5)(b)(v).

October 2, 2019
Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 14-05-017, filed 2/10/14, effective 3/15/14)

WAC 284-38-100 Filing instructions that are incorporated into this chapter. SERFF is a dynamic application that the NAIC will revise and enhance over time. To be consistent with NAIC filing standards and provide timely instructions to filers, the commissioner must incorporate documents posted on the SERFF web site into this chapter. By reference, the commissioner incorporates these documents into this chapter:

(1) The *SERFF Industry Manual* available within the SERFF application; and

(2) ((~~The *Washington State SERFF Life and Disability Rate and Form Filing General Instructions* posted on the commissioner's web site, www.insurance.wa.gov.~~)) State specific rate and form filing instructions posted on the commissioner's web site (www.insurance.wa.gov), including the:

Washington State SERFF Life and Disability Form Filing General Instructions.

AMENDATORY SECTION (Amending WSR 14-05-017, filed 2/10/14, effective 3/15/14)

WAC 284-38-110 General charitable gift annuity contract filing rules. Filers and certificate holders must submit complete filings that comply with these rules:

(1) ((~~Filings must comply with the filing instructions and procedures in the *SERFF Industry Manual* available within the SERFF application and *Washington State SERFF Life and Disability Rate and Form Filing General Instructions*.~~)) Filers must submit complete filings that comply with the *SERFF Industry Manual* available within the SERFF application as well as state specific instructions applicable to the particular filing, as posted on the commissioner's web site (www.insurance.wa.gov), including the:

Washington State SERFF Life and Disability Form Filing General Instructions.

(2) Filers must submit every charitable gift annuity contract to the commissioner electronically using SERFF.

(a) Every charitable gift annuity contract filed in SERFF must be attached to the form schedule.

(b) All written correspondence related to a charitable gift annuity contract filing must be sent in SERFF.

(3) All filed contracts must be legible for both the commissioner's review and retention as a public record. Filers must submit new and replaced contracts to the commissioner for review in final printed form displayed in ten-point or larger type.

(4) Each contract must have a unique identifying number and a way to distinguish it from other editions of the same contract.

(5) Filers must submit a completed compliance checklist provided in the SERFF application with each new charitable gift annuity contract as supporting documentation. If the filing includes more than one new contract, the filer may:

(a) Complete a separate checklist for each charitable gift annuity contract; or

(b) Complete one checklist and submit an explanatory memorandum that lists any material differences between the filed contracts.

AMENDATORY SECTION (Amending WSR 12-01-103, filed 12/21/11, effective 1/21/12)

WAC 284-44A-040 Filing instructions that are incorporated into this chapter. SERFF is a dynamic application that the NAIC will revise and enhance over time. To be consistent with NAIC filing standards and provide timely instructions to filers, the commissioner will incorporate documents posted on the SERFF web site into this chapter. By reference, the commissioner incorporates these documents into this chapter:

(1) The *SERFF Industry Manual* available within the SERFF application; and

(2) State specific rate and form filing instructions posted on the commissioner's web site (www.insurance.wa.gov), including the:

(a) *Washington State SERFF ((~~Health~~)) Life and Disability Form Filing General Instructions*; ((~~and~~))

(b) *Washington State SERFF Life, Health and Disability Rate Filing General Instructions*;

(c) *Washington State SERFF Health and Disability Form Filing General Instructions*; and

(d) *Washington State SERFF Health and Disability Binder Filing General Instructions* (also called "plan management instructions").

AMENDATORY SECTION (Amending WSR 12-01-103, filed 12/21/11, effective 1/21/12)

WAC 284-44A-050 General form and rate filing rules. (1) Each form or rate filing must be submitted to the commissioner electronically using SERFF.

(a) Every form filed in SERFF must:

(i) Be attached to the form schedule; and

(ii) Have a unique identifying number and a way to distinguish it from other versions of the same form.

(b) Filers must send all written correspondence related to a form or rate filing in SERFF.

(2) All filed forms must be legible for both the commissioner's review and retention as a public record. Filers must submit new or revised forms to the commissioner for review in final form displayed in ten-point or larger type.

(3) Filers must submit complete filings that comply with the *SERFF Industry Manual* available within the SERFF application and state specific instructions applicable to the particular filing, as revised from time to time and posted on the commissioner's web site (www.insurance.wa.gov) including the:

(a) *Washington State SERFF ((~~Health~~)) Life and Disability Form Filing General Instructions*; ((~~or~~))

(b) *Washington State SERFF Health and Disability Rate Filing General Instructions*;

(c) *Washington State SERFF Health and Disability Form Filing General Instructions*; and

(d) *Washington State SERFF Health and Disability Binder Filing General Instructions* (also called "plan management instructions").

(4) Filers must submit separate filings for each type of insurance.

AMENDATORY SECTION (Amending WSR 12-01-103, filed 12/21/11, effective 1/21/12)

WAC 284-46A-040 Filing instructions that are incorporated into this chapter. SERFF is a dynamic application that the NAIC will revise and enhance over time. To be consistent with NAIC filing standards and provide timely instructions to filers, the commissioner will incorporate documents posted on the SERFF web site into this chapter. By reference, the commissioner incorporates these documents into this chapter:

(1) The *SERFF Industry Manual* available within the SERFF application; and

(2) State specific rate and form filing instructions posted on the commissioner's web site (www.insurance.wa.gov), including the:

(a) *Washington State SERFF ((~~Health~~)) Life and Disability Form Filing General Instructions*; ((~~and~~))

(b) *Washington State SERFF Health and Disability Rate Filing General Instructions*;

(c) *Washington State SERFF Health and Disability Form Filing General Instructions;* and

(d) *Washington State SERFF Health and Disability Binder Filing General Instructions* (also called "plan management instructions").

AMENDATORY SECTION (Amending WSR 12-01-103, filed 12/21/11, effective 1/21/12)

WAC 284-46A-050 General form and rate filing rules. (1) Each form or rate filing must be submitted to the commissioner electronically using SERFF.

(a) Every form filed in SERFF must:

(i) Be attached to the form schedule; and

(ii) Have a unique identifying number and a way to distinguish it from other versions of the same form.

(b) Filers must send all written correspondence related to a form or rate filing in SERFF.

(2) All filed forms must be legible for both the commissioner's review and retention as a public record. Filers must submit new or revised forms to the commissioner for review in final form displayed in ten-point or larger type.

(3) Filers must submit complete filings that comply with the *SERFF Industry Manual* available within the SERFF application and state specific instructions applicable to the particular filing as revised from time to time and posted on the commissioner's web site (www.insurance.wa.gov), including the:

(a) *Washington State SERFF ((~~Health~~)) Life and Disability Form Filing General Instructions*; ((~~or~~))

(b) *Washington State SERFF Life, Health and Disability Rate Filing General Instructions*;

(c) *Washington State SERFF Health and Disability Form Filing General Instructions;* and

(d) *Washington State SERFF Health and Disability Binder Filing General Instructions* (also called "plan management instructions").

(4) Filers must submit separate filings for each type of insurance.

AMENDATORY SECTION (Amending WSR 12-01-103, filed 12/21/11, effective 1/21/12)

WAC 284-58-025 Filing instructions that are incorporated into this chapter. SERFF is a dynamic application that the NAIC will revise and enhance over time. To be consistent with NAIC filing standards and provide timely instructions to filers, the commissioner will incorporate documents posted on the SERFF web site into this chapter. By reference, the commissioner incorporates these documents into this chapter:

(1) The *SERFF Industry Manual* available within the SERFF application; and

(2) ((~~The~~)) State specific rate and form filing instructions posted on the commissioner's web site (www.insurance.wa.gov), including the:

(a) *Washington State SERFF Life and Disability ((~~Rate and~~)) Form Filing General Instructions* ((~~posted on the commissioner's web site (www.insurance.wa.gov)~~));

(b) *Washington State Life, Health and Disability Rate Filing General Instructions;*

(c) *Washington State SERFF Health and Disability Form Filing General Instructions;* and

(d) *Washington State SERFF Health and Disability Binder Filing General Instructions* (also called "plan management instructions").

AMENDATORY SECTION (Amending WSR 12-01-103, filed 12/21/11, effective 1/21/12)

WAC 284-58-030 General form and rate filing rules. (1) Each credit, life or disability insurance form or rate filing must be submitted to the commissioner electronically using SERFF.

(a) Every form filed in SERFF must be attached to the form schedule.

(b) Filers must send all written correspondence related to a form or rate filing in SERFF.

(2) All filed forms must be legible for both the commissioner's review and retention as a public record. Filers must submit new or revised forms to the commissioner for review in final form displayed in ten-point or larger type.

(3) Filers must submit complete filings that comply with the *SERFF Industry Manual* available within the SERFF application and ((~~the *Washington State SERFF Life and Disability Rate and Form Filing General Instructions*~~)) state specific filing instructions applicable to the particular filing, as revised from time to time and posted on the commissioner's web site (www.insurance.wa.gov), including the:

(a) *Washington State SERFF Life and Disability Form Filing General Instructions;*

(b) *Washington State SERFF Life, Health and Disability Rate Filing General Instructions;*

(c) *Washington State SERFF Health and Disability Form Filing General Instructions;* and

(d) *Washington State SERFF Health and Disability Binder Filing General Instructions* (also called "plan management instructions").

(4) Filers must submit separate filings for each type of insurance. This section does not apply to:

(a) Credit insurance filings made under RCW 48.34.040; or

(b) Group insurance where different types of insurance are incorporated into a single certificate.

WSR 19-20-111
PROPOSED RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2019-09—Filed October 2, 2019, 9:40 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-15-127.

Title of Rule and Other Identifying Information: Correction of language in essential health benefit, WAC 284-43-5642 (3)(b)(i).

Hearing Location(s): On November 14, 2019, at 3:00 p.m., at the OIC FA Capitol Campus, Conference Room.

Date of Intended Adoption: November 18, 2019.

Submit Written Comments to: Tabba Alam, P.O. Box 40260, Olympia, WA 98504-0260, email rulescoordinator @oic.wa.gov, fax 360-586-3109, by November 13, 2019.

Assistance for Persons with Disabilities: Melanie Watness, phone 360-425-7013, fax 360-586-2023, TTY 360-586-0241, email MelanieW@oic.wa.gov.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The commissioner is considering rule making to amend WAC 284-43-5642 (3)(b)(i) [to] harmonize with the requirement for the mental health/substance use disorder (MH/SUD) essential health benefits (EHB), and also the federal mental health parity requirement (MHPAEA).

Reasons Supporting Proposal: WAC 284-43-5642 (3)(b)(i) currently states that, for Affordable Care Act plans, coverage of hospitalization for mental illness is an optional benefit. This would violate the requirement for MH/SUD EHB, and also the federal MHPAEA. The commissioner will consider rule making to correct the language to say that the carrier must cover hospitalization for MH/SUD, but cannot include it in the actuarial value calculation for the hospitalization EHB (it must be included in the calculation for actuarial value of MH/SUD EHB).

Statutory Authority for Adoption: RCW 48.02.060 and 48.43.715.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Tabba Alam, P.O. Box 40260, Olympia, WA 98504-0260, 360-725-7170; Implementation and Enforcement: Molly Nollette, P.O. Box 40255, Olympia, WA 98504-0255, 360-725-7000.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed rule adopts without material change Washington state statutes and therefore is exempt under RCW 34.05.328 (5)(b)(iv).

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025.

Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 16-19-085, filed 9/20/16, effective 10/21/16)

WAC 284-43-5642 Essential health benefit categories. (1) A health benefit plan must cover "ambulatory patient services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as "ambulatory patient services" those medically necessary services delivered to enrollees in settings other than a hospital or skilled nursing facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat illness or injury.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as ambulatory patient services:

(i) Home and outpatient dialysis services;

(ii) Hospice and home health care, including skilled nursing care as an alternative to hospitalization consistent with WAC 284-44-500, 284-46-500, and 284-96-500;

(iii) Provider office visits and treatments, and associated supplies and services, including therapeutic injections and related supplies;

(iv) Urgent care center visits, including provider services, facility costs and supplies;

(v) Ambulatory surgical center professional services, including anesthesiology, professional surgical services, surgical supplies and facility costs;

(vi) Diagnostic procedures including colonoscopies, cardiovascular testing, pulmonary function studies and neurology/neuromuscular procedures; and

(vii) Provider contraceptive services and supplies including, but not limited to, vasectomy, tubal ligation and insertion or extraction of FDA-approved contraceptive devices.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the ambulatory category:

(i) Infertility treatment and reversal of voluntary sterilization;

(ii) Routine foot care for those that are not diabetic;

(iii) Coverage of dental services following injury to sound natural teeth. However, health plans must cover oral surgery related to trauma and injury. Therefore, a plan may not exclude services or appliances necessary for or resulting from medical treatment if the service is either emergency in nature or requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease;

(iv) Private duty nursing for hospice care and home health care, to the extent consistent with state and federal law;

(v) Adult dental care and orthodontia delivered by a dentist or in a dentist's office;

(vi) Nonskilled care and help with activities of daily living;

(vii) Hearing care, routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them. However, plans must cover cochlear implants and hearing screening tests that are required under the preventive services category, unless coverage for these services and devices are required as part of and classified to another essential health benefits category; and

(viii) Obesity or weight reduction or control other than:

(A) Covered nutritional counseling; and

(B) Obesity-related services for which the U.S. Preventive Services Task Force for prevention and chronic care has issued A and B recommendations on or before the applicable plan year, which issuers must cover under subsection (9) of this section.

(c) The base-benchmark plan's visit limitations on services in the ambulatory patient services category include:

(i) Ten spinal manipulation services per calendar year without referral;

(ii) Twelve acupuncture services per calendar year without referral;

(iii) Fourteen days respite care on either an inpatient or outpatient basis for hospice patients, per lifetime; and

(iv) One hundred thirty visits per calendar year for home health care.

(d) State benefit requirements classified to the ambulatory patient services category are:

(i) Chiropractic care (RCW 48.44.310);

(ii) TMJ disorder treatment (RCW 48.21.320, 48.44.460, and 48.46.530); and

(iii) Diabetes-related care and supplies (RCW 48.20.391, 48.21.143, 48.44.315, and 48.46.272).

(2) A health benefit plan must cover "emergency medical services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as emergency medical services the care and services related to an emergency medical condition.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as emergency services:

(i) Ambulance transportation to an emergency room and treatment provided as part of the ambulance service;

(ii) Emergency room and department based services, supplies and treatment, including professional charges, facility costs, and outpatient charges for patient observation and medical screening exams required to stabilize a patient experiencing an emergency medical condition;

(iii) Prescription medications associated with an emergency medical condition, including those purchased in a foreign country.

(b) The base-benchmark plan does not specifically exclude services classified to the emergency medical services category.

(c) The base-benchmark plan does not establish visit limitations on services in the emergency medical services category.

(d) State benefit requirements classified to the emergency medical services category include services necessary to screen and stabilize a covered person (RCW 48.43.093).

(3) A health benefit plan must cover "hospitalization" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as hospitalization services the medically necessary services delivered in a hospital or skilled nursing setting including, but not limited to, professional services, facility fees, supplies, laboratory, therapy or other types of services delivered on an inpatient basis.

(a) A health benefit plan must include the following services which are specifically covered by the base-benchmark plan and classify them as hospitalization services:

(i) Hospital visits, facility costs, provider and staff services and treatments delivered during an inpatient hospital stay, including inpatient pharmacy services;

(ii) Skilled nursing facility costs, including professional services and pharmacy services and prescriptions filled in the skilled nursing facility pharmacy;

(iii) Transplant services, supplies and treatment for donors and recipients, including the transplant or donor facility fees performed in either a hospital setting or outpatient setting;

(iv) Dialysis services delivered in a hospital;

(v) Artificial organ transplants based on an issuer's medical guidelines and manufacturer recommendations; and

(vi) Respite care services delivered on an inpatient basis in a hospital or skilled nursing facility.

(b) A health benefit plan must include hospitalization where mental illness is the primary diagnosis, and must classify these services under the mental health and substance use disorder benefits category.

(c) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer should not include the following benefits in establishing actuarial value for the hospitalization category:

(i) ((~~Hospitalization where mental illness is the primary diagnosis to the extent that it is classified under the mental health and substance use disorder benefits category;~~

~~(ii)~~)) Cosmetic or reconstructive services and supplies except in the treatment of a congenital anomaly, to restore a physical bodily function lost as a result of injury or illness, or related to breast reconstruction following a medically necessary mastectomy;

(((~~(iii)~~))) (ii) The following types of surgery:

(A) Bariatric surgery and supplies;

(B) Orthognathic surgery and supplies unless due to temporomandibular joint disorder or injury, sleep apnea or congenital anomaly.

(((~~(iv)~~))) (iii) Reversal of sterilizations; and

(((~~(v)~~))) (iv) Surgical procedures to correct refractive errors, astigmatism or reversals or revisions of surgical procedures which alter the refractive character of the eye.

(((~~(c)~~))) (d) The base-benchmark plan establishes specific limitations on services classified to the hospitalization category that conflict with state or federal law as of January 1, 2017, and should not be included in essential health benefit plans:

(i) The base-benchmark plan allows a waiting period for transplant services; and

(ii) The base-benchmark plan excludes coverage for sexual reassignment treatment, surgery, or counseling services. Health plans must cover such services consistent with 42 U.S.C. 18116, Section 1557, section 15, chapter 33, Laws of 2019, RCW 48.30.300 and 49.60.040.

(((~~(d)~~))) (e) The base-benchmark plan's visit limitations on services in the hospitalization category include:

(i) Sixty inpatient days per calendar year for illness, injury or physical disability in a skilled nursing facility;

(ii) Thirty inpatient rehabilitation service days per calendar year. For purposes of determining actuarial value, this benefit may be classified to the hospitalization category or to the rehabilitation services category, but not to both.

(((~~(e)~~))) (f) State benefit requirements classified to the hospitalization category are:

(i) General anesthesia and facility charges for dental procedures for those who would be at risk if the service were performed elsewhere and without anesthesia (RCW 48.43.185);

(ii) Reconstructive breast surgery resulting from a mastectomy that resulted from disease, illness or injury (RCW 48.20.395, 48.21.230, 48.44.330, and 48.46.280);

(iii) Coverage for treatment of temporomandibular joint disorder (RCW 48.21.320, 48.44.460, and 48.46.530); and

(iv) Coverage at a long-term care facility following hospitalization (RCW 48.43.125).

(4) A health benefit plan must cover "maternity and newborn services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as maternity and newborn services the medically necessary care and services delivered to women during pregnancy and in relation to delivery and recovery from delivery and to newborn children.

(a) A health benefit plan must cover the following services which are specifically covered by the base-benchmark plan and classify them as maternity and newborn services:

(i) In utero treatment for the fetus;

(ii) Vaginal or cesarean childbirth delivery in a hospital or birthing center, including facility fees;

(iii) Nursery services and supplies for newborns, including newly adopted children;

(iv) Infertility diagnosis;

(v) Prenatal and postnatal care and services, including screening;

(vi) Complications of pregnancy such as, but not limited to, fetal distress, gestational diabetes, and toxemia; and

(vii) Termination of pregnancy. Termination of pregnancy may be included in an issuer's essential health benefits package, but nothing in this section requires an issuer to offer the benefit, consistent with 42 U.S.C. 18023 (b)(a)(A)(i) and 45 C.F.R. 156.115.

(b) A health benefit plan may, but is not required to, include genetic testing of the child's father as part of the EHB-benchmark package. The base-benchmark plan specifically excludes this service. If an issuer covers this benefit, the issuer may not include this benefit in establishing actuarial value for the maternity and newborn category.

(c) The base-benchmark plan's limitations on services in the maternity and newborn services category include coverage of home birth by a midwife or nurse midwife only for low risk pregnancy.

(d) State benefit requirements classified to the maternity and newborn services category include:

(i) Maternity services that include diagnosis of pregnancy, prenatal care, delivery, care for complications of pregnancy, physician services, and hospital services (RCW 48.43.041);

(ii) Newborn coverage that is not less than the postnatal coverage for the mother, for no less than three weeks (RCW 48.43.115); and

(iii) Prenatal diagnosis of congenital disorders by screening/diagnostic procedures if medically necessary (RCW 48.20.430, 48.21.244, 48.44.344, and 48.46.375).

(5) A health benefit plan must cover "mental health and substance use disorder services, including behavioral health treatment" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as mental health and substance use disorder services, including behavioral health treatment, the medically necessary care, treatment and services for mental health conditions and substance use disorders categorized in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including behavioral health treatment for those conditions.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as mental health and substance use disorder services, including behavioral health treatment:

(i) Inpatient, residential, and outpatient mental health and substance use disorder treatment, including diagnosis, partial hospital programs or inpatient services;

(ii) Chemical dependency detoxification;

(iii) Behavioral treatment for a DSM category diagnosis;

(iv) Services provided by a licensed behavioral health provider for a covered diagnosis in a skilled nursing facility;

(v) Prescription medication including medications prescribed during an inpatient and residential course of treatment;

(vi) Acupuncture treatment visits without application of the visit limitation requirements, when provided for chemical dependency.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes these benefits in a health plan, the issuer may not include these benefits in establishing actuarial value for the category of mental health and substance use disorder services including behavioral health treatment:

(i) Counseling in the absence of illness, other than family counseling when the patient is a child or adolescent with a covered diagnosis and the family counseling is part of the treatment for mental health services;

(ii) Mental health treatment for diagnostic codes 302 through 302.9 in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, or for "V code" diagnoses except for medically necessary services for parent-child relational problems for children five years of age or younger, neglect or abuse of a child for children five years of age or younger, bereavement for children five years of age or younger, and gender dysphoria consistent with 42 U.S.C. 18116, Section 1557, RCW 48.30.300 and 49.60.040, unless this exclusion is preempted by federal law; and

(iii) Court-ordered mental health treatment which is not medically necessary.

(c) The base-benchmark plan establishes specific limitations on services classified to the mental health and substance abuse disorder services category that conflict with state or federal law as of January 1, 2017. The state EHB-benchmark plan requirements for these services are: The base-benchmark plan does not provide coverage for mental health services and substance use disorder treatment delivered in a home health setting in parity with medical surgical benefits

consistent with state and federal law. Health plans must cover mental health services and substance use disorder treatment that is delivered in parity with medical surgical benefits, consistent with state and federal law.

(d) The base-benchmark plan's visit limitations on services in this category include court-ordered treatment only when medically necessary.

(e) State benefit requirements classified to this category include:

(i) Mental health services (RCW 48.20.580, 48.21.241, 48.44.341, and 48.46.285);

(ii) Chemical dependency detoxification services (RCW 48.21.180, 48.44.240, 48.44.245, 48.46.350, and 48.46.355); and

(iii) Services delivered pursuant to involuntary commitment proceedings (RCW 48.21.242, 48.44.342, and 48.46.-292).

(f) The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) (MHPAEA) applies to a health benefit plan subject to this section. Coverage of mental health and substance use disorder services, along with any scope and duration limits imposed on the benefits, must comply with the MHPAEA, and all rules, regulations and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26) including where state law is silent, or where federal law preempts state law.

(6) A health benefit plan must cover "prescription drug services" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as prescription drug services medically necessary prescribed drugs, medication and drug therapies.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as prescription drug services:

(i) Drugs and medications both generic and brand name, including self-administrable prescription medications, consistent with the requirements of (b) through (e) of this subsection;

(ii) Prescribed medical supplies, including diabetic supplies that are not otherwise covered as durable medical equipment under the rehabilitative and habilitative services category, including test strips, glucagon emergency kits, insulin and insulin syringes;

(iii) All FDA-approved contraceptive methods, and prescription-based sterilization procedures for women with reproductive capacity;

(iv) Certain preventive medications including, but not limited to, aspirin, fluoride, and iron, and medications for tobacco use cessation, according to, and as recommended by, the United States Preventive Services Task Force, when obtained with a prescription order; and

(v) Medical foods to treat inborn errors of metabolism in accordance with RCW 48.44.440, 48.46.510, 48.20.520, 48.21.300, and 48.43.176.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services for the prescription drug services category. If an issuer includes these services, the issuer may not include the following benefits in establishing actuarial value for the prescription drug services category:

(i) Insulin pumps and their supplies, which are classified to and covered under the rehabilitation and habilitation services category; and

(ii) Weight loss drugs.

(c) The base-benchmark plan's visit limitations on services in the prescription drug services category include:

(i) Prescriptions for self-administrable injectable medication are limited to thirty day supplies at a time, other than insulin, which may be offered with more than a thirty day supply. This limitation is a floor, and an issuer may permit supplies greater than thirty days as part of its health benefit plan;

(ii) Teaching doses of self-administrable injectable medications are limited to three doses per medication per lifetime.

(d) State benefit requirements classified to the prescription drug services category include:

(i) Medical foods to treat inborn errors of metabolism (RCW 48.44.440, 48.46.510, 48.20.520, 48.21.300, and 48.43.176);

(ii) Diabetes supplies ordered by the physician (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143). Inclusion of this benefit requirement does not bar issuer variation in diabetic supply manufacturers under its drug formulary;

(iii) Mental health prescription drugs to the extent not covered under the hospitalization or skilled nursing facility services, or mental health and substance use disorders categories (RCW 48.44.341, 48.46.291, 48.20.580, and 48.21.241);

(e) An issuer's formulary is part of the prescription drug services category. The formulary filed with the commissioner must be substantially equal to the base-benchmark plan formulary, both as to U.S. Pharmacopoeia therapeutic category and classes covered and number of drugs in each class. If the base-benchmark plan formulary does not cover at least one drug in a category or class, an issuer must include at least one drug in the uncovered category or class.

(i) An issuer must file its formulary quarterly, following the filing instructions defined by the insurance commissioner in WAC 284-44A-040, 284-46A-050, and 284-58-025.

(ii) An issuer's formulary does not have to be substantially equal to the base-benchmark plan formulary in terms of formulary placement.

(7) A health benefit plan must cover "rehabilitative and habilitative services" in a manner substantially equal to the base-benchmark plan.

(a) For purposes of determining a plan's actuarial value, an issuer must classify as rehabilitative services the medically necessary services that help a person keep, restore or improve skills and function for daily living that have been lost or impaired because a person was sick, hurt or disabled.

(b) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as rehabilitative services:

(i) Cochlear implants;

(ii) Inpatient rehabilitation facilities and professional services delivered in those facilities;

(iii) Outpatient physical therapy, occupational therapy and speech therapy for rehabilitative purposes;

(iv) Braces, splints, prostheses, orthopedic appliances and orthotic devices, supplies or apparatus used to support, align or correct deformities or to improve the function of moving parts; and

(v) Durable medical equipment and mobility enhancing equipment used to serve a medical purpose, including sales tax.

(c) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base-benchmark plan specifically excludes these services. If an issuer includes the following benefits in a health plan, the issuer may not include these benefits in establishing actuarial value for the rehabilitative and habilitative services category:

(i) Off-the-shelf shoe inserts and orthopedic shoes;

(ii) Exercise equipment for medically necessary conditions;

(iii) Durable medical equipment that serves solely as a comfort or convenience item; and

(iv) Hearing aids other than cochlear implants.

(d) For purposes of determining a plan's actuarial value, an issuer must classify as habilitative services the range of medically necessary health care services and health care devices designed to assist a person to keep, learn or improve skills and functioning for daily living. Examples include services for a child who isn't walking or talking at the expected age, or services to assist with keeping or learning skills and functioning within an individual's environment, or to compensate for a person's progressive physical, cognitive, and emotional illness. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient or outpatient settings.

(i) As a minimum level of coverage, an issuer must establish limitations on habilitative services on parity with those for rehabilitative services. A health benefit plan may include such limitations only if the limitations take into account the unique needs of the individual and target measurable, and specific treatment goals appropriate for the person's age and physical and mental condition. When habilitative services are delivered to treat a mental health diagnosis categorized in the most recent version of the DSM, the mental health parity requirements apply and supersede any rehabilitative services parity limitations permitted by this subsection.

(ii) A health benefit plan must not limit an enrollee's access to covered services on the basis that some, but not all, of the services in a plan of treatment are provided by a public or government program.

(iii) An issuer may establish utilization review guidelines and practice guidelines for habilitative services that are recognized by the medical community as efficacious. The guidelines must not require a return to a prior level of function.

(iv) Habilitative health care devices may be limited to those that require FDA approval and a prescription to dispense the device.

(v) Consistent with the standards in this subsection, speech therapy, occupational therapy, physical therapy, and aural therapy are habilitative services. Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational or custodial services are not classified as habilitative services.

(vi) An issuer must not exclude coverage for habilitative services received at a school-based health care center unless the habilitative services and devices are delivered pursuant to federal Individuals with Disabilities Education Act of 2004 (IDEA) requirements and included in an individual educational plan (IEP).

(e) The base-benchmark plan's visit limitations on services in the rehabilitative and habilitative services category include:

(i) Inpatient rehabilitation facilities and professional services delivered in those facilities are limited to thirty service days per calendar year; and

(ii) Outpatient physical therapy, occupational therapy and speech therapy are limited to twenty-five outpatient visits per calendar year, on a combined basis, for rehabilitative purposes.

(f) State benefit requirements classified to this category include:

(i) State sales tax for durable medical equipment; and

(ii) Coverage of diabetic supplies and equipment (RCW 48.44.315, 48.46.272, 48.20.391, and 48.21.143).

(g) An issuer must not classify services to the rehabilitative services category if the classification results in a limitation of coverage for therapy that is medically necessary for an enrollee's treatment for cancer, chronic pulmonary or respiratory disease, cardiac disease or other similar chronic conditions or diseases. For purposes of this subsection, an issuer must establish limitations on the number of visits and coverage of the rehabilitation therapy consistent with its medical necessity and utilization review guidelines for medical/surgical benefits. Examples of these are, but are not limited to, breast cancer rehabilitation therapy, respiratory therapy, and cardiac rehabilitation therapy. Such services may be classified to the ambulatory patient or hospitalization services categories for purposes of determining actuarial value.

(8) A health plan must cover "laboratory services" in a manner substantially equal to the base-benchmark plan. For purposes of determining actuarial value, an issuer must classify as laboratory services the medically necessary laboratory services and testing, including those performed by a licensed provider to determine differential diagnoses, conditions, outcomes and treatment, and including blood and blood services, storage and procurement, and ultrasound, X-ray, MRI, CAT scan and PET scans.

(a) A health benefit plan must include the following services, which are specifically covered by the base-benchmark plan, and classify them as laboratory services:

(i) Laboratory services, supplies and tests, including genetic testing;

(ii) Radiology services, including X-ray, MRI, CAT scan, PET scan, and ultrasound imaging; and

(iii) Blood, blood products, and blood storage, including the services and supplies of a blood bank.

(b) A health benefit plan may, but is not required to, include the following services as part of the EHB-benchmark package. The base- benchmark plan specifically excludes procurement and storage of personal blood supplies provided

by a member of the enrollee's family when this service is not medically indicated. If an issuer includes this benefit in a health plan, the issuer may not include this benefit in establishing the health plan's actuarial value.

(9) A health plan must cover "preventive and wellness services, including chronic disease management" in a manner substantially equal to the base-benchmark plan. For purposes of determining a plan's actuarial value, an issuer must classify as preventive and wellness services, including chronic disease management, the services that identify or prevent the onset or worsening of disease or disease conditions, illness or injury, often asymptomatic; services that assist in the multidisciplinary management and treatment of chronic diseases; and services of particular preventative or early identification of disease or illness of value to specific populations, such as women, children and seniors.

(a) If a plan does not have in its network a provider who can perform the particular service, then the plan must cover the item or service when performed by an out-of-network provider and must not impose cost-sharing with respect to the item or service. In addition, a health plan must not limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity or recorded gender. If a provider determines that a sex-specific recommended preventive service is medically appropriate for an individual, and the individual otherwise satisfies the coverage requirements, the plan must provide coverage without cost-sharing.

(b) A health benefit plan must include the following services as preventive and wellness services, including chronic disease management:

(i) Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices;

(ii)(A) Screening and tests for which the U.S. Preventive Services Task Force for Prevention and Chronic Care have issued A and B recommendations on or before the applicable plan year.

(B) To the extent not specified in a recommendation or guideline, a plan may rely on the relevant evidence base and reasonable medical management techniques, based on necessity or appropriateness, to determine the frequency, method, treatment, or setting for the provision of a recommended preventive health service;

(iii) Services, tests and screening contained in the U.S. Health Resources and Services Administration ("HRSA") Bright Futures guidelines as set forth by the American Academy of Pediatricians; and

(iv) Services, tests, screening and supplies recommended in the HRSA women's preventive and wellness services guidelines:

(A) If the plan covers children under the age of nineteen, or covers dependent children age nineteen or over who are on the plan pursuant to RCW 48.44.200, 48.44.210, or 48.46.320, the plan must provide the child with the full range of recommended preventive services suggested under HRSA guidelines for the child's age group without cost-sharing. Services provided in this regard may be combined in one visit as medically appropriate or may be spread over more than one visit, without incurring cost-sharing, as medically appropriate; and

(B) A plan may use reasonable medical management techniques to determine the frequency, method, treatment or setting for a recommended preventive service, including providing multiple prevention and screening services at a single visit or across multiple visits.

(v) Chronic disease management services, which typically include, but are not limited to, a treatment plan with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, measuring care quality and outcomes, and support for patient self-management through education or tools; and

(vi) Wellness services.

(c) The base-benchmark plan establishes specific limitations on services classified to the preventive services category that conflict with state or federal law as of January 1, 2017, and should not be included in essential health benefit plans.

Specifically, the base-benchmark plan excludes coverage for obesity or weight control other than covered nutritional counseling. Health plans must cover certain obesity-related services that are listed as A or B recommendations by the U.S. Preventive Services Task Force, consistent with 42 U.S.C. 300gg-13 (a)(1) and 45 C.F.R. 147.130 (a)(1)(i).

(d) The base-benchmark plan does not establish visit limitations on services in this category. In accordance with Section 2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services, the base-benchmark plan does not impose cost-sharing requirements with respect to the preventive services listed under (b)(i) through (iv) of this subsection that are provided in-network.

(e) State benefit requirements classified in this category are:

(i) Colorectal cancer screening as set forth in RCW 48.43.043;

(ii) Mammogram services, both diagnostic and screening (RCW 48.21.225, 48.44.325, and 48.46.275); and

(iii) Prostate cancer screening (RCW 48.20.392, 48.21.227, 48.44.327, and 48.46.277).

(10) Some state benefit requirements are limited to those receiving pediatric services, but are classified to other categories for purposes of determining actuarial value.

(a) These benefits include:

(i) Neurodevelopmental therapy, consisting of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay, which cannot be combined with rehabilitative services for the same condition (RCW 48.44.450, 48.46.520, and 48.21.310). This state benefit requirement may be classified to ambulatory patient services or mental health and substance abuse disorder including behavioral health categories; and

(ii) Treatment of congenital anomalies in newborn and dependent children (RCW 48.20.430, 48.21.155, 48.44.212, and 48.46.250). This state benefit requirement may be classified to hospitalization, ambulatory patient services or maternity and newborn categories.

(b) The base-benchmark plan contains limitations or scope restrictions that conflict with state or federal law as of

January 1, 2017. Specifically, the plan covers outpatient neurodevelopmental therapy services only for persons age six and under. Health plans must cover medically necessary neurodevelopmental therapy for any DSM diagnosis without blanket exclusions.

(11) Issuers must know and apply relevant guidance, clarifications and expectations issued by federal governmental agencies regarding essential health benefits. Such clarifications may include, but are not limited to, Affordable Care Act implementation and frequently asked questions jointly issued by the U.S. Department of Health and Human Services, the U.S. Department of Labor and the U.S. Department of the Treasury.

(12) This section applies to health plans that have an effective date of January 1, 2017, or later.

WSR 19-20-112
PROPOSED RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2019-4—Filed October 2, 2019, 9:42 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-13-077.

Title of Rule and Other Identifying Information: Implementation of the Balance Billing Protection Act (chapter 427, Laws of 2019).

Hearing Location(s): On November 5, 2019, at 11:30 a.m., at the Office of the Insurance Commissioner (OIC), 5000 Capitol Boulevard S.E., Tumwater, WA 98501.

Date of Intended Adoption: November 15, 2019.

Submit Written Comments to: Jane Beyer, P.O. Box 40260, Olympia, WA 98504-0260, email rulescoordinator@oic.wa.gov, fax 360-586-3109, by November 4, 2019.

Assistance for Persons with Disabilities: Melanie Watness, phone 360-725-7013, fax 360-586-2023, TTY 360-586-0241, email MelanieW@oic.wa.gov, by November 4, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposal includes rules determined by OIC to be necessary to implement and administer the Balance Billing Protection Act. The rules include:

- Definitions of key terms,
- Key consumer protections,
- Process related to out-of-network provider claim submission, carrier payment and dispute resolution,
- The means through which providers can determine whether a patient's health plan is subject to the requirements of the act,
- When and in what format the OIC consumer notice must be used, and clarification of the provider/facility and carrier transparency requirements of the act, including providing consumers with sufficient information to understand whether a service they plan to, or have received, is subject to the protections of the act,
- For purposes of enforcement, OIC's interpretation of "pattern of unresolved violations,"
- Processes related to self-funded group health plan opt-in, and
- Amendment to WAC 284-170-480 needed to implement section 30 of the act.

Reasons Supporting Proposal: The proposed rule provides clarity regarding several aspects of implementation and administration of the Balance Billing Protection Act, which will contribute to successful implementation of the act and its consumer protections.

Statutory Authority for Adoption: RCW 48.02.060; section 15, chapter 427, Laws of 2019.

Statute Being Implemented: Balance Billing Protection Act, chapter 427, Laws of 2019.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Jane Beyer, P.O. Box 40260, Olympia, WA, 360-725-7043; Implementation: Molly Nollette/Todd Dixon, P.O. Box 40255, Tumwater, WA, 360-725-7117/360-725-7262; and Enforcement: Toni Hood, P.O. Box 40255, Tumwater, WA, 360-725-7050.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is required under RCW 34.05.328. A preliminary cost-benefit analysis may be obtained by contacting Tabba Alam, P.O. Box 40260, Olympia, WA, phone 360-725-7170, email TabbaA@oic.wa.gov.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rule content is explicitly and specifically dictated by statute.

October 2, 2019
Mike Kreidler
Insurance Commissioner

Chapter 284-43B WAC

BALANCE BILLING

NEW SECTION

WAC 284-43B-010 Definitions. (1) The definitions in RCW 48.43.005 apply throughout this chapter unless the context clearly requires otherwise, or the term is defined otherwise in subsection (2) of this section.

(2) The following definitions shall apply throughout this chapter:

(a) "Allowed amount" means the maximum portion of a billed charge a health carrier will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service or item rendered by a participating provider or facility or by a nonparticipating provider or facility.

(b) "Balance bill" means a bill sent to an enrollee by an out-of-network provider or facility for health care services provided to the enrollee after the provider or facility's billed

amount is not fully reimbursed by the carrier, exclusive of permitted cost-sharing.

(c) "Emergency medical condition" means a medical, mental health, or substance use disorder condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain or emotional distress, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical, mental health, or substance use disorder treatment attention to result in a condition (i) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

(d) "Emergency services" means a medical screening examination, as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition, and further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient. Stabilize, with respect to an emergency medical condition, has the meaning given in section 1867 (e)(3) of the Social Security Act (42 U.S.C. 1395dd (e)(3)).

(e) "Facility" means a hospital licensed under chapter 70.41 RCW or an ambulatory surgical facility licensed under chapter 70.230 RCW.

(f) "In-network" or "participating" means a provider or facility that has contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees and be reimbursed by the carrier at a contracted rate as payment in full for the health care services, including applicable cost-sharing obligations. A single case reimbursement agreement between a provider or facility and a carrier used for the purpose described in WAC 284-170-200 constitutes a contract exclusively for purposes of this definition under the Balance Billing Protection Act and is limited to the services and parties to the agreement.

(g) "Median in-network contracted rate for the same or similar service in the same or similar geographical area" means the median amount negotiated for an emergency or surgical or ancillary service for participation in the carrier's health plan network with in-network providers of emergency or surgical or ancillary services furnished in the same or similar geographic area. If there is more than one amount negotiated with the health plan's in-network providers for the emergency or surgical or ancillary service in the same or similar geographic area, the median in-network contracted rate is the median of these amounts. In determining the median described in the preceding sentence, the amount negotiated for each claim for the same or similar service with each in-network provider is treated as a separate amount (even if the same amount is paid to more than one provider or to the same provider for more than one claim). If no per-service amount has been negotiated with any in-network providers for a particular service, the median amount must be calculated based upon the service that is most similar to the service provided. For purposes of this subsection "median" means the middle number of a sorted list of reimbursement amounts negotiated with in-network providers with respect to a certain emergency or surgical or ancillary service, with each paid claim's negotiated reimbursement amount separately represented on the list, arranged in order from least to greatest. If there is an even number of items in the sorted list of negotiated reimbursement amounts, the median is found by taking the average of the two middlemost numbers.

(h) "Offer to pay," "carrier payment," or "payment notification" means a claim that has been adjudicated and paid by a carrier to an out-of-network or nonparticipating provider for emergency services or for surgical or ancillary services provided at an in-network facility.

(i) "Out-of-network" or "nonparticipating" means a provider or facility that has not contracted with a carrier or a carrier's contractor or subcontractor to provide health care services to enrollees.

(j) "Provider" means a person regulated under Title 18 RCW or chapter 70.127 RCW to practice health or health-related services or otherwise practicing health care services in this state consistent with state law, or an employee or agent of a person acting in the course and scope of his or her employment, that provides emergency services, or surgical or ancillary services at an in-network facility.

(k) "Same or similar geographic area" means the geographic area methodology used to calculate the data set established under section 26, chapter 427, Laws of 2019.

(l) "Surgical or ancillary services" means surgery, anesthesiology, pathology, radiology, laboratory, or hospitalist services.

NEW SECTION

WAC 284-43B-020 Balance billing prohibition and consumer cost-sharing. (1) If an enrollee receives any emergency services from an out-of-network facility or provider, or any nonemergency surgical or ancillary services at an in-network facility from an out-of-network provider:

(a) The enrollee satisfies his or her obligation to pay for the health care services if he or she pays the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract. The enrollee's obligation must be determined using the carrier's median in-network contracted rate for the same or similar service in the same or similar geographical area. The carrier must provide an explanation of benefits to the enrollee and the out-of-network provider that reflects the cost-sharing amount determined under this subsection.

(b) The carrier, out-of-network provider, or out-of-network facility, and any agent, trustee, or assignee of the carrier, out-of-network provider, or out-of-network facility must ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection.

(c)(i) For emergency services provided to an enrollee, the out-of-network provider or out-of-network facility, and any agent, trustee, or assignee of the out-of-network provider or out-of-network facility may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does

not impact the provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest;

(ii) For emergency services provided to an enrollee in an out-of-network hospital located and licensed in Oregon or Idaho, the carrier must hold an enrollee harmless from balance billing; and

(iii) For nonemergency surgical or ancillary services provided at an in-network facility, the out-of-network provider and any agent, trustee, or assignee of the out-of-network provider may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the provider's ability to collect a past due balance for an applicable in-network cost-sharing amount with interest.

(d) For emergency services and nonemergency surgical or ancillary services provided at an in-network facility, the carrier must treat any cost-sharing amounts determined under (a) of this subsection paid or incurred by the enrollee for an out-of-network provider or facility's services in the same manner as cost-sharing for health care services provided by an in-network provider or facility and must apply any cost-sharing amounts paid or incurred by the enrollee for such services toward the enrollee's maximum out-of-pocket payment obligation.

(e) If the enrollee pays an out-of-network provider or out-of-network facility an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection, the provider or facility must refund any amount in excess of the in-network cost- sharing amount to the enrollee within thirty business days of the provider or facility's receipt of the enrollee's payment. Simple interest must be paid to the enrollee for any unrefunded payments at a rate of twelve percent per annum beginning on the first calendar day after the thirty business days.

(2) The carrier must make payments for health care services described in section 6, chapter 427, Laws of 2019, provided by an out-of-network provider or facility directly to the provider or facility, rather than the enrollee.

(3) A health care provider or facility, or any of its agents, trustees or assignees may not require a patient at any time, for any procedure, service, or supply, to sign or execute by electronic means, any document that would attempt to avoid, waive, or alter any provision of this section.

NEW SECTION

WAC 284-43B-030 Out-of-network claim payment and dispute resolution. The allowed amount paid to an out-of-network provider for health care services described under section 6, chapter 427, Laws of 2019, shall be a commercially reasonable amount, based on payments for the same or similar services provided in the same or a similar geographic area.

(1) Within thirty calendar days of receipt of a claim from an out-of-network provider or facility, the carrier shall offer to pay the provider or facility a commercially reasonable amount. Payment of an adjudicated claim shall be considered an offer to pay. The amount actually paid to an out-of-network provider by a carrier may be reduced by the applicable consumer cost-sharing determined under WAC 284-43B-020 (1)(a). The date of receipt by the provider or facility of the carrier's offer to pay is five calendar days after a transmittal of the offer is mailed to the provider or facility, or the date of transmittal of an electronic notice of payment. The claim submitted by the out-of-network provider or facility to the carrier must include the following information:

(a) Patient name;

(b) Patient date of birth;

(c) Provider name;

(d) Provider location;

(e) Place of service, including the name and address of the facility in which, or on whose behalf, the service that is the subject of the claim was provided;

(f) Provider federal tax identification number;

(g) Federal Center for Medicare and Medicaid Services individual national provider identifier number, and organizational national provider identifier number, if the provider works for an organization or is in a group practice that has an organization number;

(h) Date of service;

(i) Procedure code; and

(j) Diagnosis code.

(2) If the out-of-network provider or facility wants to dispute the carrier's offer to pay, the provider or facility must notify the carrier no later than thirty calendar days after receipt of the offer to pay or payment notification from the carrier. A carrier may not require a provider or facility to reject or return payment of the adjudicated claim as a condition of putting the payment into dispute.

(3) If the out-of-network provider or facility disputes the carrier's offer to pay, the carrier and provider or facility have thirty calendar days after the provider or facility receives the offer to pay to negotiate in good faith.

(4) If the carrier and the out-of-network provider or facility do not agree to a commercially reasonable payment amount within the thirty-calendar day period under subsection (3) of this section, and the carrier, out-of-network provider or out-of-network facility chooses to pursue further action to resolve the dispute, the dispute shall be resolved through arbitration, as provided in section 8, chapter 427, Laws of 2019.

(5)(a) To initiate arbitration, the carrier, provider, or facility must provide written notification to the commissioner and the noninitiating party no later than ten calendar days following completion of the period of good faith negotiation under subsection (3) of this section. The written notification to the commissioner must be made electronically and provide dates related to each of the time period limitations described in subsections (1) through (4) of this section.

(b) If an out-of-network provider or out-of-network facility chooses to address multiple claims in a single arbitration proceeding as provided in section 8, chapter 427, Laws of 2019, notification must be provided no later than ten calendar days following completion of the period of good faith negotiation under subsection (3) of this section for the most recent claim that is to be addressed through the arbitration. All of the claims at issue must:

(i) Involve identical carrier and provider or facility parties;

(ii) Involve claims with the same or related current procedural terminology codes relevant to a particular procedure; and

(iii) Occur within a two month period of one another, such that the earliest claim that is the subject of the arbitration occurred no more than two months prior to the latest claim that is the subject of the arbitration. For purposes of this subsection, a provider or facility claim occurs on the date the service is provided to a patient or, in the case of inpatient facility admissions, the date the admission ends.

(c) A notification submitted to the commissioner later than ten calendar days following completion of the period of good faith negotiation will be considered untimely and will be rejected. A party that has submitted an untimely notice is permanently foreclosed from seeking arbitration related to the claim or claims that were the subject of the untimely notice.

(d) Within seven calendar days of receipt of notification from the initiating party, the commissioner must provide the parties with a list of approved arbitrators or entities that provide arbitration. The arbitrator selection process must be completed within twenty calendar days of receipt of the original list of arbitrators from the commissioner, as follows:

(i) If the parties are unable to agree on an arbitrator from the original list sent by the commissioner, they must notify the commissioner within five calendar days of receipt of the original list of arbitrators. The commissioner must send the parties a list of five arbitrators within five calendar days of receipt of notice from the parties under this subsection.

(ii) If, after the opportunity to veto up to two of the five named arbitrators on the list of five arbitrators sent by the commissioner to the parties, more than one arbitrator remains on the list, the parties must notify the commissioner within five calendar days of receipt of the list of five arbitrators. The commissioner will choose the arbitrator from among the remaining arbitrators on the list.

(e) For purposes of this subsection, the date of receipt of a list of arbitrators is the date of electronic transmittal of the list to the parties by the commissioner. The date of receipt of notice from the parties to the commissioner is the date of electronic transmittal of the notice to the commissioner by the parties.

(6) If a noninitiating party fails to timely respond without good cause to a notice initiating arbitration, the initiating party will choose the arbitrator.

NEW SECTION

WAC 284-43B-040 Determining whether an enrollee's health plan is subject to the requirements of the act. To implement section 7, chapter 427, Laws of 2019, carriers must make information regarding whether an enrollee's health plan is subject to the requirements of chapter 427, Laws of 2019, available to providers and facilities using the most current version of the Health Insurance Portability and Accountability Act (HIPAA) mandated X12 Health Care Eligibility Benefit Response (271) transaction information through use of a standard message that is placed in a standard location within the 271 transaction. The designated lead organization for administrative simplification in Washington state, after consultation with carriers, providers and facilities through a new or an existing workgroup or committee, must post the language of the standard message and the location within the 271 transaction in which the message is to be placed on its web site on or before November 1, 2019. This information also must be posted on the web site of the office of the insurance commissioner.

NEW SECTION

WAC 284-43B-050 Notice of consumer rights and transparency. (1) The commissioner shall develop a standard template for a notice of consumer rights under the Balance Billing Protection Act. The notice may be modified periodically, as determined necessary by the commissioner. The notice template will be posted on the public web site of the office of the insurance commissioner.

(2) The standard template for the notice of consumer rights under the Balance Billing Protection Act must be provided to consumers enrolled in any health plan issued in Washington state as follows:

(a) Carriers must:

(i) Include the notice in the carrier's communication to an enrollee, in electronic or any other format, that authorizes nonemergency surgical or ancillary services at an in-network facility;

(ii) Post the notice on their web site in a prominent and relevant location, such as in a location that addresses coverage of emergency services and prior authorization requirements for nonemergency surgical or ancillary services performed at in-network facilities; and

(iii) Provide the notice to any enrollee upon request.

(b) Health care facilities and providers must:

(i) For any facility or provider that is owned and operated independently from all other businesses and that has more than fifty employees, upon confirming that a patient's health plan is subject to the Balance Billing Protection Act, include the notice in any communication to a patient, in electronic or any other format, confirming the scheduling of nonemergency surgical or ancillary services at a facility;

(ii) Post the notice on their web site, if the provider or facility maintains a web site, in a prominent and relevant location near the list of the carrier health plan provider networks with which the provider or facility is an in-network provider; and

(iii) Provide the notice upon request of a patient.

(3) For claims processed on or after July 1, 2020, when processing a claim that is subject to the balance billing prohibition in section 6, chapter 427, Laws of 2019, the carrier must indicate on any form used by the carrier to notify enrollees of the amount the carrier has paid on the claim:

(a) Whether the claim is subject to the prohibition in the act; and

(b) The federal Center for Medicare and Medicaid Services individual national provider identifier number, and organizational national provider identifier number, if the provider works for an organization or is in a group practice that has an organization number.

(4) A facility or health care provider meets its obligation under section 11 or 12, chapter 427, Laws of 2019, to include

a listing on its web site of the carrier health plan provider networks in which the facility or health care provider participates by posting this information on its web site within fourteen calendar days of receipt of a fully executed contract from a carrier. If the information is posted in advance of the effective date of the contract, the date that network participation will begin must be indicated.

(5) Not less than thirty days prior to executing a contract with a carrier, a hospital or ambulatory surgical facility must provide the carrier with a list of the nonemployed providers or provider groups that have privileges to practice at the hospital or ambulatory surgical facility or are contracted to provide surgical or ancillary services at the hospital or ambulatory surgical facility. The list must include the name of the provider or provider group, mailing address, federal tax identification number or numbers and contact information for the staff person responsible for the provider's or provider group's contracting. The hospital or ambulatory surgical facility must notify the carrier within thirty days of a removal from or addition to the nonemployed provider list. A hospital or ambulatory surgical facility also must provide an updated list of these providers within fourteen calendar days of a written request for an updated list by a carrier.

(6) An in-network provider must submit accurate information to a carrier regarding the provider's network status in a timely manner, consistent with the terms of the contract between the provider and the carrier.

NEW SECTION

WAC 284-43B-060 Enforcement. (1) If the commissioner has cause to believe that any health facility or provider has engaged in a pattern of unresolved violations of section 6 or 7, chapter 427, Laws of 2019, the commissioner may submit information to the department of health or the appropriate disciplining authority for action.

(2) In determining whether there is cause to believe that a health care provider or facility has engaged in a pattern of unresolved violations, the commissioner shall consider, but is not limited to, consideration of the following:

(a) Whether there is cause to believe that the health care provider or facility has committed two or more violations of section 6 or 7, chapter 427, Laws of 2019;

(b) Whether the health care provider or facility has failed to submit claims to carriers containing all of the elements required in WAC 284-43B-030(1) on multiple occasions, putting a consumer or consumers at risk of being billed for services to which the prohibition in section 6, chapter 427, Laws of 2019 applies;

(c) Whether the health care provider or facility has been nonresponsive to questions or requests for information from the commissioner related to one or more complaints alleging a violation of section 6 or 7, chapter 427, Laws of 2019; and

(d) Whether, subsequent to correction of previous violations, additional violations have occurred.

(3) Prior to submitting information to the department of health or the appropriate disciplining authority, the commissioner may provide the health care provider or facility with an opportunity to cure the alleged violations or explain why the actions in question did not violate section 6 or 7, chapter 427, Laws of 2019.

NEW SECTION

WAC 284-43B-070 Self-funded group health plan opt in. (1) A self-funded group health plan that elects to participate in sections 6 through 8, chapter 427, Laws of 2019, shall provide notice to the commissioner of their election decision on a form prescribed by the commissioner. The completed form must include an attestation that the self-funded group health plan has elected to participate in and be bound by sections 6 through 8, chapter 427, Laws of 2019. The form will be posted on the commissioner's public web site for use by self-funded group health plans.

(2) A self-funded group health plan may elect to initiate its participation on January 1st of any year or in any year on the first day of the self-funded group health plan's plan year.

(3) A self-funded group health plan's election occurs on an annual basis. On its election form, the plan must indicate whether it chooses to affirmatively renew its election on an annual basis or whether it should be presumed to have renewed on an annual basis until the commissioner receives advance notice from the plan that it is terminating its election as of either December 31st of a calendar year or the last day of its plan year. Notices under this subsection must be submitted to the commissioner at least thirty days in advance of the effective date of the election to initiate participation and the effective date of the termination of participation.

(4) Self-funded group health plan sponsors and their third party administrators may develop their own internal processes related to member notification, member appeals and other functions associated with their fiduciary duty to enrollees under the Employee Retirement Income Security Act of 1974 (ERISA).

NEW SECTION

WAC 284-43B-080 Effective date. Chapter 284-43B WAC takes effect on January 1, 2020.

AMENDATORY SECTION (Amending WSR 16-14-106, filed 7/6/16, effective 8/6/16)

WAC 284-170-480 Participating provider—Filing and approval. (1) An issuer must file for prior approval all participating provider agreements and facility agreements thirty calendar days prior to use. If a carrier negotiates a provider or facility contract or a compensation agreement that deviates from an approved agreement, then the issuer must file that negotiated contract or agreement with the commissioner for approval thirty days before use. The commissioner must receive the filings electronically in accordance with chapters 284-44A, 284-46A, and 284-58 WAC.

(2)(a) An issuer may file a provider or facility contract template with the commissioner. A "contract template" is a sample contract and compensation agreement form that the issuer will use to contract with multiple providers or facilities. A contract template must be issued exactly as approved.

(i) When an issuer modifies the contract template, an issuer must refile the modified contract template for

approval. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material. The modified template must be issued to providers and facilities upon approval.

(ii) Alternatively, issuers may file the modified contract template for prospective contracting and a contract addendum or amendment that would be issued to currently contracted providers or facilities for prior approval. The filing must include any correspondence that will be sent to a provider or facility that explains the amendment or addendum. The correspondence must provide sufficient information to clearly inform the provider or facility what the changes to the contract will be. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material.

(iii) Changes to a previously filed and approved provider compensation agreement modifying the compensation amount or terms related to compensation must be filed and are deemed approved upon filing if there are no other changes to the previously approved provider contract or compensation agreement.

(b)(i) All negotiated contracts and compensation agreements must be filed with the commissioner for approval thirty calendar days prior to use and include all contract documents between the parties.

(ii) If the only negotiated change is to the compensation amount or terms related to compensation, it must be filed and is deemed approved upon filing.

(3) If the commissioner takes no action within thirty calendar days after submission, the form is deemed approved except that the commissioner may extend the approval period an additional fifteen calendar days upon giving notice before the expiration of the initial thirty-day period. Approval may be subsequently withdrawn for cause.

(4) The issuer must maintain provider and facility contracts at its principal place of business in the state, or the issuer must have access to all contracts and provide copies to facilitate regulatory review upon twenty days prior written notice from the commissioner.

(5) Nothing in this section relieves the issuer of the responsibility detailed in WAC 284-170-280 (3)(b) to ensure that all provider and facility contracts are current and signed if the provider or facility is listed in the network filed for approval with the commissioner.

(6) If an issuer enters into a reimbursement agreement that is tied to health outcomes, utilization of specific services, patient volume within a specific period of time, or other performance standards, the issuer must file the reimbursement agreement with the commissioner thirty days prior to the effective date of the agreement, and identify the number of enrollees in the service area in which the reimbursement agreement applies. Such reimbursement agreements must not cause or be determined by the commissioner to result in discrimination against or rationing of medically necessary services for enrollees with a specific covered condition or disease. If the commissioner fails to notify the issuer that the agreement is disapproved within thirty days of receipt, the agreement is deemed approved. The commissioner may subsequently withdraw such approval for cause.

(7) Provider contracts and compensation agreements must clearly set forth the carrier provider networks and applicable compensation agreements associated with those networks so that the provider or facility can understand their participation as an in-network provider and the reimbursement to be paid. The format of such contracts and agreements may include a list or other format acceptable to the commissioner so that a reasonable person will understand and be able to identify their participation and the reimbursement to be paid as a contracted provider in each provider network.

WSR 19-20-113
PROPOSED RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter R 2019-08—Filed October 2, 2019, 9:53 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-15-134.

Title of Rule and Other Identifying Information: Technical corrections for producer accounting systems.

Hearing Location(s): On November 5, 2019, at 8:30 a.m., at the Office of the Insurance Commissioner (OIC), 302 Sid Snyder Avenue S.W., #200, Olympia, WA 98504.

Date of Intended Adoption: November 8, 2019.

Submit Written Comments to: Bode Makinde, P.O. Box 40260, Olympia, WA 98504-0260, email rulescoordinator@oic.wa.gov, fax 360-586-3109, by November 4, 2019.

Assistance for Persons with Disabilities: Melanie Watness, phone 360-725-7013, fax 360-586-2023, TTY 360-586-0241, email MelanieW@oic.wa.gov, by November 4, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The commissioner will consider adopting rules that is [are] intended to clarify the types of accounting records or accounting system that is required by the state. The clarification is needed based upon what is being discovered and reviewed when an insurance agency is being examined

Reasons Supporting Proposal: The revision is intended to clarify the types of accounting records or accounting system that is required by the state. The commissioner's financial examination team has suggested the clarification based upon what is being discovered and reviewed when an insurance agency is being examined.

Statutory Authority for Adoption: RCW 48.02.060, 48.17.005, 48.15.180, 48.17.480, and 48.17.600.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Bode Makinde, P.O. Box 40260, Olympia, WA, 98504-0260, 360-725-7041; Implementation: Todd Dixon, P.O. Box 40255, Olympia, WA 98504-0255, 360-725-7156; and Enforcement: Toni Hood, P.O. Box 40255, Olympia, WA 98504-0255, 360-725-7264.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. The proposed rule adopts without material change Washington state statutes and therefore is exempt under RCW 34.05.328 (5)(b)(iii).

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules only correct typographical errors, make address or name changes, or clarify language of a rule without changing its effect.

Explanation of exemptions: Much of this proposed rule simply corrects the word "indentify" and clarifies requirements that already exist in the WAC.

The clarifications further describe accounting recordkeeping for a producer.

October 2, 2019
Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending WSR 12-15-050, filed 7/16/12, effective 8/16/12)

WAC 284-12-080 Requirements for separate accounts. (1) The purpose of this section is to effectuate RCW 48.15.180, 48.17.600 and 48.17.480 with respect to the separation and accounting of premium funds by insurance producers, title insurance agents and surplus line brokers, collectively referred to in this section as "producers." Pursuant to RCW 48.30.010, the commissioner has found and hereby defines it to be an unfair practice for any producer, except as allowed by statute, to conduct insurance business without complying with the requirements of RCW 48.15.180, 48.17.600 and this section.

(2) All funds representing premiums as defined in RCW 48.18.170, which includes premium taxes and commissions, and return premiums received on Washington business by a producer in his or her fiduciary capacity on or after January 1, 1987, must be deposited in one or more identifiable separate accounts which may be interest bearing.

(a) A producer must not deposit funds other than premiums as defined in RCW 48.18.170, which includes premium taxes and commissions and return premiums to the separate account except as follows:

(i) Funds reasonably sufficient to pay bank charges;

(ii) Funds a producer may deem prudent for advancing premiums, or establishing reserves for the paying of return premiums;

(iii) Funds for contingencies as may arise in the business of receiving and transmitting premiums or return premiums; and

(iv) Fees paid by insureds as permitted under RCW 48.17.270(2).

(b) A producer may commingle Washington premiums as defined in RCW 48.18.170, which includes premium taxes and commissions, and return premiums with those produced in other states, provided adequate records are maintained to identify the amounts for Washington business. There must be no commingling of any funds not permitted by this section.

(3)(a) The separate account funds must be:

(i) Deposited in a checking account, demand account, or a savings account in a bank, national banking association, savings and loan association, mutual savings bank, stock savings bank, credit union, or trust company located in the state of Washington. The account must be insured by an entity of the federal government; or

(ii) Invested in United States government bonds and treasury certificates or other obligations for which the full faith and credit of the United States government is pledged for payment of principal and interest, and repurchase agreements collateralized by securities issued by the United States government. Insurers may, of course, restrict investments of separate account funds by their agent.

(b) A nonresident licensee, or a resident producer with affiliated operations under common ownership in two or more states, may utilize comparable accounts in another state provided such accounts otherwise meet the requirements of RCW 48.15.180, 48.17.600, 48.17.480 and this rule, and are accessible to the commissioner for purposes of examination or audit at the expense of the producer.

(4) Disbursements or withdrawals from a separate account must only be made for the following purposes, and in the manner stated:

(a) For charges imposed by a bank or other financial institution for operation of the separate account;

(b) For payments of premiums, directly to insurers or other producers entitled thereto;

(c) For payments of return premiums, which includes premium taxes, directly to the insureds or other persons entitled thereto;

(d) For payments of earned commissions and other funds belonging to the separate account's producer, directly to another account maintained by such producer as an operating or business account, but only to the extent that the premium funds for the policy or policies have actually been deposited into the separate premium account;

(e) For transfer of fiduciary funds, directly to another separate premium account which meets the requirements of this section;

(f) For payment of surplus line premium taxes to the state; and

(g) For payment of earned producer fees, but only to the extent that the fees were originally deposited in the separate premium account.

(5)(a) The funds deposited in the separate premium account must be paid promptly to the insurer or to another producer entitled thereto, in accordance with the terms of any applicable agreement between the parties.

(b) Return premiums received by a producer and the producer's share of any premiums required to be refunded, must be deposited promptly to the separate account. The funds must be paid promptly to the insured or person entitled thereto.

(6)(a) When a producer receives a premium payment in the form of an instrument, such as a check, which is made payable to an insurer, general agent or surplus line broker, the producer may forward the instrument directly to the payee if

that can be done without endorsement or alteration. In this case, the producer's separate account is not involved because the producer has not "received" any funds.

(b) If the producer receives a premium payment in the form of cash or an instrument requiring endorsement by the producer, the premium must be deposited into the producer's separate account, unless the insurer entitled to such funds has established other procedures by written direction to a producer who is its appointed agent, which procedures:

(i) Recognize that the producer is receiving premiums directly on behalf of the insurer; and

(ii) Direct the producer to give adequate receipts on behalf of the insurer; and

(iii) Require deposit of the proceeds into the insurer's own account or elsewhere as permitted by the insurer's direction.

Thus, for example, an insurer may utilize the services of a licensed insurance producer, acting as a "captive agent," in the sale of its insurance and in the operation of its places of business, and directly receive payments intended for it without the payments being deposited into and accounted for through the licensed insurance producer's separate account. In these cases, for purposes of this rule, the insurer, as distinguished from the insurance producer, is actually "receiving" the funds and is immediately responsible therefor.

(c) When a producer receives premiums as a surplus line broker, licensed under chapter 48.15 RCW, after a binder or other written evidence of insurance has been issued to the insured, subject to the express written direction of the insurer involved, the premiums, except premium taxes, may be removed from the separate account.

(7) The commissioner recognizes the practical problems of accounting for the small amounts of interest involved spread over a large number of insurers and insureds. Therefore, absent any agreement between the producer and the insured or insurer to the contrary, interest earned on the deposits held in the separate account may be retained by the producer and used to offset bank charges, establish reserves, pay return premiums, or for any of the purposes listed in subsection (2) of this section, or the interest may be removed to the operating account.

(8) A producer must establish and maintain accounting records ((~~and an appropriate accounting system~~)) for all premiums as defined in RCW 48.18.170, which includes premium taxes and commissions, return premiums, and fees received by the producer, and must make the records available for inspection by the commissioner ((~~during regular business hours upon demand~~)) during the five years immediately after the date of the transaction.

(9) The accounting ((~~system used~~)) records must:

(a) Effectively isolate the separate premium account from any operating accounts ((~~and segment or indentify~~));

(b) Identify all Washington business from that of other states((~~. All recordkeeping systems, whether manual or electronic must~~));

(c) Provide an audit trail ((~~so that details~~)) to identify underlying ((~~the summary data, such as invoices, checks, and statements, may be identified and made available on request. The system must provide the means to trace any transaction back to its original source or forward to final entry, as is accomplished by a conventional double-entry bookkeeping system. When automatic data processing systems are used, a description of the system must be available for review by the commissioner. A balance forward system (as in an ordinary checking account) is not acceptable.~~)) documents; and

(d) Provide the origin and disposition of all premium transactions.

(10)(a) A producer that is a business entity may utilize one separate account for the funds received by its affiliated persons operating under its license, and the affiliated persons may deposit the funds they receive in this capacity directly into the separate account of their firm or corporation.

(b) Funds received by an insurance producer who is employed by and offices with another insurance producer may be deposited into and accounted for through the separate account of the employing insurance producer. This provision does not, however, authorize the insurance producer employee to represent an insurer as to which he or she has no appointment.

(11) Premium taxes deposited to the separate premium account are held in trust for the state and must be maintained in the account until paid to the state.

(12) The separate premium account is a fiduciary account and not the personal asset or account of the producer. A producer must not make withdrawals from the account except as provided in this section. The separate premium account must not be encumbered in any manner nor be pledged as collateral for a loan.

(13) For the purposes of this section, a commission is earned no earlier than when the policy is bound or effective.

WSR 19-20-116
PROPOSED RULES
HEALTH CARE AUTHORITY

[Filed October 2, 2019, 10:20 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-16-054.

Title of Rule and Other Identifying Information: WAC 182-501-0200 Third-party resources.

Hearing Location(s): On November 5, 2019, at 10:00 a.m., at the Health Care Authority (HCA), Cherry Street Plaza, Sue Crystal Room 106A, 626 8th Avenue, Olympia, WA 98504. Metered public parking is available street side around building. A map is available at https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: Not sooner than November 6, 2019.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by November 5, 2019.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication relay services 711, email amber.lougheed@hca.wa.gov, by October 25, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is

revising this section to strike subsection (2)(a) to align with changes in 42 U.S.C. 1396a (a)(25)(E) which removed prenatal care from the list of medical services that the agency pays and then seeks reimbursements from a liable third party. State medicaid agencies must use standard coordination of benefits cost avoidance when processing prenatal services claims.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; 42 U.S.C. 1396a (a)(25)(E).

Statute Being Implemented: RCW 41.05.021, 41.05.160; 42 U.S.C. 1396a (a)(25)(E).

Rule is necessary because of federal law, 42 U.S.C. 1396a (a)(25)(E).

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Valerie Smith, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1344; Implementation and Enforcement: Mark Benya, P.O. Box 45565, Olympia, WA 98504-5565, 360-725-1891.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Citation of the specific federal statute or regulation and description of the consequences to the state if the rule is not adopted: 42 U.S.C. 1396a (a)(25)(E) as amended by Section 53102 (a)(1) of the Bipartisan Budget Act of 2018, Third Party Liability in Medicaid and CHIP.

October 2, 2019
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 16-23-021, filed 11/4/16, effective 1/1/17)

WAC 182-501-0200 Third-party resources. (1) The medicaid agency requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) The agency pays for medical services and seeks reimbursement from a liable third party when the claim is for any of the following:

(a) ((~~Prenatal care;~~

~~(b)~~)) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or

(((~~(c)~~))) (b) Preventive pediatric services as covered under the early and periodic screening, diagnosis and treatment program.

(3) The agency pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

(a) The provider submits to the agency documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and

(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing ((~~an absent~~)) a noncustodial parent to pay support. For the purpose of this section, "is enforcing" means the ((~~absent~~)) noncustodial parent either:

(i) Is not complying with an existing court order; or

(ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill the agency or the client for a covered service when a third party pays a provider the same amount as or more than the agency rate.

(5) When the provider receives payment from a third party after receiving reimbursement from the agency, the provider must refund to the agency the amount of the:

(a) Third-party payment when the payment is less than the agency's maximum allowable rate; or

(b) Agency payment when the third-party payment is equal to or more than the agency's maximum allowable rate.

(6) The agency does not pay for medical services if third-party benefits are available to pay for the client's medical services when the provider bills the agency, except under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third-party payment when the client either:

(a) Receives direct third-party reimbursement for the services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 182-503-0540 for assignment of rights.

(8) The agency considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third-party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, the agency or managed care organization (MCO) is responsible for providing medical services under WAC 182-501-0100.

WSR 19-20-118
PROPOSED RULES
DEPARTMENT OF RETIREMENT SYSTEMS

[Filed October 2, 2019, 10:35 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-14-109.

Title of Rule and Other Identifying Information: WAC 415-02-030 Definitions, 415-02-325 2008 Early retirement factors, 415-110-710 What are the return to work rules for SERS Plan 2 and Plan 3?, 415-112-525 What are the return to work rules for TRS Plan 1, Plan 2, and Plan 3?, and 415-113-300 How is my benefit affected if I return to work after retiring from multiple DRS retirement systems?

Hearing Location(s): On November 5, 2019, at 10:00 a.m., at the Department of Retirement Systems, 6835 Capitol Boulevard S.E., Tumwater, WA 98501.

Date of Intended Adoption: November 6, 2019.

Submit Written Comments to: Jilene Siegel, Department of Retirement Systems, P.O. Box 48380, Olympia, WA 98504-8380, email Rules@drs.wa.gov, by November 4, 2019.

Assistance for Persons with Disabilities: Contact Jilene Siegel, phone 360-664-7291, TTY 711, email Rules@drs.wa.gov, by October 31, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: To implement chapter 295, Laws of 2019 (HB [E2SHB] 1139), Educator workforce supply, as it relates to postretirement employment.

Statutory Authority for Adoption: RCW 41.50.050.

Statute Being Implemented: Sections 307-309, chapter 295, Laws of 2019.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of retirement systems, governmental.

Name of Agency Personnel Responsible for Implementation: Amy McMahan, Department of Retirement Systems, P.O. Box 48380, Olympia, WA 98504-8380, 360-664-7307.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 (5)(a)(i) does not apply to this proposed rule and is not voluntarily made applicable by the agency.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rule content is explicitly and specifically dictated by statute.

Is exempt under RCW 19-85-025(4).

Explanation of exemptions: These rules only impact retirees of the state retirement systems and participating public employers, and do not affect small businesses.

October 2, 2019
Jilene Siegel
Rules Coordinator

AMENDATORY SECTION (Amending WSR 16-17-047, filed 8/11/16, effective 9/11/16)

WAC 415-02-030 Definitions. This section contains definitions of words and phrases commonly used in the department of retirement systems' rules. It also serves as a directory for finding definitions within the RCW and WAC.

(1) **Accumulated contributions** means the sum of all contributions paid into a member's defined benefit account, including interest.

(2) **Appeal** means the proceeding through which a party obtains review of a department action in an adjudicative proceeding conducted under chapter 34.05 RCW (the Administrative Procedure Act) and chapter 415-08 WAC (the department's appeal rules).

(3) **Average final compensation** is defined in RCW 41.32.010(30) (TRS); RCW 41.35.010(14) (SERS); RCW 41.40.010(17) (PERS); and RCW 41.37.010(14) (PSERS).

(4) **Average final salary** for WSPRS is defined in RCW 43.43.120(15).

(5) **Cafeteria plan** means a "qualified" employee benefit program under IRC section 125, such as certain health and welfare plans.

(6) **Calendar month.**

(a) Refers to one of the twelve named months of the year, extending from the first day of the named month through the last day. For example: January 1st through January 31st is a calendar month. February 1st through February 29th is a calendar month in a leap year. March 13th through April 12th is ***not*** a calendar month.

(b) Exception: For the purpose of administering the break in employment required by RCW 41.32.570, 41.32.802, 41.32.862, 41.35.060, 41.37.050 and 41.40.037 for retirees returning to work, one calendar month means thirty consecutive calendar days. For example: Kim's retirement date is August 1st. August 31st would be the earliest Kim could return to work and meet the requirement for a one calendar month break in employment.

(7) **Compensation earnable or earnable compensation** definitions can be found in RCW 41.32.010(10) and 41.32.345 (TRS); RCW 41.35.010(6) (SERS); RCW 41.37.010(6) (PSERS); and RCW 41.40.010(8) (PERS).

(8) **Contribution rate** is:

(a) For employees: The fraction (percent) of compensation a member contributes to a retirement system each month.

(b) For employers: The fraction (percent) of payroll a member's employer contributes to a retirement system each month. Contribution rates vary for the different systems and plans.

(9) **Deferred compensation** refers to the amount of the participant's compensation, which the participant voluntarily defers from earnings before taxes to a deferred compensation program.

(10) **Defined benefit plan** is a pension plan in which a lifetime retirement allowance is available, based on the member's service credit and compensation.

(11) **Defined contribution plan** is a plan in which part of members' or participants' earnings are deferred into investment accounts in which tax is deferred until funds are withdrawn. The benefit is based on the contributions and the amount of return from the investment of the contributions. Members or participants receive the full market rate of return minus expenses. There is no guaranteed rate of return and the value of an account will increase or decrease based upon market fluctuations.

(12) **Department** means the department of retirement systems.

(13) **Director** means the director of the department of retirement systems.

(14) **Employee** means a worker who performs labor or services for a retirement systems employer under the control and direction of the employer as determined under WAC 415-02-110(2). An employee may be eligible to participate as a member of one of the state-administered retirement systems according to eligibility requirements specified under the applicable retirement system.

(15) **Employer** is defined in RCW 41.26.030(2) (LEOFF), 41.32.010(11) (TRS), 41.34.020(5) (Plan 3), 41.35.010(4) (SERS), 41.37.010(4) (PSERS) and 41.40.010(4) (PERS).

(16) **Ex-spouse** refers to a person who is a party to a "dissolution order" as defined in RCW 41.50.500(3).

(17) **Final average salary for LEOFF** is defined in RCW 41.26.030(12).

(18) **HERPs** mean higher education retirement plans described in chapter 28B.10 RCW, which are non-DRS retirement plans offered by institutions of higher education, such as, but not limited to, University of Washington retirement plan (UWRP) and Western Washington University retirement plan (WWURP).

(19) **Independent contractor** means a contract worker who is not under the direction or control of the employer as determined under WAC 415-02-110 (2) and (3).

(20) **IRC** means the Federal Internal Revenue Code of 1986, as subsequently amended.

(21) **Indexed retirement allowance** means a defined benefit retirement allowance from an indexed retirement plan, payable to a member who separates after having completed at least twenty service credit years, that is increased by twenty-five one-hundredths of one percent, compounded for each month from the date of separation to the date that the retirement allowance commences.

(22) **Indexed retirement plan** means one of the following retirement plans, which are administered by the department of retirement systems and provide an indexed retirement allowance: Law Enforcement Officers' and Firefighters Retirement System Plan 2 (RCW 41.26.530), Public Employees' Retirement System Plan 3 (RCW 41.40.790), School Employees' Retirement System Plan 3 (RCW 41.35.620), and Teachers' Retirement System Plan 3 (RCW 41.32.840).

(23) **JRF** means the judges' retirement fund created by chapter 2.12 RCW.

(24) **JRS** means the Washington judicial retirement system created by chapter 2.10 RCW.

(25) **LEOFF** means the Washington law enforcement officers' and firefighters' retirement system created by chapter 41.26 RCW.

(26) **Member** means a person who is included in the membership of one of the retirement systems created by chapters 2.10, 2.12, 41.26, 41.32, 41.34, 41.35, 41.37, 41.40, or 43.43 RCW.

(27) **Nonadministrative position or nonadministrative capacity** refers to retirees returning to work in a position at a school district, charter school, educational service district, state school for the deaf, state school for the blind, or tribal school which:

(a) Does not require an administrative certification, as defined by the office of the superintendent of public instruction, (currently positions requiring the certification include: Principal, vice principal, program administrator, conditional administrator, superintendent or program administrator certifications); or

(b) Does not evaluate staff.

(28) **Normal retirement** means qualifying for retirement based on the standard age and service credit requirements as specified in RCW 2.10.100 (JRS), 2.12.020 (JRF), 41.26.090 (LEOFF Plan 1), 41.26.430(1) (LEOFF Plan 2), 41.32.470 (TRS Plan 1), 41.32.765(1) (TRS Plan 2), 41.32.875(1) (TRS Plan 3), 41.35.420(1) (SERS Plan 2), 41.35.680(1) (SERS Plan 3), 41.37.210(1) (PSERS), 41.40.180 (PERS Plan 1), 41.40.630(1) (PERS Plan 2), 41.40.820(1) (PERS Plan 3), or 43.43.250 (WSPRS).

((~~(28)~~)) (29) **Participant** means an eligible employee who participates in a deferred compensation plan.

((~~(29)~~)) (30) **Participation agreement** means an agreement that an eligible employee signs to become a participant in a deferred compensation plan.

((~~(30)~~)) (31) **Pension plan** is a plan that provides a lifelong post retirement payment of benefits to employees.

((~~(31)~~)) (32) **PERS** means the Washington public employees' retirement system created by chapter 41.40 RCW.

((~~(32)~~)) (33) **Petition** means the method by which a party requests a review of an administrative determination prior to an appeal to the director. The department's petitions examiner performs the review under chapter 415-04 WAC.

((~~(33)~~)) (34) **Plan 1** means the retirement plans in existence prior to the enactment of chapters 293, 294 and 295, Laws of 1977 ex. sess.

((~~(34)~~)) (35) **Plan 2** means the retirement plans established by chapters 293, 294 and 295, Laws of 1977 ex. sess., chapter 341, Laws of 1998, and chapter 329, Laws of 2001.

((~~(35)~~)) (36) **Plan 3** means the retirement plans established by chapter 239, Laws of 1995, chapter 341, Laws of 1998, and chapter 247, Laws of 2000.

((~~(36)~~)) (37) **Plan year** is the twelve-month period that begins on January 1st and ends on December 31st of the same calendar year.

((~~(37)~~)) (38) **Portability** is the ability to use membership in more than one Washington state retirement system in order to qualify for retirement benefits. See chapters 41.54 RCW and 415-113 WAC.

((~~(38)~~)) (39) **PSERS** means the Washington public safety employees' retirement system created by chapter 41.37 RCW.

((~~(39)~~)) (40) **Public record** is defined in RCW 42.17.020(41).

((~~(40)~~)) (41) **Restoration** is the process of restoring a member's service credit for prior periods.

((~~(41)~~)) (42) **Retirement system employer - See "employer."**

((~~(42)~~)) (43) **Rollover** means a distribution that is paid to or from an eligible retirement plan within the statutory time limit allowed.

((~~(43)~~)) (44) **Separation date** is the date a member ends employment in a position eligible for retirement.

(((~~44~~))) (45) **SERS** means the Washington school employees' retirement system created by chapter 41.35 RCW.

(((~~45~~))) (46) **Split account** is the account the department establishes for a member or retiree's ex-spouse.

(((~~46~~))) (47) **Surviving spouse** refers to a person who was married to the member at the time of the member's death and who is receiving or is eligible to receive a survivor benefit.

(((~~47~~))) (48) **Survivor beneficiary** means a person designated by the member to receive a monthly benefit allowance after the member dies.

(((~~48~~))) (49) **Survivor benefit** is a feature of a retirement plan that provides continuing payments to a designee after the death of a member or retiree.

(((~~49~~))) (50) **TRS** means the Washington state teachers' retirement system created by chapter 41.32 RCW.

(((~~50~~))) (51) **The Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA)** is the federal law that requires employers to reemploy and preserve job security, pension and welfare benefits for qualified employees who engage in military service.

(((~~51~~))) (52) **WSPRS** means the Washington state patrol retirement system created by chapter 43.43 RCW.

AMENDATORY SECTION (Amending WSR 17-04-050, filed 1/26/17, effective 2/26/17)

WAC 415-02-325 2008 Early retirement factors. (1) **What are the 2008 early retirement factors?** In chapter 491, Laws of 2007, the legislature created optional early retirement factors (ERFs) for members retiring on or after September 1, 2008. Referred to as the 2008 ERFs, these optional factors are available to Plan 2 and Plan 3 members of the following retirement systems: Public employees' retirement system (PERS); school employees' retirement system (SERS); and teachers' retirement system (TRS). The 2008 ERFs provide a higher retirement benefit than the three percent ERFs, but impose stricter return to work rules.

(2) **If I retire before age sixty-five using the 2008 ERFs, how will my benefit be calculated?** Your normal (age sixty-five) retirement benefit will be multiplied by the factor shown in the following table, based on your age at the time of your early retirement.

Retirement Age	2008 Early Retirement Factor
55	0.80
56	0.83
57	0.86
58	0.89
59	0.92
60	0.95
61	0.98
62	1.00
63	1.00
64	1.00
65	1.00

(3) **Am I eligible for the 2008 ERFs?** Plan 2 and Plan 3 members of PERS, SERS, and TRS, who entered membership prior to May 1, 2013, must be at least age fifty-five and have at least thirty service credit years to be eligible for retirement using the 2008 ERFs.

(4) **What are the return to work rules if I retire under the 2008 ERFs?** The legislation that created the 2008 ERFs also established restrictions on retirees who return to an employer after selecting the 2008 ERF option. The 2008 ERF return to work restrictions are a broad prohibition to avoid incentives for early retirement while the member continues to collect payments from a public employer before reaching full retirement age. A retiree's benefit will stop if they retire under the 2008 ERFs and return to a DRS-covered employer, in any capacity for which they receive compensation, before age sixty-five.

(5) **What are the exceptions to the return to work rules if I retire from SERS or TRS under the 2008 ERFs?** Under legislation effective May 8, 2019, you may return to work in a nonadministrative position as defined in WAC 415-02-030 for a school district, charter school, educational service district, state school for the deaf, state school for the blind, or tribal school without suspension of your benefit until you exceed eight hundred sixty-seven hours in a calendar year.

(6) **What organizations are DRS-covered employers?** For the purpose of this section, a DRS-covered employer is any organization that employs one or more members of any retirement system administered by DRS. This includes, but is not limited to, public agencies, boards and commissions, counties, cities and towns, public schools and educational service districts, higher education institutions, libraries and utilities throughout the state. It also includes first class cities that maintain separate retirement systems but also employ members of the law enforcement officers' and fire fighters' retirement system.

(((~~6~~))) (7) **What types of compensation impact my benefit if I retire under the 2008 ERFs and return to work before age sixty-five?** The legislature defines "employment with an employer" for purposes of the 2008 ERF return to work restrictions as including "any personal service contract, service by an employer as a temporary or project employee, or any other similar compensated relationship with any employer." The phrase "any other similar compensated relationship with any employer" includes both employment with a DRS-covered employer and any other type of compensated relationship with a DRS-covered employer.

Example:

Bob, an attorney for the city of Olympia, retires using the 2008 ERFs. Can Bob receive his pension if he subsequently provides legal services to Spokane County? It depends on whether Bob's compensated relationship with Spokane County meets the definition of "employment with an employer." Below are examples of the different types of potential compensated relationships Bob could have, and

whether those relationships would be considered "employment with an employer."

Personal service contract. If Bob has a personal service contract with Spokane County to provide legal services, then Bob would be considered to be in a "similar compensated relationship with an employer" within the meaning of the statute. Bob's monthly benefit would be suspended for any month in which he provides this compensated service to Spokane County.

Sole proprietorship or partnership. 2008 ERF retiree is sole proprietor or partner. If Bob is a sole proprietor or a partner of a law firm; the firm contracts with Spokane County to provide services; and Bob or any other employee of the law firm provides legal services to Spokane County, then Bob would be considered to be in a "similar compensated relationship with an employer" within the meaning of the statute. Bob's monthly benefit would be suspended for any month in which he or his firm provides service to Spokane County under the contract.

Corporation. 2008 ERF retiree is a shareholder of a publicly traded corporation. If Bob is a shareholder of a publicly traded corporation and the corporation contracts with Spokane County to provide services, then Bob would not be considered to be in a "similar compensated relationship with an employer" within the meaning of the statute. Bob's monthly benefit would not be suspended for any month in which the corporation provides service to Spokane County.

Corporation. ERF retiree is an employee of the corporation. If Bob is working for the corporation solely on matters unrelated to the corporation's contract with Spokane County, Bob is not in a "similar compensated relationship" with Spokane County. Bob's monthly benefit would not be suspended for any month in which the corporation provides service to Spokane County.

If Bob is working for the corporation on matters that are related to the corporation's contract with Spokane County, then Bob would be considered to be in a "similar compensated relationship with an employer."

((~~(7)~~)) (8) **What is considered compensation?** Compensation is financial consideration for work performed, regardless of whether that consideration is paid as a salary, hourly amount, or flat dollar amount. A reimbursement is not considered compensation.

Examples:

((~~Basketball referee~~)) Independent contractor - A TRS Plan 2 member retires using the 2008 ERFs at age 62. He receives a $2,500 monthly pension payment. When he is 64, he ((~~referees one high school basketball game~~)) enters a contract to provide training for school employees. He receives a flat dollar amount of $50 ((~~for refereeing the game~~)) per trainee. Under the 2008 ERF return to work restrictions, he has ((~~returned to the employment of an employer and~~)) received compensation from a DRS-covered employer. Therefore, his $2,500 pension benefit is forfeited for the month he ((~~earned the $50 payment~~)) performed the services.

Board/commission - A PERS Plan 3 member retires using the 2008 ERFs at age 60. She receives a $1,200 monthly pension payment. When she is 62, she is elected as a member of the local school board. As a school board member she does not receive a salary; however, she does receive reimbursements for travel and food. Under the 2008 ERF return to work restrictions, she is able to continue to receive her pension while receiving those reimbursements.

((~~(8)~~)) (9) **What are a DRS employer's responsibilities for determining whether an employee is a 2008 ERF retiree?** RCW 41.50.139 requires DRS employers to obtain, in writing, the retirement status of all new employees. If the employer fails to report a 2008 ERF retiree's retirement status to the department, the employer is liable for any overpayments that may occur.

((~~(9)~~)) (10) **What are a DRS employer's responsibilities for determining whether a contractor's employees are 2008 ERF retirees?** DRS employers who hire a contractor to perform services for their organization will need to inquire with the contractor and confirm with DRS to determine if any of the workers providing services to the DRS employer through the contractor retired using the 2008 ERFs, or if the company is owned by an individual who retired using the 2008 ERFs, and whether the nature of the service and compensation would result in a retirement benefit being suspended. See WAC 415-108-710 (PERS), 415-110-710 (SERS), and 415-112-525 (TRS).

AMENDATORY SECTION (Amending WSR 16-17-047, filed 8/11/16, effective 9/11/16)

WAC 415-110-710 What are the return to work rules for SERS Plan 2 and Plan 3? (1) **How soon can I return to work after I retire without impacting my SERS retirement benefit?**

(a) You may begin working immediately after you retire without impacting your SERS retirement benefit if:

(i) You go to work for a private employer;

(ii) You are an independent contractor as defined in WAC 415-02-110; or

(iii) Your only employment is as an elected official and you end your SERS membership under RCW 41.35.030 (2)(b).

(b) If you retire and then return to work sooner than thirty consecutive calendar days from your accrual date (effective retirement date), your monthly retirement benefit will be reduced in accordance with RCW 41.35.060(1) until you remain absent for at least thirty consecutive calendar days.

(c) If you retire and remain absent at least thirty consecutive calendar days from your accrual date, you may return to work in any position (eligible or ineligible) for any employer whose retirement plan is administered by the department of retirement systems (DRS) or a public institution of higher education, without impacting your SERS retirement benefit until you reach your applicable hour limit.

Example: Amy's last day at work for the ABC school district is June 19, 2015, and her official retirement date is September 1, 2015, (when she starts getting her monthly benefit). She wants to return to work at the start of the new school year on September 8, 2015. She needs to wait thirty consecutive calendar days from her September 1st retirement date before returning to work. If she returns to work before Octo-

ber 1st, her benefit will be reduced until she meets the required thirty-day break from employment.

(2) **What is the annual hour limit?** Except as provided in subsection (5) of this section regarding the 2008 early retirement factors (ERFs), after being absent at least thirty consecutive calendar days as described in subsection (1)(c) of this section, your annual hour limit will be based on the position you return to.

(a) **No limit.** You may work as many hours as you want without affecting your retirement benefit if you work:

(i) In a position that is not eligible for membership in a DRS or higher education retirement plan;

(ii) As an independent contractor;

(iii) For a private employer; or

(iv) If you end your SERS membership as an elected official under RCW 41.35.030 (2)(b).

(b) **Eight hundred sixty-seven-hour limit.** You may work up to eight hundred sixty-seven hours in a calendar year, in a position which is eligible for membership in a DRS or public institution of higher education retirement plan, before your retirement benefit is suspended.

(3) **What hours count toward the limit?**

(a) **Counted toward the eight hundred sixty-seven hour limit:** All compensated hours that are worked in an eligible position covered by a DRS or higher education retirement plan, including the use of earned sick leave, vacation days, paid holidays, compensatory time, and cashouts of compensatory time.

(b) **Not counted toward the hour limit:** Cashouts of unused sick and vacation leave.

(4) **What happens if I work more than the annual eight hundred sixty-seven hour limit?**

(a) If you work more than the annual limit, your retirement benefit will be suspended. The suspension will be effective the day after you exceed the hour limit. DRS will prorate your retirement benefit for the month in which you exceed the limit.

(b) Your retirement benefit will be restarted beginning the next calendar year (January) or the day after you terminate all eligible employment, whichever occurs first.

(c) DRS will recover any overpayments made to you for the month(s) in which you exceeded the hour limit and received a retirement benefit. See RCW 41.50.130.

(5) ((~~**What if I retired using the 2008 early retirement factors (ERFs)?**~~

~~(a) If you retire using the 2008 ERFs and then return to work before age sixty-five:~~

~~(i) You will not receive your retirement benefit for any month in which you are an employee in a position covered by a DRS or higher education retirement plan including, but not limited to, permanent, nonpermanent, project, temporary, eligible and ineligible positions.~~

~~(ii) You will not receive your retirement benefit for any month in which you earn compensation for service performed as a contractor, or as the result of service performed by those in your employ, for an employer covered by a DRS or higher education retirement plan.~~

~~(iii) Your retirement benefit will stop effective the first day of the month you return to work and will restart the first day of the month after you stop working.~~

~~(b) If you retire using the 2008 ERFs and then return to work at or after age sixty-five, you can work under the rules described in subsections (2) and (3) of this section.~~

~~(6)~~)) **If you retire using the 2008 ERFs and return to work before age sixty-five except as described in subsection (6) of this section:**

(a)(i) You will not receive your retirement benefit for any month in which you are an employee in a position covered by a DRS or higher education retirement plan including, but not limited to, permanent, nonpermanent, project, temporary, eligible and ineligible positions.

(ii) You will not receive your retirement benefit for any month in which you earn compensation for service performed as a contractor, or as the result of service performed by those in your employ, for an employer covered by a DRS or higher education retirement plan.

(iii) Your retirement benefit will stop effective the first day of the month you return to work and will restart the first day of the month after you stop working.

(b) Upon reaching age sixty-five you can work under the rules described in subsections (2) and (3) of this section.

(6) **As a 2008 ERF retiree, can I work and still receive my retirement benefit?**

(a) If you retire using the 2008 ERFs, effective May 8, 2019, you may return to work before age sixty-five in a non-administrative position at a school district, charter school, educational service district, state school for the deaf, state school for the blind, or tribal school and work up to eight hundred sixty-seven hours in a calendar year. If you work more than eight hundred sixty-seven hours, your benefit will be subject to suspension and restarting as described in subsection (4) of this section.

(b) Upon reaching age sixty-five you can work under the rules described in subsections (2) and (3) of this section.

(7) **Can I return to SERS membership?**

(a) If you retire from SERS, you have the option to return to membership if you are employed by a SERS employer and meet the eligibility criteria. The option to return to membership is prospective from the first day of the month following the month in which you request to return to membership. See RCW 41.35.030(3).

(b) If you reenter SERS membership and later choose to retire again, DRS will recalculate your retirement benefit under the applicable statutes and regulations. See WAC 415-110-830. You will be subject to the return to work rules in place at the time of your reretirement.

(c) If you are a retiree from another retirement system administered by DRS, you may choose to enter SERS membership if you are eligible. See WAC 415-110-725. The option to enter membership is prospective from the first day of the month following the month in which you request membership. See RCW 41.04.270 and 41.35.030.

((~~(7)~~)) (8) **What if I retired from SERS and another DRS retirement system?**

(a) If you retired from SERS using the 2008 ERFs and another DRS retirement system and are under age sixty-five:

(i) Your SERS retirement benefit will be impacted as described in subsections (5) and (6) of this section.

(ii) The retirement benefit from the other DRS retirement system will be impacted based on the rules for that system.

(b) If you retired from SERS and another DRS retirement system without using the 2008 ERFs, or using the 2008 ERFs and have reached age sixty-five, see WAC 415-113-300 to determine the effect of returning to work.

Note: You may have a choice of returning to membership. See the following WAC sections for more information: WAC 415-108-725, 415-110-725, 415-112-546, 415-106-725, and 415-104-111.

((~~(8)~~)) (9) **Terms used.**

(a) 2008 Early retirement factors (ERFs) - RCW 41.35.420 (3)(b) for SERS Plan 2, or RCW 41.35.680 for SERS Plan 3.

(b) Accrual date - RCW 41.35.450, 41.35.640.

(c) Elected official - WAC 415-110-550.

(d) Eligible position - RCW 41.35.010; WAC 415-110-680 through 415-110-700.

(e) Ineligible position - RCW 41.35.010.

(f) Member - RCW 41.35.010.

(g) Month - Calendar month as defined in WAC 415-02-030.

(h) Nonadministrative position - WAC 415-02-030.

(i) Public institution of higher education - RCW 28B.10.400.

((~~(i)~~)) (j) SERS - School employees' retirement system.

AMENDATORY SECTION (Amending WSR 16-17-047, filed 8/11/16, effective 9/11/16)

WAC 415-112-525 What are the return to work rules for TRS Plan 1, Plan 2, and Plan 3? (1) **How soon can I return to work after I retire without impacting my TRS retirement benefit?**

(a) You may begin working immediately after you retire without impacting your TRS retirement benefit if:

(i) You go to work for a private employer;

(ii) You are an independent contractor as defined in WAC 415-02-110; or

(iii) You are a TRS Plan 1 retiree, your only employment is as an elected official, and you end your TRS membership under RCW 41.32.263.

(b) If you retire and then return to work for a public employer except as provided in (a) of this subsection, sooner than thirty consecutive calendar days from your accrual date (effective retirement date), your retirement allowance will be reduced until you remain absent for at least thirty consecutive calendar days. See RCW 41.32.570 (TRS Plan 1), 41.32.802 (TRS Plan 2), or 41.32.862 (TRS Plan 3).

(c) If you retire and remain absent at least thirty consecutive calendar days from your accrual date, you may return to work in any position (eligible or ineligible) for any employer whose retirement plan is administered by the department of retirement systems (DRS) or a public institution of higher education, without impacting your TRS retirement benefit until you reach your applicable hour limit.

(d) **Examples:**

(i) **Return to work with no reduction**

Casey's last day of work is January 20th. Her accrual date (effective retirement date) is February 1st, and there are 28 days in February. If Casey wants to return to work for a public employer after she retires, she will need to wait until at least March 3rd to avoid the daily percentage reduction in her retirement allowance.

(ii) **Return to work before thirty day waiting period ends**

Brian's last day of work is September 1st. His accrual date (effective retirement date) is October 1st. Brian returns to work October 10 through October 17th. In November, Brian's retirement allowance will be reduced by 5.5% for every seven hours worked during October. Brian's new thirty day wait period would be October 18th through November 16th.

(2) **What is the annual hour limit?** Except as provided in subsection (5) of this section regarding the 2008 early retirement factors, after being absent at least thirty consecutive calendar days as described in subsection (1)(c) of this section, your annual hour limit will be based on the position you return to.

(a) **No limit.** You may work as many hours as you want without affecting your retirement benefit if:

(i) You go to work for a private employer;

(ii) You are an independent contractor as defined in WAC 415-02-110; or

(iii) You are a TRS Plan 1 retiree, and:

(A) Your only employment is as an elected official, and you end your TRS membership under RCW 41.32.263; or

(B) You go to work for a nonpublic educational institution.

(iv) You are a TRS Plan 2 or Plan 3 member working as an on-call substitute teacher.

(b) **Eight hundred sixty-seven-hour limit.** You may work up to eight hundred sixty-seven hours in a year (July through June for TRS Plan 1, January through December for TRS Plan 2 and Plan 3) before your retirement benefit is suspended.

(3) **What hours count toward the limit?**

(a) **Counted toward the eight hundred sixty-seven-hour limit:** All compensated hours that are worked in an eligible position, including the use of earned sick leave, vacation days, paid holidays, compensatory time, and cashouts of compensatory time.

(b) **Not counted toward the hour limit:** Cashouts of unused sick and vacation leave.

(4) **What happens if I work more than the annual eight hundred sixty-seven-hour limit?**

(a) If you work more than the annual limit, your retirement benefit will be suspended. The suspension will be effective the day after you exceed the hour limit. DRS will prorate your retirement benefit for the month in which you exceed the limit.

(b) Your retirement benefit will be restarted beginning the next year (July for TRS Plan 1, January for TRS Plan 2 or Plan 3) or the day after you terminate all eligible employment, whichever occurs first.

(c) DRS will recover any overpayments made to you for the month(s) in which you exceeded the hour limit and received a retirement benefit. See RCW 41.50.130.

(5) **What if I am a TRS Plan 2 or Plan 3 member and retired using the 2008 early retirement factors (ERFs)?**

(a) If you retire using the 2008 ERFs and ((~~then~~)) return to work before age sixty-five except as described in subsection (6) of this section:

(i) You will not receive your retirement benefit for any month in which you are an employee in a position covered by a DRS or higher education retirement plan including, but not limited to, permanent, nonpermanent, project, temporary, eligible and ineligible positions.

(ii) You will not receive your retirement benefit for any month in which you earn compensation for service performed as a contractor, or as the result of service performed by those in your employ, for an employer covered by a DRS or higher education retirement plan.

(iii) Your retirement benefit will stop effective the first day of the month you return to work and will restart the first day of the month after you stop working.

(b) ((~~If you retire using the 2008 ERFs,~~)) Upon reaching age sixty-five you can work under the rules described in subsections (2) and (3) of this section.

(6) **As a 2008 ERF retiree, can I work and still receive my retirement benefit?**

(a) If you retire using the 2008 ERFs, effective May 8, 2019, you may return to work before age sixty-five in a nonadministrative position at a school district, charter school, educational service district, state school for the deaf, state school for the blind, or tribal school and work up to eight hundred sixty-seven hours in a calendar year. If you work more than eight hundred sixty-seven hours, your benefit will be subject to suspension and restarting described in subsection (4) of this section.

(b) If you retire using the 2008 ERFs and return to work as a substitute teacher in a classroom between June 10, 2016, and May 7, 2019, you will continue to receive your retirement benefit for up to eight hundred sixty-seven hours in a calendar year.

(c) Upon reaching age sixty-five you can work under the rules described in subsections (2) and (3) of this section.

(7) **Can I return to TRS membership?**

(a) You may choose to return to membership if you are employed by a public educational institution and are otherwise eligible. Membership will be prospective from the first day of the month following the month in which you request to return to membership. See RCW 41.32.044.

(b) If you reenter TRS membership and later choose to retire again, DRS will recalculate your retirement benefit under the applicable statutes and regulations. You will be subject to the return to work rules in place at the time of your reretirement.

(c) If you are a retiree from another retirement system administered by DRS, you may choose to enter TRS membership if you are eligible. See WAC 415-112-546. The option to enter membership is prospective from the first day of the month following the month in which you request membership. See RCW 41.04.270 and 41.35.030.

((~~(7)~~)) (8) **What if I retired from TRS and another DRS retirement system?**

(a) If you retired from TRS using the 2008 ERFs and another DRS retirement system, and are under age sixty-five:

(i) Your TRS retirement benefit will be impacted as described in subsections (5) and (6) of this section.

(ii) The retirement benefit from the other DRS retirement system will be impacted based on the rules for that system.

(b) If you retired from TRS and another DRS retirement system without using the 2008 ERFs, or using the 2008 ERFs and have reached age sixty-five, see WAC 415-113-300 to determine the effect of returning to work.

Note: You may have a choice of returning to membership. See the following WAC sections for more information: 415-108-725, 415-110-725, 415-112-546, 415-106-725, and 415-104-111.

((~~(8)~~)) (9) **Terms used.**

(a) "Accrual date" - WAC 415-112-520; RCW 41.32.795, 41.32.855.

(b) "Eligible position" - RCW 41.32.010.

(c) "Employer" - RCW 41.32.010.

(d) "Nonadministrative position" - WAC 415-02-030.

(e) "Year."

(i) For TRS Plan 1, a "year" is July 1st through June 30th.

(ii) For TRS Plan 2 and Plan 3, a "year" is January 1st through December 31st.

AMENDATORY SECTION (Amending WSR 16-17-047, filed 8/11/16, effective 9/11/16)

WAC 415-113-300 How is my benefit affected if I return to work after retiring from multiple DRS retirement systems? (1) If you ((~~retired using the 2008 early retirement factors (ERFs) and return to work for a DRS employer before age sixty-five, your retirement benefit(s) based on the 2008 ERFs will be immediately suspended. Any benefit(s) not based on the 2008 ERFs will be subject to rules for that system.~~

~~(2) If you are retired from multiple DRS systems and return to work for a DRS employer, your benefits will be affected according to rules of each respective system with the following exception:~~)) are retired from multiple DRS systems and return to work for a DRS employer, your benefits will be affected according to rules of each respective system.

(a) If your system and plan has an annual hourly limit, the annual hourly limit is based on the calendar year, except as described in subsection (b) of this section.

(b) If one of the systems you retired from is TRS Plan 1, your annual hourly limit for all your systems will be counted using a fiscal year (July through June).

See WAC 415-108-710 (PERS), 415-110-710 (SERS), ((~~415-112-541 (TRS Plan 1), 415-112-541 (TRS Plan 2 and Plan 3)~~)) 415-112-525 (TRS), 415-106-700 (PSERS), RCW 41.26.500 (LEOFF Plan 2), 43.43.130 (WSPRS).

((~~(3)~~)) (2) Term used.

Employer - See WAC 415-02-030.

WSR 19-20-119
PROPOSED RULES
HEALTH CARE AUTHORITY

[Filed October 2, 2019, 10:44 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-10-061.

Title of Rule and Other Identifying Information: WAC 182-543-1100 Client eligibility and 182-543-4200 Wheelchairs—Power-drive.

Hearing Location(s): On November 5, 2019, at 10:00 a.m., at the Health Care Authority (HCA), Cherry Street Plaza, Sue Crystal Conference Room 106A, 626 8th Avenue, Olympia, WA 98504. Metered public parking is available street side around building. A map is available at https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: Not sooner than November 6, 2019.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by November 5, 2019.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication relay services 711, email amber.lougheed@hca.wa.gov, by October 25, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is making changes to two sections in the medical equipment chapter. In WAC 182-543-1100(6), the agency is removing the requirement that a client enrolled in the alternative benefits plan have a qualifying condition to receive habilitative services. This revision aligns with WAC 182-545-400 Habilitative services.

In WAC 182-543-4200, the agency is clarifying the differences between adults and children who use power-drive wheelchairs by creating separate subsections. The rule clarifies that the agency pays for medically necessary power-drive wheelchairs that are prior authorized. In addition to the criteria set out in the rule, subsection (1)(c) states that the agency may pay for power wheelchairs on a case-by-case basis when prior authorized. Subsection (2) clarifies that the agency reviews requests for power wheelchairs for eligible children under the early and periodic screening, diagnosis and treatment program. Subsection (6) clarifies that the agency pays for more than one wheelchair when medically necessary for the client.

Reasons Supporting Proposal: Eligibility criteria for power wheelchairs is different for adults and children, and separating this information helps clarify the rule.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Melinda Froud, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1408; Implementation and Enforcement: Erin Mayo, P.O. Box 45506, Olympia, WA 98504-5506, 360-725-1729.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. This rule does not impose any costs on businesses.

October 2, 2019
Wendy Barcus
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-24-021, filed 11/27/18, effective 1/1/19)

WAC 182-543-1100 Client eligibility. (1) Refer to the table in WAC 182-501-0060 to see which Washington apple health programs include home health services, including medical equipment and related services, in their benefit package.

(2) For clients eligible under an alien emergency medical (AEM) program, see WAC 182-507-0115.

(3) Clients who are eligible for services under medicare and medicaid (medically needy program-qualified medicare beneficiaries) are eligible for medical equipment and related services.

(4) Clients who are enrolled in a medicaid agency-contracted managed care organization (MCO) must arrange for medical equipment and related services directly through the client's agency-contracted MCO. The agency does not pay for medical equipment or services provided to a client who is enrolled in an agency-contracted MCO, but chose not to use one of the MCO's participating providers.

(5) For clients who reside in a skilled nursing facility, see WAC 182-543-5700.

(6) Clients enrolled in the alternative benefits plan (defined in WAC 182-500-0010) are eligible for medical equipment when used as a habilitative service ((~~to treat a qualifying condition~~)) in accordance with WAC 182-545-400.

AMENDATORY SECTION (Amending WSR 18-24-021, filed 11/27/18, effective 1/1/19)

WAC 182-543-4200 Covered wheelchairs—Power-drive. The medicaid agency pays for medically necessary power-drive wheelchairs when prior authorized.

(1) **Adults.**

(a) The medicaid agency pays for power-drive wheelchairs for clients age twenty-one and older when the prescribing physician certifies that the following clinical criteria are met:

(((~~a~~))) (i) The client can ((~~independently~~)) effectively and safely operate a power-drive wheelchair;

(((~~b~~))) (ii) The client's medical condition ((~~negates~~)) prevents the ((~~client's ability to self-propel~~)) client from self-pro-

pelling any of the wheelchairs listed in the manual wheelchair category ((~~in any setting where normal life activities take place; and~~

~~(c)~~)) .

(b) A power-drive wheelchair will((~~:~~

~~(i)~~)) provide the client the only means of independent mobility in any setting where normal life activities take place((~~; or~~

~~(ii) Enable a child to achieve age-appropriate independence and developmental milestones~~)).

(c) The agency may also pay for power wheelchairs on a case-by-case basis when prior authorized as described in WAC 182-501-0165. The agency determines medical necessity based on documentation submitted by the provider.

(2) **Children.** The agency reviews requests for power wheelchairs for a person age twenty and younger using the standard for coverage under the EPSDT program according to the provisions of WAC 182-534-0100.

(3) **Three or four wheeled power-drive scooters/power-operated vehicles (POV).** Additionally, for a three or four-wheeled power-drive scooter/power-operated vehicle (POV), the prescribing physician must certify the client's condition is unlikely to require a standard power-drive wheelchair within the next two years.

(((~~3~~))) (4) **Client's primary wheelchair.** When the agency approves a power-drive wheelchair for a client who already has a manual wheelchair, the power-drive wheelchair becomes the client's primary chair, unless the client meets the criteria in subsection (((~~5~~))) (6) of this section.

(((~~4~~))) (5) **Payment for primary wheelchair.** The agency pays to maintain only the client's primary wheelchair, unless the conditions of subsection (((~~6~~))) (7) of this section apply.

(((~~5~~))) (6) **Approval for more than one wheelchair.** The agency pays for one manual wheelchair and one power-drive wheelchair for noninstitutionalized clients ((~~only when one of the following circumstances applies~~)) when medically necessary for the client to have mobility in all settings where the client's normal life activities take place. Situations that demonstrate medical necessity include, but are not limited to, the following:

(a) The architecture of locations where the client's normal life activities take place are completely unsuitable for a power-drive wheelchair, due to conditions such as narrow hallways, narrow doorways, steps at the entryway, and insufficient turning radius;

(b) The architecture of the bathroom in locations where the client's normal life activities take place is such that power-drive wheelchair access is not possible, and the client needs a manual wheelchair to safely and successfully complete bathroom activities and maintain personal cleanliness; or

(c) The client has a power-drive wheelchair, but also requires a manual wheelchair because the power-drive wheelchair cannot be transported to meet the client's community, workplace, or educational activities. In this case, the manual wheelchair would allow the caregiver to transport the client in a standard automobile or van. The agency requires the client's situation to meet the following conditions:

(i) The client's activities that require the second wheelchair must be located farther than one-fourth of a mile from the client's home or along a pathway that does not provide for safe use of a power wheelchair; and

(ii) Cabulance, public buses, or personal transit are not available, practical, or possible for financial or other reasons.

(((~~6~~))) (7) **Payment for more than one wheelchair.** When the agency approves both a manual wheelchair and a power-drive wheelchair for a noninstitutionalized client who meets one of the circumstances in subsection (((~~5~~))) (6) of this section, the agency pays to maintain both wheelchairs.

WSR 19-20-120
PROPOSED RULES
NOXIOUS WEED CONTROL BOARD

[Filed October 2, 2019, 11:02 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-16-012 and 19-16-03 [19-16-037].

Title of Rule and Other Identifying Information: Chapter 16-750 WAC, State noxious weed list and schedule of monetary penalties, the Washington state noxious weed control board (WSNWCB) is proposing to amend the state noxious weed list for 2020, create two new sections regarding the executive secretary and the education specialist, and update three additional sections of chapter 16-750 WAC.

Hearing Location(s): On November 5, 2019, at 1:00 p.m., at the Coast Wenatchee Center Hotel, 201 North Wenatchee Avenue, Wenatchee, WA 98801.

Date of Intended Adoption: November 26, 2019.

Submit Written Comments to: Mary Fee, WSNWCB, P.O. Box 42560, Olympia, WA 98504-2560, email mfee@agr.wa.gov or noxiousweeds@agr.wa.gov, fax 360-902-2053, by November 4, 2019.

Assistance for Persons with Disabilities: Contact Deanna Painter, phone 360-902-2061, TTY 800-833-6388, email dpainter@agr.wa.gov, by October 30, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The Washington state noxious weed list provides the basis for noxious weed control efforts for county noxious weed control boards and other entities. It also provides guidelines for WSNWCB. This proposal makes a few amendments to WAC 16-750-005 and 16-750-011. Specifically, the board is considering:

1. WAC 16-750-005 one proposed Class A addition, South American spongeplant, *Limnobium laevigatum*.

2. WAC 16-750-011 proposed Class B designation changes:

- Designate Eurasian watermilfoil, *Myriophyllum spicatum*, in Kitsap County of region 2, and Kittitas and Whitman counties of region 5.
- Designate Bohemian knotweed, *Polygonum x bohemicum*, in San Juan County of region 2, Stevens County of region 4, and Whitman and Yakima counties of region 5.

- Designate Japanese knotweed, *Polygonum cuspidatum*, in Stevens County of region 4.
- Designate Himalayan knotweed, *Persicaria wallichii*, in Clark County of region 3 and Stevens County of region 4.
- Designate lesser celandine, *Ficaria verna*, in all of regions 1, 3, 4, 5, 6 and 2 except for King and Whatcom counties.
- Designate leafy spurge, *Euphorbia virgata*, in Whitman County of region 5 and Garfield County of region 6.
- Designate purple loosestrife, *Lythrum salicaria*, in Pierce County of region 2 and Benton County of region 6.
- Designate wand loosestrife, *Lythrum virgatum*, in Mason County of region 1, Pierce County of region 2, and Benton County of region 6.
- Designate poison hemlock, *Conium maculatum*, in Douglas County of region 4.
- Designate policeman's helmet, *Impatiens glandulifera*, in Pacific County of region 1 and Pierce County of region 2.
- Designate Ravenna grass, *Saccharum ravennae*, in Grant County of region 5.
- Designate rush skeletonweed, *Chondrilla juncea*, in Kitsap County of region 2.
- Designate European coltsfoot, *Tussilago farfara*, in Grant County of region 5.

Designation changes are intended to better match the distribution/threat of these noxious weeds.

WSNWCB is also proposing the following changes:

1. WAC 16-750-140, adding a standing legislative committee.

2. WAC 16-750-142, create a new section for WSNWCB—Executive secretary and education specialist—Hiring and dismissal.

3. WAC 16-750-145, editing WSNWCB—Executive secretary—Definition.

4. WAC 16-750-146, adding new section for WSNWCB—Education specialist—Definition.

5. WAC 16-750-150, repealing section on WSNWCB—Executive secretary—Hiring and dismissal. Moved to WAC 16-750-142.

Reasons Supporting Proposal: Under RCW 17.10.080, WSNWCB is charged with updating the state noxious weed list on an annual basis to ensure it accurately reflects the noxious weed control priorities and noxious weed distribution. Under RCW 17.10.070, WSNWCB is charged with adopting, amending, or repealing rules, pursuant to the Administrative Procedure Act, chapter 34.05 RCW, as may be necessary to carry out the duties and authorities assigned to the board by this chapter.

The proposed addition of South American spongeplant, *Limnobium laevigatum*, as a Class A noxious weed, is intended to keep it from spreading from the one known location in Washington state.

Designation changes of thirteen Class B noxious weeds are intended to better match the distribution/threat of these noxious weeds. Class B noxious weeds are generally designated where they are absent, limited, or pose a serious threat to health, agriculture, or natural areas so the economic impact is not unreasonable.

The additional edits to the remaining sections are intended to improve the ability of WSNWCB to carry out the duties and authorities assigned to the board per chapter 17.10 RCW.

Statutory Authority for Adoption: RCW 17.10.070, 17.10.080.

Statute Being Implemented: Chapter 17.10 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: WSNWCB, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Mary Fee, 1111 Washington Street S.E., Olympia, WA 98504, 360-902-2053.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. WSNWCB is not one of the agencies listed in this section.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. Approximately two hundred fifty businesses responded to an online survey emailed to licensed nurseries and agricultural industry associations. Participating businesses do not appear to carry any of the Class B noxious weeds that have proposed designation changes, nine of which are already on Washington state department of agriculture's (WSDA) quarantine list (chapter 16-752 WAC). Of the five species that are not already on the quarantine list, only Ravenna grass is known for being [an] ornamental species, and it is currently undergoing rule making by WSDA to be added to the quarantine list. An analysis of the direct economic effects of the proposed rule amendments indicates that costs to businesses would be negligible or none at all. The thirteen Class B noxious weeds may be designated for control in counties where they are either absent or limited in distribution, business in these counties should not be faced with more-than-minor costs to control those noxious weeds.

Based upon the above analysis, WSNWCB concludes that direct minor costs, if any, imposed would affect less than ten percent of businesses and would not exceed $100 in lost sales or revenue as a direct result of these proposed rule-making changes. Nor would any of these amendments to the noxious weed list directly cause the creation of or loss of any jobs. WSNWCB concludes that businesses will not be disproportionately impacted, nor would the proposed rule changes impose more than a minor cost on businesses in an industry. Therefore, we conclude that a formal small business economic impact statement is not required.

A copy of the detailed cost calculations may be obtained by contacting Mary Fee, P.O. Box 42560, Olympia, WA 98504-2560, phone 360-902-2053, fax 360-902-2094, TTY 800-833-6388, email mfee@agr.wa.gov.

October 2, 2019
Mary Fee
Executive Secretary

AMENDATORY SECTION (Amending WSR 17-24-035, filed 11/29/17, effective 1/1/18)

WAC 16-750-005 State noxious weed list—Class A noxious weeds.

Common Name	Scientific Name
broom, French	*Genista monspessulana*
broom, Spanish	*Spartium junceum*
common crupina	*Crupina vulgaris*
cordgrass, common	*Spartina anglica*
cordgrass, dense-flowered	*Spartina densiflora*
cordgrass, salt meadow	*Spartina patens*
cordgrass, smooth	*Spartina alterniflora*
dyer's woad	*Isatis tinctoria*
eggleaf spurge	*Euphorbia oblongata*
false brome	*Brachypodium sylvaticum*
floating primrose-willow	*Ludwigia peploides*
flowering rush	*Butomus umbellatus*
garlic mustard	*Alliaria petiolata*
giant hogweed	*Heracleum mantegazzianum*
goatsrue	*Galega officinalis*
hydrilla	*Hydrilla verticillata*
Johnsongrass	*Sorghum halepense*
knapweed, bighead	*Centaurea macrocephala*
knapweed, Vochin	*Centaurea nigrescens*
kudzu	*Pueraria montana* var. *lobata*
meadow clary	*Salvia pratensis*
oriental clematis	*Clematis orientalis*
purple starthistle	*Centaurea calcitrapa*
reed sweetgrass	*Glyceria maxima*
ricefield bulrush	*Schoenoplectus mucronatus*
sage, clary	*Salvia sclarea*
sage, Mediterranean	*Salvia aethiopis*
silverleaf nightshade	*Solanum elaeagnifolium*
small-flowered jewelweed	*Impatiens parviflora*
South American spongeplant	*Limnobium laevigatum*
Syrian bean-caper	*Zygophyllum fabago*
Texas blueweed	*Helianthus ciliaris*
thistle, Italian	*Carduus pycnocephalus*
thistle, milk	*Silybum marianum*
thistle, slenderflower	*Carduus tenuiflorus*
variable-leaf milfoil	*Myriophyllum heterophyllum*
wild four o'clock	*Mirabilis nyctaginea*

AMENDATORY SECTION (Amending WSR 18-24-010, filed 11/26/18, effective 1/1/19)

WAC 16-750-011 State noxious weed list—Class B noxious weeds.

	Name		Will be a "Class B designate" in all lands lying within:
(1)	blueweed, *Echium vulgare*	(a)	regions 1, 2, 3, 4, 6
		(b)	region 5, except Spokane County
(2)	Brazilian elodea, *Egeria densa*	(a)	region 1, except Grays Harbor County
		(b)	region 2, except Kitsap County
		(c)	King County of region 2, except lakes Dolloff, Fenwick, Union, Washington, and Sammamish, and the Sammamish River
		(d)	region 3, except Wahkiakum County
		(e)	regions 4, 5, and 6
(3)	bugloss, annual, *Anchusa arvensis*	(a)	regions 1, 2, 3, 4, and 6
		(b)	region 5, except Spokane County
(4)	bugloss, common, *Anchusa officinalis*	(a)	regions 1, 2, 3, and 6
		(b)	All of region 4 except those areas lying within the Entiat River Valley between the Columbia River confluence and Stormy Creek in Chelan County
		(c)	region 5, except Spokane County

	Name		Will be a "Class B designate" in all lands lying within:
(5)	butterfly bush, *Buddleja davidii*	(a)	Grays Harbor County of region 1
		(b)	San Juan County of region 2
		(c)	Cowlitz County of region 3
(6)	camelthorn, *Alhagi maurorum*	(a)	regions 1, 2, 3, 4, 5, and 6
(7)	common fennel, *Foeniculum vulgare* (except bulbing fennel, *F. vulgare* var. *azoricum*)	(a)	region 1, except Jefferson County
		(b)	region 2, except King and Skagit counties
		(c)	region 3, except Clark County
		(d)	regions 4, 5, and 6
(8)	common reed, *Phragmites australis* (nonnative genotypes only)	(a)	regions 1, 2, 3, and 4
		(b)	region 5, except Grant County
		(c)	Asotin, Columbia, and Garfield counties of region 6
(9)	Dalmatian toadflax, *Linaria dalmatica* ssp. *dalmatica*	(a)	regions 1, 2, and 3
		(b)	Adams, Kittitas, and Lincoln counties of region 5
		(c)	Benton, Franklin, and Walla Walla counties of region 6
(10)	Eurasian watermilfoil, *Myriophyllum spicatum*	(a)	region 1, except Pacific County
		(b)	Island, Kitsap, and San Juan counties of region 2
		(c)	Clark and Cowlitz counties of region 3
		(d)	Chelan and Okanogan counties, and all lakes with public boat launches except Fan Lake in Pend Oreille County of region 4
		(e)	Adams ((~~and~~)), Kittitas, Lincoln, and Whitman counties of region 5
		(f)	Asotin, Columbia, and Garfield counties of region 6
(11)	European coltsfoot, *Tussilago farfara*	(a)	regions 1, 2, 3, 4, 5, and 6
		((~~(b)~~	~~region 5, except Grant County~~))
(12)	fanwort, *Cabomba caroliniana*	(a)	regions 1, 2, 4, 5, and 6
		(b)	region 3, except Cowlitz County
(13)	gorse, *Ulex europaeus*	(a)	region 1, except Grays Harbor and Pacific counties
		(b)	regions 2, 3, 4, 5, 6
(14)	grass-leaved arrowhead, *Sagittaria graminea*	(a)	region 1
		(b)	region 2, except Snohomish County
		(c)	regions 3, 4, 5, and 6
(15)	hairy willow-herb, *Epilobium hirsutum*	(a)	regions 1, 3, and 4
		(b)	region 2, except Thurston and Whatcom counties
		(c)	region 5, except Klickitat County
		(d)	region 6, except Benton and Franklin counties
(16)	hawkweed oxtongue, *Picris hieracioides*	(a)	regions 1, 2, 4, 5, and 6
		(b)	region 3, except Skamania County
(17)	hawkweed, orange, *Hieracium aurantiacum*	(a)	regions 1, 3, and 6
		(b)	region 2, except Whatcom County
		(c)	region 4, except Pend Oreille and Stevens counties
		(d)	region 5, except Kittitas and Spokane counties

	Name		Will be a "Class B designate" in all lands lying within:
(18)	hawkweeds: All nonnative species and hybrids of the Meadow subgenus (*Pilosella*), including, but not limited to, mouseear (*Hieracium pilosella*), pale (*H. lactucella*), queen-devil (*H. glomeratum*), tall (*H. piloselloides*), whiplash (*H. flagellare*), yellow (*H. caespitosum*), and yellow-devil (*H.* x *floribundum*)	(a)	region 1
		(b)	region 2, except Thurston County
		(c)	region 3, except Cowlitz County
		(d)	region 4, except Pend Oreille and Stevens counties
		(e)	region 5, except Klickitat and Spokane counties
		(f)	region 6
(19)	hawkweeds: All nonnative species and hybrids of the Wall subgenus (*Hieracium*), including, but not limited to, common (*Hieracium lachenalii*), European (*H. sabaudum*), polar (*H. atratum*), smooth (*H. laevigatum*), spotted (*H. maculatum*), and wall (*H. murorum*)	(a)	regions 1, 3, 5, and 6
		(b)	region 2, except King, Skagit, and Whatcom counties
		(c)	region 4, except Stevens County
(20)	herb-Robert, *Geranium robertianum*	(a)	regions 4, 5, and 6
(21)	hoary alyssum, *Berteroa incana*	(a)	regions 1, 2, 3, and 6
		(b)	region 4, except Pend Oreille and Ferry counties
		(c)	region 5, except Klickitat County
(22)	houndstongue, *Cynoglossum officinale*	(a)	regions 1, 2, and 3
		(b)	Chelan and Douglas counties of region 4
		(c)	Yakima, Grant and Adams counties of region 5
		(d)	Benton and Franklin counties of region 6
(23)	indigobush, *Amorpha fruticosa*	(a)	regions 1, 2, and 4
		(b)	Lewis County of region 3
		(c)	region 5, except Klickitat County
(24)	knapweed, black, *Centaurea nigra*	(a)	regions 1, 2, 3, 4, 5, and 6
(25)	knapweed, brown, *Centaurea jacea*	(a)	regions 1, 2, 3, 4, 5, and 6
(26)	knapweed, diffuse, *Centaurea diffusa*	(a)	region 1
		(b)	region 2
		(c)	region 3, except Cowlitz County
		(d)	Adams County of region 5
(27)	knapweed, meadow, *Centaurea* x *moncktonii*	(a)	regions 1 and 4
		(b)	region 2, except Whatcom County
		(c)	Thurston County of region 2, except below the ordinary high-water mark of the Nisqually River
		(d)	Lewis and Wahkiakum counties of region 3
		(e)	region 5, except Kittitas and Klickitat counties
		(f)	region 6, except Franklin and Walla Walla counties

	Name		Will be a "Class B designate" in all lands lying within:
(28)	knapweed, Russian, *Rhaponticum repens*	(a)	regions 1, 2, and 3
		(b)	Ferry and Pend Oreille counties of region 4
		(c)	Lincoln, Spokane, and Whitman counties of region 5
		(d)	Adams County of region 5, except for the area west of Highway 17 and north of Highway 26
		(e)	Asotin and Garfield counties of region 6
(29)	knapweed, spotted, *Centaurea stoebe*	(a)	region 1, except Grays Harbor
		(b)	region 2, except Whatcom County
		(c)	Clark, Lewis, and Wahkiakum counties of region 3
		(d)	Ferry County of region 4
		(e)	Adams, Grant and Yakima counties of region 5
		(f)	region 6, except Columbia and Walla Walla counties
(30)	knotweed, Bohemian, *Polygonum* x *bohemicum*	(a)	Island ((~~County~~)) and San Juan counties of region 2
		(b)	Skamania County of region 3
		(c)	region 4, ((~~except Stevens County~~)) 5, and 6
		(((~~(d)~~	~~region 5, except Whitman and Yakima counties~~
		~~(e)~~	~~region 6~~))
(31)	knotweed, giant, *Polygonum sachalinense*	(a)	region 2, except King, Pierce, and Snohomish counties
		(b)	region 3, except Cowlitz and Lewis counties
		(c)	regions 4, 5, and 6
(32)	knotweed, Himalayan, *Persicaria wallichii*	(a)	region 1, except Pacific County
		(b)	region 2, except King and Pierce counties
		(c)	((~~Cowlitz, Lewis and Skamania counties of~~)) region 3, except Wahkiakum County
		(d)	region 4, ((~~except Stevens County~~)) 5, and 6
		(((~~(e)~~	~~regions 5 and 6~~))
(33)	knotweed, Japanese, *Polygonum cuspidatum*	(a)	Island, San Juan, and Whatcom counties of region 2
		(b)	Skamania County of region 3
		(c)	region 4, except Okanogan ((~~and Stevens counties~~)) County
		(d)	region 5, except Spokane County
		(e)	region 6
(34)	kochia, *Bassia scoparia*	(a)	regions 1, 2, and 3
		(b)	Stevens and Pend Oreille counties of region 4
		(c)	Adams County of region 5
(35)	lesser celandine, *Ficaria verna*	(a)	((~~Snohomish County of region 2~~)) region 1, 3, 4, 5, and 6
		(b)	((~~Skamania County of region 3~~)) region 2, except King and Whatcom counties
		(((~~(c)~~	~~Pend Oreille and Stevens counties of region 4~~))
(36)	loosestrife, garden, *Lysimachia vulgaris*	(a)	regions 1, 2, 3, 4, 5, 6
(37)	loosestrife, purple, *Lythrum salicaria*	(a)	Clallam, Jefferson, and Mason counties of region 1
		(b)	region 2, except Kitsap, ((~~Pierce,~~)) Skagit, and Snohomish counties

	Name		Will be a "Class B designate" in all lands lying within:
		(c)	Clark, Lewis, and Skamania counties of region 3
		(d)	region 4, except Douglas County
		(e)	region 5, except Grant and Spokane counties
		(f)	((~~Columbia, Garfield, and Walla Walla counties of~~)) region 6, except Asotin and Franklin counties
(38)	loosestrife, wand, *Lythrum virgatum*	(a)	Clallam ((~~and~~)), Jefferson, and Mason counties of region 1
		(b)	region 2, except Kitsap, ((~~Pierce,~~)) Skagit, and Snohomish counties
		(c)	Clark, Lewis, and Skamania counties of region 3
		(d)	region 4, except Douglas County
		(e)	region 5, except Grant and Spokane counties
		(f)	((~~Columbia, Garfield, and Walla Walla counties of~~)) region 6, except Asotin and Franklin counties
(39)	Malta starthistle, *Centaurea melitensis*	(a)	regions 1, 2, and 3
		(b)	region 4, except T36 R38 in the area contained within Hwy 395/Hwy 20, Pingston Creek Road, and Highland Loop Road in Stevens County
		(c)	region 5, except Klickitat and Whitman counties
(40)	parrotfeather, *Myriophyllum aquaticum*	(a)	region 1, except Pacific County
		(b)	regions 2, 4, 5, and 6
		(c)	Clark and Skamania counties of region 3
(41)	perennial pepperweed, *Lepidium latifolium*	(a)	regions 1, 2, and 4
		(b)	region 3, except Clark and Cowlitz counties
		(c)	Kittitas, Lincoln and Spokane counties of region 5
		(d)	Columbia and Garfield counties of region 6
(42)	poison hemlock, *Conium maculatum*	(a)	Clallam, Mason, and Pacific counties of region 1
		(b)	region 2, except King, Skagit, and Whatcom counties
		(c)	Clark and Skamania counties of region 3
		(d)	Chelan, Douglas, and Pend Oreille counties of region 4
		(e)	Grant, Kittitas and Lincoln counties of region 5
(43)	policeman's helmet, *Impatiens glandulifera*	(a)	region 1, ((~~except Pacific County~~)) 3, 4, 5, and 6
		(b)	region 2, except ((~~Pierce,~~)) Thurston((~~,~~)) and Whatcom counties
		((~~(c)~~	~~regions 3, 4, 5, and 6~~))
(44)	puncturevine, *Tribulus terrestris*	(a)	regions 1, 2, and 3
		(b)	Ferry, Pend Oreille, and Stevens counties of region 4
		(c)	region 5, except Grant, Klickitat, and Yakima counties
(45)	Ravenna grass, *Saccharum ravennae*	(a)	Cowlitz County of region 3
		(b)	region 4, except Chelan County
		(c)	region 5, except ((~~Grant and Yakima counties~~)) Yakima County
		(d)	region 6, except Benton County
(46)	rush skeletonweed, *Chondrilla juncea*	(a)	regions 1, 2, and 3
		(b)	((~~region 2, except Kitsap County~~

	Name		Will be a "Class B designate" in all lands lying within:
		~~(e)~~))	region 4, except all areas of Stevens County south of Township 29
		(((~~(d)~~))) (c)	Kittitas and Yakima counties of region 5, and Adams County, except those areas lying east of Sage Road, the western border of Range 36
		(((~~(e)~~))) (d)	Asotin County of region 6
(47)	saltcedar, *Tamarix ramosissima* (unless intentionally planted prior to 2004)	(a)	regions 1, 3, 4, and 5
		(b)	region 2, except King and Thurston counties
		(c)	region 6, except Benton and Franklin counties
(48)	Scotch broom, *Cytisus scoparius*	(a)	regions 4 and 6
		(b)	region 5, except Klickitat County
(49)	shiny geranium, *Geranium lucidum*	(a)	regions 1, 4, 5, and 6
		(b)	regions 2, except Thurston County
		(c)	region 3, except Clark County
(50)	spurge flax, *Thymelaea passerina*	(a)	region 4, except Okanogan County
		(b)	regions 5 and 6
(51)	spurge laurel, *Daphne laureola*	(a)	region 1, except Clallam and Jefferson counties
		(b)	region 2, except King, Kitsap, and Pierce counties
		(c)	region 3, except Skamania County
		(d)	regions 4, 5, and 6
(52)	spurge, leafy, *Euphorbia virgata*	(a)	regions 1, 2, 3, and 4
		(b)	region 5, except Spokane ((~~and Whitman counties~~)) County
		(c)	region 6, except Columbia ((~~and Garfield counties~~)) County
(53)	spurge, myrtle, *Euphorbia myrsinites*	(a)	region 1, except Clallam and Jefferson counties
		(b)	region 2, except King, Kitsap, Pierce, and Whatcom counties
		(c)	regions 3, 5, and 6
		(d)	region 4, except Okanogan and Stevens counties
(54)	sulfur cinquefoil, *Potentilla recta*	(a)	region 1
		(b)	region 2, except Pierce and Thurston counties
		(c)	region 3, except Lewis and Skamania counties
		(d)	Adams, Grant, Lincoln, and Whitman counties of region 5
		(e)	region 6, except Asotin County
(55)	tansy ragwort, *Jacobaea vulgaris*	(a)	Island and San Juan counties of region 2
		(b)	Clark and Wahkiakum counties of region 3
		(c)	regions 4 and 6
		(d)	region 5, except Klickitat County
(56)	thistle, musk, *Carduus nutans*	(a)	regions 1, 2, 3, and 6
		(b)	region 4, except Douglas and Ferry counties
		(c)	region 5, except Kittitas County
(57)	thistle, plumeless, *Carduus acanthoides*	(a)	regions 1, 2, 3, 5, 6
		(b)	region 4, except those areas north of State Highway 20 in Stevens County

	Name		Will be a "Class B designate" in all lands lying within:
(58)	thistle, Scotch, *Onopordum acanthium*	(a)	regions 1, 2, and 3
		(b)	region 4, except Douglas County
		(c)	region 5, except Spokane and Whitman counties
(59)	velvetleaf, *Abutilon theophrasti*	(a)	regions 1, 2, 3, and 4
		(b)	region 5, except Yakima County
		(c)	region 6, except Franklin County
(60)	water primrose, *Ludwigia hexapetala*	(a)	regions 1, 2, 4, 5, and 6
		(b)	region 3, except Cowlitz County
(61)	white bryony, *Bryonia alba*	(a)	regions 1, 2, 3, and 4
		(b)	region 5, except Whitman County
		(c)	Benton County of region 6
(62)	wild chervil, *Anthriscus sylvestris*	(a)	regions 1, 4, and 6
		(b)	region 2, except Island and Whatcom counties
		(c)	Wahkiakum and Lewis counties of region 3
		(d)	region 5, except Whitman County
(63)	yellow archangel, *Lamiastrum galeobdolon*	(a)	Clallam County of region 1
		(b)	Island, San Juan, Skagit, and Whatcom counties of region 2
		(c)	Skamania and Wahkiakum counties of region 3
		(d)	regions 4, 5, and 6
(64)	yellow floating heart, *Nymphoides peltata*	(a)	regions 1, 2, and 6
		(b)	region 3, except Cowlitz County
		(c)	region 4, except Stevens County
		(d)	region 5, except Spokane County
(65)	yellow nutsedge, *Cyperus esculentus*	(a)	regions 1 and 4
		(b)	region 2, except Skagit and Thurston counties
		(c)	region 3, except Clark County
		(d)	region 5, except Klickitat and Yakima counties
		(e)	region 6, except Franklin and Walla Walla counties
(66)	yellow starthistle, *Centaurea solstitialis*	(a)	regions 1, 2, and 3
		(b)	region 4, except T36 R38 in the area contained within Hwy 395/Hwy 20, Pingston Creek Road, and Highland Loop Road in Stevens County
		(c)	region 5, except Klickitat, and Whitman counties

AMENDATORY SECTION (Amending WSR 12-01-050, filed 12/15/11, effective 1/15/12)

WAC 16-750-140 State noxious weed control board —Committees. Standing committees shall fairly reflect the composition of the board and unless advertised and open to the public, not more than four voting members may attend a committee meeting.

(1) Executive committee. An executive committee is authorized to deal with housekeeping and personnel matters, subject to board approval at the next scheduled board meeting. The chairperson appoints the executive committee with approval of the board.

(2) Standing committees. The standing committees of the board are: Budget, executive, legislative, noxious weed, and education. The board chairperson appoints the chairperson and other members of each committee.

(3) Ad-hoc committees may be appointed from time to time.

(4) Committee voting procedures.

(a) All members of a particular committee have the right to vote. Other members in attendance may enter into discussion, but shall have no vote.

(b) Proxy voting is not permitted.

(c) All questions decided by the committee will be by majority of the committee members present.

(5) Advisory committees. Advisory committees are established by the board as deemed necessary to the functioning of the board. Advisory committees are limited in their scope to the purposes determined by the board.

(6) Notice. Notice of committee meetings shall be given to the executive secretary.

(7) Committee reports.

(a) Committee reports and recommendations are submitted to the board in writing except when committees meet in conjunction with the board.

(b) Minority reports may be submitted by members of a committee, if signed by those members.

(8) Committee compensation. Board members attending meetings of committees will, upon request, be reimbursed on the same basis as for attendance at regularly called board meetings.

(9) All committee appointments will be reviewed in January of even-numbered years.

NEW SECTION

WAC 16-750-142 State noxious weed control board —Executive secretary and education specialist—Hiring and dismissal. The board has the responsibility for hiring and removing from office the executive secretary and education specialist which are exempt employees. The executive secretary or education specialist may be dismissed by a majority vote of the full board upon the recommendation of the chairperson and the executive committee. Prior to initiating a dismissal the executive committee will notify the department. Neglect of duty, gross inefficiency, gross incompetence, gross misconduct, malfeasance or willful violation of obligations may give cause for a recommendation for dismissal or dismissal. Before any action is taken by the board to dismiss the executive secretary or education specialist, the chairperson and one member of the executive committee will confer with the employee and provide in writing and fully explain the charges and contemplated recommendation for dismissal. The privilege of a hearing before the executive committee or full board will be granted to the employee prior to any formal action taken by the board. The employee is granted thirty days preparation time for the hearing and is entitled to present evidence, to be assisted by favorable witnesses, and to confront unfavorable witnesses at the hearing.

AMENDATORY SECTION (Amending WSR 99-24-029, filed 11/23/99, effective 1/3/00)

WAC 16-750-145 State noxious weed control board —Executive secretary—Definition. The executive secretary acts as the chief administrative officer for the board ((~~and~~)), duties of whom are fixed by the board which include, but are not limited to, as follows:

(1) Implements and administers the statutes, administrative rules, and policies of the noxious weed control program assigned to the board;

(2) Plans, develops, and prepares administrative rules and policies for the state noxious weed control program in conjunction with the board and the department; arranges public hearings in compliance with the Administrative Procedure Act and acts as chief hearing officer for the board; conducts elections for positions on the board;

(3) ((~~Coordinates the educational and weed control efforts of county and regional noxious weed control boards and weed districts;~~

~~(4)~~)) Coordinates board activities with the department, maintains a liaison and performs coordinating activities with other public and private agencies;

(((~~(5)~~))) (4) Negotiates agreements, ((~~on behalf~~)) with consultation and approval of the board, with federal agencies, tribes, and other public and private agencies;

(((~~(6)~~))) (5) Represents the board before the state legislature; coordinates the development, edits, and oversees the production of the biennial report to the county noxious weed boards and weed districts on how state funds were spent and recommendations for the continued best use of state funds for noxious weed control;

(((~~(7) Plans, prepares, and presents programs on noxious weed control, specific weed species, and the role of the board;~~))) (6) Acts as the principal spokesperson of the board to the media, technical audiences, and the public;

(((~~(8) Maintains a collection of scientific and technical information relating to noxious weeds and integrated vegetation management; prepares written findings for the inclusion of species on the state noxious weed list;~~

~~(9) Develops, maintains, and ensures dissemination of information relating to noxious weeds to county noxious weed control boards and weed districts and keeps the general public and program participants informed of board activities and accomplishments;~~

~~(10)~~))) (7) Provides technical advice to county noxious weed boards and weed districts on the state noxious weed law and related rules;

(((~~(11)~~))) (8) Plans and coordinates statewide approaches to selected noxious weeds, assists in the development of statewide noxious weed survey standards, coordinates efforts with department weed specialists;

(((~~(12)~~))) (9) Coordinates the activities of the board by scheduling all regular and committee meetings; in consultation with the chair, prepares meeting agendas; prepares all board correspondence; updates board on local, state, and federal noxious weed activities; acts as an ex officio, nonvoting member of all committees;

(((~~(13)~~))) (10) Records the official minutes of the board and ensures their distribution; maintains all board records, acts as public records officer;

(((~~(14)~~))) (11) Oversees fiscal management of the board's administrative budget and cooperates with the department in budget development;

(((~~(15)~~))) (12) Supervises ((~~all~~)) additional board employees, approves hiring, rehiring, promotion, and termination of ((~~all~~)) additional board employees and ensures these processes and any disciplinary actions comply with state and department personnel policies; notifies board and department prior to initiating an adverse personnel action against any employee;

(((~~(16)~~))) (13) Performs other assignments as determined by the board.

NEW SECTION

WAC 16-750-146 State noxious weed control board —Education specialist—Definition. The education specialist duties whom are fixed by the board which include, but are not limited to, as follows:

(1) Supports and assists the educational and weed control efforts of county and regional noxious weed control boards and weed districts;

(2) Plans, prepares, and presents programs on noxious weed control, specific weed species, and the role of the board;

(3) Maintains a collection of scientific and technical information relating to noxious weeds and integrated vegetation management; prepares written findings for the inclusion of species on the state noxious weed list;

(4) Develops, maintains, and ensures dissemination of information relating to noxious weeds to county noxious weed control boards and weed districts and keeps the general public and program participants informed of board activities and accomplishments;

(5) Performs other assignments as determined by the board.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 16-750-150	State noxious weed control board—Executive secretary—Hiring and dismissal.

WSR 19-20-121
PROPOSED RULES
POLLUTION LIABILITY INSURANCE AGENCY

[Filed October 2, 2019, 11:10 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-23-126.

Title of Rule and Other Identifying Information: Chapter 374-100 WAC, State Environmental Policy Act (SEPA), this proposal is for a new chapter and reflects the pollution liability insurance agency's (PLIA) adoption of rules as required by RCW 43.21C.110 to ensure agency review for sites entering and managed in PLIA programs.

Hearing Location(s): On November 6, 2019, at 12-2 p.m. and 5:30-7:30 p.m., at the Spokane Public Library; on November 12, 2019, at 12-2 p.m., at the Lacey Timberland Library; and on November 13, 2019, at 1-3 p.m., at the Olympia Timberland Library. See https://plia.wa.gov/public/ for details.

Date of Intended Adoption: November 15, 2019.

Submit Written Comments to: Phi V. Ly, P.O. Box 40930, Olympia, WA 98504-0930, email rules@plia.wa.gov, fax 360-407-0509, 800-822-3905, by November 13, 2019.

Assistance for Persons with Disabilities: Contact Xyzlinda Marshall, phone 360-407-0515, fax 360-407-0509, TTY 711 or 800-833-6388, email rules@plia.wa.gov, by November 13, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: PLIA provides an effective and efficient government funding model to support owners and operators in meeting financial responsibility and environmental clean-up requirements for underground storage tanks. PLIA programs offer owners and operators of underground storage tanks with insurance, financial assistance, and technical assistance related to cleanup and meeting the substantive requirements of the Model Toxics Control Act. These activities require implementing statutory guidelines and adopting of rules to reflect agency review.

The proposed rules are new and reflect the agency's compliance with SEPA, chapter 43.21C RCW. It is anticipated that PLIA's implementation of SEPA will further enhance the loan and grant program. PLIA will implement the SEPA checklist and review process to all loan and grant program participants.

Reasons Supporting Proposal: SEPA, RCW 43.21C.120, requires PLIA to adopt rules according to the provisions of Chapter 197-11 WAC because these guidelines apply to the agency's programs, activities, and actions. These rules ensure that PLIA provides consistent agency review of program sites.

Statutory Authority for Adoption: RCW 43.21C.120.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Unknown.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Phi V. Ly, 300 Desmond Drive, Lacey, WA 98506, 360-407-0517.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Adoption of SEPA rules does not require [a] cost-benefit analysis because the requirements pertain to existing agency actions and activities.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules are adopting or incorporating by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule.

October 2, 2019
Phi V. Ly
Legislative and
Policy Manager

Chapter 374-100 WAC

STATE ENVIRONMENTAL POLICY ACT (SEPA)

NEW SECTION

WAC 374-100-010 Authority. The pollution liability insurance agency adopts these rules under RCW 43.21C.120 (State Environmental Policy Act) and chapter 197-11 WAC (SEPA rules).

NEW SECTION

WAC 374-100-020 Adoption by reference. (1) The provisions of chapter 197-11 WAC (SEPA guidelines adopted by the department of ecology), are hereby adopted by PLIA, and are incorporated in and made a part of this chapter by reference herein, to the extent that the SEPA guidelines are applicable to the programs, activities, and actions of PLIA.

(2) The provisions of this chapter are intended to implement the provisions of chapter 197-11 WAC, and to be consistent therewith.

NEW SECTION

WAC 374-100-030 Purpose. (1) The purpose of this chapter is to implement chapter 197-11 WAC, SEPA rules, as applicable to the pollution liability insurance agency.

(2) These policies and procedures are developed to implement SEPA in a manner which reduces duplication, establishes effective and uniform rules, encourages public involvement, and promotes certainty with respect to the requirements of the act.

NEW SECTION

WAC 374-100-040 Additional definitions. In addition to the definitions contained in WAC 197-11-700 through 197-11-799, the following terms shall have the listed meanings:

(1) "PLIA" means the pollution liability insurance agency.

(2) "Proponent" means applicant, as defined in WAC 197-11-716 or party with a proposal, as defined in WAC 197-11-784.

NEW SECTION

WAC 374-100-050 Categorical exemptions. The following activities of the PLIA are within the categorical exemptions contained in the indicated subsections of WAC 197-11-800:

(1) Actions that must be undertaken immediately or within a time too short to allow full compliance with this chapter, to avoid an imminent threat to public health or safety, to prevent an imminent danger to public or private property, or to prevent an imminent threat of serious environmental degradation as provided in WAC 197-11-880 including, but not limited to:

(a) Performance of emergency removal and disposal of petroleum products from a tank;

(b) Performance of emergency removal and disposal of soil or groundwater contaminated with petroleum products;

(c) Approval of funding for emergency projects;

(d) Emergency disaster response or maintenance.

(2) All inspections conducted by PLIA of either private or public property for any purpose as provided in WAC 197-11-800 (12)(b) including, but not limited to:

(a) Performing initial investigations of a reported release of heating oil;

(b) Performing periodic review of an environmental covenant;

(c) Inspection related to insurance policies.

(3) All review and payment of claims as provided in WAC 197-11-800 (14)(e) including, but not limited to:

(a) Review and payment of insurance claims under the heating oil pollution liability insurance program;

(b) Review and payment of insurance claims under the commercial underground storage tank reinsurance program.

(4) Providing grants or loans by PLIA's underground storage tank loan and grant program to another agency, as provided in WAC 197-11-800(15).

NEW SECTION

WAC 374-100-060 Summary of information which may be required of an applicant. (1) The applicant for each proposal for which the PLIA is the lead agency shall submit a complete environmental checklist along with a complete application for the required approval.

(2) After review of the environmental checklist, the PLIA may require the applicant to submit additional information necessary to properly evaluate the potential environmental impacts of the project. Field investigation or research may be required of the applicant or conducted by the PLIA at the applicant's cost.

(3) Preparation of EIS is the responsibility of PLIA. The responsible official shall be satisfied that any EIS issued by the PLIA is in compliance with these rules and chapter 197-11 WAC.

(4) Whenever someone other than the PLIA prepares an EIS the responsible official shall:

(a) Coordinate scoping to ensure that the individual preparing the document receives all substantive information submitted by any agency or person.

(b) Direct the areas of research and study to be undertaken and the content and organization of the document.

(c) Assist in obtaining information on file with another agency that is needed by the person preparing the document.

(5) An EIS is required for each project for which a determination is made that the proposal will have a probable significant adverse impact on the environment. The applicant may prepare the EIS if judged by the PLIA to be qualified, have the PLIA develop the EIS, or hire a consultant to do so. In any case, the EIS shall be prepared under the direction of the responsible official at the expense of the applicant and final approval is that of the responsible official. Cost of preparing the EIS shall be paid by the applicant and shall include fees of the consultant, the PLIA consultation time and cost of any required materials. If the applicant chooses to hire a consultant to prepare the EIS, the consultant must be mutually

agreed upon by the applicant and the PLIA. A performance bond in an amount specified by the PLIA may be required of the applicant to ensure payment of the PLIA expenses pursuant to WAC 197-11-914. Private applicants are encouraged to be involved in the EIS preparation process.

(6) A supplemental EIS shall be prepared as an addition to the EIS if the PLIA decides that:

(a) There are substantial changes to a proposal which will have a probable significant adverse environmental impact; or

(b) There is significant new information relative to the probable significant environmental impact of a proposal.

(c) Pursuant to WAC 197-11-600 (3)(c), written comments on the DEIS warrant additional discussion for purposes of its action than that found in the FEIS.

NEW SECTION

WAC 374-100-070 Timing of the SEPA process. (1) As provided by WAC 197-11-055, the SEPA process shall be completed before the pollution liability insurance agency is irrevocably committed to a particular course of action. At the same time, the SEPA process should not be undertaken until a proposal is sufficiently definite to permit meaningful environmental analysis.

(2) When PLIA receives an application or proposal, the agency shall determine whether PLIA's SEPA action is "categorically exempt" or statutorily exempt from SEPA. If exempt, and WAC 197-11-305 does not remove categorical exempt status, PLIA has no further obligation under SEPA.

(3) The threshold determination and any required environmental impact statement (EIS) for PLIA nonproject actions shall be completed prior to official adoption of the action in question.

(4) The threshold determination and any required EIS for issuance of a loan or grant under PLIA's underground storage tank loan and grant program shall be completed prior to issuance of the loan or grant in question. Applicants shall provide all environmental and design information necessary to prepare the appropriate environmental document.

(5) The threshold determination and any required EIS for PLIA actions of a project nature shall in all cases be completed prior to the approval of the location or design of the project in question. Where the project involves remedial actions under the Model Toxics Control Act conducted a potentially liable person under an order or consent decree, the timing and review requirements of WAC 197-11-250 through 197-11-268 will govern as appropriate.

NEW SECTION

WAC 374-100-080 Lead agency determination. (1) PLIA will endeavor to determine whether PLIA or another agency is the SEPA lead agency within five working days of receiving the nonexempt proposal. See WAC 197-11-050 and 197-11-922 through 197-11-940. If PLIA is not the lead agency, PLIA shall send the complete environmental checklist and a copy of the application or proposal to the lead agency with an explanation of why PLIA identified the agency as the lead agency.

(2) PLIA may determine it would be appropriate to share or divide lead agency responsibilities with other agencies. In such an event, one agency will be designated the nominal lead agency, and shall be responsible for complying with the duties of the lead agency under the SEPA rules. Other agencies with jurisdiction shall be notified of the agreement and determination of the nominal lead agency.

(3) Whenever PLIA is an agency of jurisdiction and determines that a DNS issued by another lead agency is inappropriate and that the proposal in question could cause significant harm to the resources under its jurisdiction, the agency may assume lead agency status per WAC 197-11-948. Within ten days of assuming lead agency status, PLIA will notify the proponent of the proposal in writing as to the reasons for its assumption of lead agency status. Prior to preparation of an EIS for the proposal, PLIA will consult with the proponent and give the proponent an opportunity to modify or change the proposal in such a way that an EIS may not be necessary as outlined in WAC 197-11-360(4).

NEW SECTION

WAC 374-100-090 Availability, distribution, and costs of environmental documents. (1) When PLIA is the lead agency, PLIA personnel shall distribute SEPA documents as required by chapter 197-11 WAC unless another agency is nominal colead with PLIA. The following are acceptable methods of distribution:

(a) Email environmental documents including attached checklists and backup materials provided the recipient agency or interested party has made its email address available to PLIA;

(b) Mail environmental documents, including attached checklists and backup materials, on CDs or as hardcopies to agency mailing lists that include either general lists or lists for specific proposals or subject areas.

(2) A requestor asking for additional hard copies of a SEPA document may be required to pay additional copying fees per WAC 197-11-504.

(3) PLIA shall use reasonable methods to inform the public when PLIA issues a DNS under WAC 197-11-340, a mitigated DNS under WAC 197-11-350, a scoping notice under WAC 197-11-360, a draft EIS under WAC 197-11-455, a draft supplemental EIS under WAC 197-11-620, a final EIS under WAC 197-11-460, or when PLIA schedules a public hearing under WAC 197-11-502, 197-11-535, and 197-11-610. PLIA shall use two or more of the following reasonable methods of public notice, taking into consideration the geographic area affected by the proposal, the size and complexity of the proposal, the public notice requirements associated with PLIA's non-SEPA decision (underlying governmental decision), public interest expressed in the proposal, and whether the proposal is a project or regulation:

(a) Notify persons or groups who have expressed interest in the proposal or in the type of proposal being considered, who have expressed interest in proposals located in the affected geographic area, and who PLIA has identified as potentially interested parties;

(b) Publish a notice in a newspaper of general circulation in the area in which the proposal will be implemented;

(c) Post the property with appropriate signage;

(d) Post notices and environmental documents on PLIA's web site.

(4) As required under WAC 197-11-508 for state agencies, PLIA shall submit the following environmental documents to the department of ecology for publication in the SEPA register:

(a) DNSs under WAC 197-11-340;

(b) DSs (scoping notices) under WAC 197-11-408;

(c) EISs under WAC 197-11-455, 197-11-460, and 197-11-620;

(d) Adoption notices to the extent required by WAC 197-11-610 and 197-11-630; and

(e) Notices of action under RCW 43.21C.080 and 43.21C.087.

NEW SECTION

WAC 374-100-100 Agency policy—Substantive authority and mitigation. (1) The policy of the pollution liability insurance agency is to avoid or mitigate adverse environmental impacts that may result from agency actions or approvals. This policy results from:

(a) The legislated duties of the agency with respect to protection of human health and the environment; and

(b) Recognition of the fact that each person has a fundamental and inalienable right to a healthful environment and that each person has a responsibility to contribute to the preservation and enhancement of the environment (RCW 43.21C.020(3)).

(2) If an action is subject to SEPA, and the proposed activity requires an action, approval or permit from the agency, and is reasonably likely to have an adverse environmental impact as identified in an environmental document, the agency may:

(a) Require reasonable alternatives to the action, approval or permit and/or proven measures which will mitigate or eliminate the identified potential adverse impact, and make such alternatives and/or proven mitigation measures conditions of the agency's approval; or

(b) Deny the proposal if significant adverse impacts as identified in a final or supplemental environmental impact statement prepared under chapter 197-11 WAC are not satisfactorily avoided or mitigated by proven techniques.

NEW SECTION

WAC 374-100-110 Designation of responsible official. (1) The responsible official shall carry out duties and functions for the purpose of assuring PLIA's compliance with SEPA and the SEPA rules.

(2) When PLIA is the lead agency, the responsible official shall review the environmental checklist and make the threshold determination in compliance with this chapter, chapters 43.21C RCW and 197-11 WAC, and specifically, WAC 197-11-330.

(3) The responsible official shall carry out further SEPA compliance under WAC 197-11-340, 197-11-350, or 197-11-360, as appropriate. This includes notice and circulation requirements for threshold determinations.

NEW SECTION

WAC 374-100-120 Procedures when consulted. When a request by another agency for consultation is made pursuant to the provisions of WAC 197-11-912, such request shall be referred for response to the responsible official who shall coordinate the research and field investigations which may be necessary, and supervise the transmittal of the requested information to the lead agency within the time periods specified by WAC 197-11-502.

NEW SECTION

WAC 374-100-130 Severability. If any provision of this chapter or its application to any person or circumstance is held invalid, the remainder of this chapter, or the application of the provision to other persons or circumstances, shall not be affected.

WSR 19-20-122
PROPOSED RULES
POLLUTION LIABILITY INSURANCE AGENCY

[Filed October 2, 2019, 11:11 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-16-144.

Title of Rule and Other Identifying Information: Chapter 374-80 WAC, Advice and technical assistance program, this proposal amends and expands the agency's technical assistance program to the owners and operators of petroleum underground storage tanks.

Hearing Location(s): On November 6, 2019, at 12-2 p.m. and 5:30-7:30 p.m., at the Spokane Public Library; on November 12, 2019, at 12-2 p.m., at the Lacey Timberland Library; and on November 13, 2019, at 1-3 p.m., at the Olympia Timberland Library. See https://plia.wa.gov/public/ for details.

Date of Intended Adoption: November 15, 2019.

Submit Written Comments to: Phi V. Ly, P.O. Box 40930, Olympia, WA 98504-0930, email rules@plia.wa.gov, fax 360-407-0509, 800-822-3905, by November 13, 2019.

Assistance for Persons with Disabilities: Contact Xyzlinda Marshall, phone 360-407-0515, fax 360-407-0509, TTY 711 or 800-833-6388, email rules@plia.wa.gov, by November 13, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The pollution liability insurance agency (PLIA) provides an effective and efficient government funding model to support owners and operators in meeting financial responsibility and environmental clean-up requirements for underground storage tanks. PLIA's technical assistance program provides expert advice to owners and operators of underground storage tanks in meeting clean-up requirements.

This proposal amends existing rules to expand the scope of advice and technical assistance and to include petroleum storage tanks. The amendments also clarify program proce-

dures to include: (1) How to notify PLIA of suspected and confirmed releases, (2) how PLIA conducts an initial investigation of a heating oil tank release, (3) describes environmental covenants where PLIA is the holder, and (4) identifies the process by which PLIA issues an opinion on whether actions meet the substantive requirements of the Model Toxics Control Act.

Reasons Supporting Proposal: PLIA's technical assistance program has expanded to include additional processes for owners and operators of heating oil tanks. The amended rules also clarify the process[es], procedures, and guidelines for how PLIA operates the program. The title changes also reflect the agency's expansion of the program.

Statutory Authority for Adoption: RCW 70.149.040 (5), (9).

Statute Being Implemented: Not applicable.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Unknown.

Name of Agency Personnel Responsible for Drafting: Phi V. Ly, 300 Desmond Drive, Lacey, WA 98506, 360-407-0517; Implementation: Kristin Evered, 300 Desmond Drive, Lacey, WA 98506, 360-407-0523; and Enforcement: Carrie Pederson, 300 Desmond Drive, Lacey, WA 98506, 360-407-0519.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. Cost-benefit analysis not required for existing program. These amended rules provide further clarification of the program procedures.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules are adopting or incorporating by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule.

October 2, 2019
Phi V. Ly
Legislative and
Policy Manager

Chapter 374-80 WAC

((~~HEATING OIL TANKS~~)) ADVICE AND TECHNICAL ASSISTANCE PROGRAM

AMENDATORY SECTION (Amending WSR 03-06-015, filed 2/21/03, effective 3/24/03)

WAC 374-80-010 Authority and purpose. The purpose of this chapter is to establish a program for providing technical assistance ((~~to the owners and operators of active or abandoned heating oil tanks if contamination resulting from a release from a heating oil tank is suspected~~)) to a person regarding a release or suspected release of (1) heating oil from an active, decommissioned, or abandoned heating oil tank; or (2) petroleum from a qualified petroleum storage tank system. Under this program, the agency will provide advice and technical assistance regarding a completed or proposed independent remedial action and application of chapter 70.149 or 70.105D RCW.

Any opinion provided by the agency under this program is advisory only and not binding upon either the agency or the department of ecology. Participation in this program is not a settlement with the state under the Model Toxics Control Act. Persons conducting independent remedial actions do so at their own risk, and may be required to take additional remedial actions by the department of ecology if such actions are determined to be necessary under the Model Toxics Control Act.

AMENDATORY SECTION (Amending WSR 97-20-094, filed 9/29/97, effective 10/30/97)

WAC 374-80-020 Definitions. Unless the context requires otherwise, the definitions in this section shall apply throughout this chapter.

(1) "Abandoned heating oil tank" means a consumptive use heating oil tank system that has been abandoned or decommissioned and is no longer in service or use.

(2) "Active heating oil tank" means a consumptive use heating oil tank that is in use.

(3) "Agency" means the Washington state pollution liability insurance agency (PLIA).

(4) ((~~"Corrective action" means those actions reasonably required to be under-taken by an owner or operator to remove, treat, neutralize, contain, or clean up an accidental release in order to comply with a statute, ordinance, rule, regulation, directive, order or similar legal requirement, at the time of an accidental release, of the United States, the state of Washington, or a political subdivision of the United States or the state of Washington.~~

~~(5)~~)) "Applicant" means the person seeking advice and assistance from the petroleum technical assistance program, whose application has been accepted by the agency.

(5) "Decommissioned heating oil tank" means a heating oil tank system that has been removed from operation by an approved method such as abandonment in place (e.g., cleaning and filling with an inert material) or by removal from the ground.

(6) "Director" means the director of the Washington state pollution liability insurance agency.

(((~~6~~))) (7) "Heating oil" means any petroleum product used for space heating in oil-fired furnaces, heaters and boilers, including stove oil, diesel fuel, or kerosene. "Heating oil" does not include petroleum products used as fuel in motor vehicles, marine vessels, trains, buses, aircraft, or any off-highway equipment not used for space heating, or ((~~for industrial processing or~~)) the generation of electrical energy or waste oil, hoists, pipelines, spills from transportation or a form of transport.

(((~~(7) "Owner" means the person, or his or her authorized representative, legally responsible for an active or abandoned heating oil tank, its contents, and the premises upon which the heating oil tank is located.~~

~~(8) "Owner or operator" means a person in control of, or having the responsibility for, the daily operation of a heating oil tank.~~

~~(9)~~)) (8) "Heating oil tank system" means a tank and its connecting pipes, whether above or below ground, or in a basement, with pipes connected to the tank for space heating of human living or working space on the premises where the tank is located.

(9) "MTCA" means the Model Toxics Control Act, chapter 70.105D RCW and implementing regulations in chapters 173-340 and 173-204 WAC.

(10) "Petroleum" means any petroleum-based substance including crude oil or any fraction that is liquid at standard conditions of temperature and pressure. The term petroleum includes, but is not limited to, petroleum and petroleum-based substances comprised of a complex blend of hydrocarbons, such as motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, used oils, mineral spirits, Stoddard solvents, waste oils and heating oils. The term petroleum does not include propane, asphalt, or any other petroleum product that is not liquid at standard conditions of temperature and pressure. Standard conditions of temperature and pressure are at sixty degrees Fahrenheit and 14.7 pounds per square inch absolute.

(11) "Petroleum storage tank system" means a storage tank system that contains petroleum or a mixture of petroleum with de minimis quantities of other substances. The systems include those containing motor fuels, jet fuels, distillate fuel oils, residual fuel oils, lubricants, petroleum solvents, used oils, and heating oils. "Petroleum storage tank system" does not include any storage tank system regulated under chapter 70.105 RCW.

(12) "Program" means petroleum technical assistance program.

(13) "Qualified petroleum storage tank system" means a storage tank system that has been identified as eligible for services under the petroleum technical assistance program by the department of ecology based on the relative risk posed by the release to human health and the environment.

(14) "Release" means any intentional or unintentional entry of ((~~heating oil~~)) petroleum into the environment((~~.~~

~~(10) "Service provider" means an independent contractor responsible for site assessment, testing or analysis of the results of testing.~~

~~(11) "Site assessment" means an investigation of a heating oil tank site to determine if a release of heating oil has occurred.~~

~~(12) "Sampling and testing" means an approved and recognized technique(s) or procedure(s) for measuring or determining the presence and extent of hydrocarbons in soil and/or water.~~)) including, but not limited to, a spill, leak, emission, escape, or leaching into the environment.

(15) "Remedial action" has the same meaning as defined in RCW 70.105D.020.

(16) "Sampling and testing" means a PLIA-approved and recognized technique(s) or procedure(s) for measuring or determining the presence and extent of hydrocarbons in soil and/or water.

(17) "Site" has the same meaning as defined in RCW 70.105D.020.

(18) "Site characterization" means an investigation of the nature and extent of the release.

AMENDATORY SECTION (Amending WSR 03-06-015, filed 2/21/03, effective 3/24/03)

WAC 374-80-040 Procedures. (((~~(1) The agency will provide, as resources permit, technical assistance to the owners and operators of active or abandoned heating oil tanks if contamination resulting from a release from an active or abandoned heating oil tank is suspected. Technical assistance regarding administrative requirements may include observation of testing, site assessment, as well as review of the results of reports and other appropriate review activities approved by the director.~~

~~(2) Such technical assistance will be provided only upon request by the owner of a heating oil tank. If the operator of a heating oil tank is not the owner, the operator must provide the agency with specific written authorization of the owner before technical assistance is provided, or before a site is visited by a representative of the agency.~~

~~(3) To receive technical assistance under this program, the owner or operator of an active or abandoned heating oil tank must submit an application, provided by the agency, requesting advice and assistance, and agreeing to the terms of the program.~~

~~(4) Upon receipt of a request for technical assistance, the agency will provide the tank owner or operator:~~

~~(a) Information regarding procedures for the program;~~

~~(b) An application requesting technical assistance;~~

~~(c) An agreement between the tank owner and the agency regarding the procedures and reimbursement requirements of the program.~~

~~(5) Technical assistance provided under the program may include:~~

~~(a) Observation of sampling and testing, site assessment or other appropriate assessments scheduled by the tank owner;~~

~~(b) Interpretation of the results of testing and/or assessment(s);~~

~~(c) A report from PLIA to the heating oil tank owner of the results of testing and/or assessment(s); and~~

~~(d) Other appropriate activities approved by the director.~~

~~(6) The heating oil tank owner or operator will select a service provider to perform sampling and testing, site assessment or other appropriate assessments. The tank owner or operator will enter into an agreement with the service provider regarding scope or extent of work and fees for services.~~

~~(7) Technical assistance will be provided only if sampling and testing as well as site assessment are performed in accordance with sampling, testing and assessment protocol approved by the director.~~

~~(8) The original copy of the results of all testing and site assessment activities must be forwarded to the agency for review and evaluation.~~

~~(9) Upon completion of review and evaluation, the agency will, in writing, inform the heating oil tank owner of the results of review and assessment of data. The agency report will note whether it appears there is or is not contamination present at the site. If contamination is discovered, the report will note whether or not the contamination appears to be a threat to human health and the environment. If the contamination does appear to be a threat to human health and the environment, the heating oil tank owner will be advised of the requirement for corrective action. The determination as to whether or not the contamination appears to be a threat to human health and the environment will be made in accordance with the terms and requirements of the Model Toxics Control Act (chapter 70.105D RCW) and its regulations (chapter 173-340 WAC).~~)) (1) **Application.** To receive advice and technical assistance under this program, a person who is conducting or otherwise interested in independent remedial actions where there is a suspected or confirmed release of petroleum or heating oil from a qualified petroleum storage tank system or a heating oil tank, must submit an application provided by the agency requesting advice and assistance and agreeing to the terms of the program.

(2) **Eligibility.** An applicant that has received funding from the PLIA underground storage tank loan and grant program; the heating oil pollution liability insurance program; or the commercial underground storage tank reinsurance program are presumed eligible for the program unless a specific determination is made by PLIA or the department of ecology that the applicant does not have a qualified petroleum storage tank system.

(3) **Services.** The agency may provide the following advice and technical assistance under the program:

(a) Observe and/or interpret the results of sampling and testing, site characterization results, or other appropriate assessments conducted by the applicant;

(b) Provide technical assistance on how to meet the substantive requirements of MTCA;

(c) Review planned independent remedial actions for a site or property and provide written opinions on whether further remedial action is likely necessary to meet the substantive requirements of MTCA;

(d) Review completed independent remedial actions for a site or property and provide written opinions on whether further remedial action is necessary to meet the substantive requirements of MTCA; and

(e) Other appropriate activities approved by the director.

(4) The applicant may select an independent contractor to perform site characterization, sampling and testing, or other remedial actions. The independent contractor is not to be considered for any purpose an employee or agent of PLIA. The applicant will enter into an agreement with the contractor regarding scope or extent of work and fees for services.

(5) **Sampling, testing, and site characterization protocols.** The agency will provide requested advice and technical assistance only if sampling, testing, and site characterization are performed in accordance with protocols approved by the director.

(6) **Rescinding opinions.** The agency may rescind a no further action determination if PLIA's understanding of the conditions at the site change and the site no longer meets the substantive requirements of MTCA.

(a) Where the issues are minor or administrative in nature, the agency will provide the applicant with a notice of suspension detailing the issues to be addressed. The applicant will have sixty days to address the issues. If the issues are addressed to PLIA's satisfaction, the notice of suspension will be removed. If the issues are not addressed to PLIA's satisfaction, the agency will issue a letter rescinding the no further action determination. PLIA may notify the department of ecology of this action.

(b) Where the issues are substantive in nature, the agency will issue a letter rescinding the no further action determination. PLIA will notify the department of ecology of this action.

NEW SECTION

WAC 374-80-045 Environmental covenant. (1) **Consultation.** Where PLIA issues a written opinion under this program, and the remedial action requires an environmental covenant, PLIA must consult with and seek comment on the draft environmental covenant from a city or county department with land use planning authority for real property subject to the covenant. The consultation and opportunity for comment must take place before the property owner records the environmental covenant.

(2) **Periodic review.** Where PLIA has issued a written opinion under this program, and the remedial action requires an environmental covenant, PLIA must conduct a review of the effectiveness of the environmental covenant periodically. The agency must conduct the periodic review at least once every five years.

(3) **Violation.** If the terms of the environmental covenant are not complied with, the agency may rescind the no further action determination.

(a) Where the issues are minor or administrative in nature, the agency will provide the applicant with a notice of suspension detailing the issues to be addressed. The applicant must address the issues within sixty days. If the issues are addressed to PLIA's satisfaction, the notice of suspension will be removed. If the issues are not addressed to PLIA's satisfaction, the agency will issue a letter rescinding the no further action determination. PLIA may notify the department of ecology of this action.

(b) Where the issues are substantive in nature, the agency will issue a letter rescinding the no further action determination. PLIA will notify the department of ecology of this action.

(4) **Termination.** If the conditions at the site requiring an environmental covenant no longer exist, the property owner may petition the agency to have the covenant terminated. PLIA will seek public comment on the proposed termination of the environmental covenant. If, after the public comment period, PLIA agrees to termination of the environmental covenant, the agency will seek termination by consent of the covenant.

(5) **Reimbursement.** The agency may recover costs related to environmental covenants from the applicant and/or

the property owner. These costs are not covered by WAC 374-80-050.

AMENDATORY SECTION (Amending WSR 03-06-015, filed 2/21/03, effective 3/24/03)

WAC 374-80-050 Reimbursement. (1) The agency ((~~shall collect, from the heating oil tank owner or operator requesting technical assistance, the costs incurred in providing such advice and assistance.~~

~~(2) Funds received by the agency from cost reimbursement must be deposited in the heating oil pollution liability trust account.~~

~~(3) Costs incurred that shall be covered in reimbursement may include travel costs and expenses associated with monitoring site assessment, review of reports and analyses and preparation of written opinions and conclusions. The fee for such technical assistance will be $350.00.~~

~~(4) The fee must be paid prior to the agency issuing its report of review and assessment of data.~~)) must collect, from the applicant, a fee to cover the costs incurred in providing advice and technical assistance under the program.

(2) The fee for providing advice and technical assistance under this program is:

(a) One thousand dollars if there is a release or suspected release of heating oil from an active, decommissioned, or abandoned heating oil tank system.

(b) Seven thousand five hundred dollars if there is a release or threatened release of petroleum from a qualified petroleum storage tank system.

(3) The applicant must pay the fee upon acceptance into the program. No advice or technical assistance will be provided until the fee has been paid.

(4) The fee is nonrefundable. However, if the agency determines that an applicant's petroleum storage tank system is ineligible after the applicant enters the program, the agency may refund the fee.

(5) Fees received by the agency under the program must be deposited in the heating oil pollution liability trust account.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 374-80-030 Communications.

WSR 19-20-123
PROPOSED RULES
POLLUTION LIABILITY INSURANCE AGENCY

[Filed October 2, 2019, 11:12 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 17-16-146.

Title of Rule and Other Identifying Information: Chapter 374-20 WAC, Public records, this proposal amends and updates the agency's public records rule to align with recommended model rules and to reflect current agency practices.

Hearing Location(s): On November 6, 2019, at 12-2 p.m. and 5:30-7:30 p.m., at the Spokane Public Library; on November 12, 2019, at 12-2 p.m., at the Lacey Timberland Library; and on November 13, 2019, at 1-3 p.m., at the Olympia Timberland Library. See https://plia.wa.gov/public/ for details.

Date of Intended Adoption: November 15, 2019.

Submit Written Comments to: Phi V. Ly, P.O. Box 40930, Olympia, WA 98504-0930, email rules@plia.wa.gov, fax 360-407-0509, 800-822-3905, by November 13, 2019.

Assistance for Persons with Disabilities: Contact Xyzlinda Marshall, phone 360-407-0515, fax 360-407-0509, TTY 711 or 800-833-6388, email rules@plia.wa.gov, by November 13, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The pollution liability insurance agency (PLIA) recognizes the importance of transparency and accountability in its activities and actions. Pursuant to the state's Public Records Act (PRA), PLIA established rules at the agency's inception. Since then, PLIA programs and activities have expanded, and the agency's rules required updates to reflect current and actual practices to further ensure compliance with the intent of PRA. PLIA is adopting the model rules and best practices recommended by the attorney general's office (chapter 44-14 WAC).

Reasons Supporting Proposal: PLIA seeks to update its public records rule to conform to and reflect (1) statutory changes to PRA, (2) recommendations by the attorney general's office, and (3) actual agency practices and procedures.

Statutory Authority for Adoption: Chapter 42.56 RCW, Public Records Act.

Statute Being Implemented: Not applicable.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Unknown.

Name of Agency Personnel Responsible for Drafting: Phi V. Ly, 300 Desmond Drive, Lacey, WA 98506, 360-407-0517; Implementation and Enforcement: Xyzlinda Marshall, 300 Desmond Drive, Lacey, WA 98506, 360-407-0515.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. An analysis is not applicable for PLIA's compliance with the state PRA.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(3) as the rules are adopting or incorporating by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule.

October 2, 2019
Phi V. Ly
Legislative and
Policy Manager

AMENDATORY SECTION (Amending WSR 90-14-019, filed 6/27/90, effective 7/28/90)

WAC 374-20-010 Purpose. The purpose of this chapter is to implement those provisions of ((~~RCW 42.17.250 through 42.17.320~~)) chapter 42.56 RCW relating to access to public records.

AMENDATORY SECTION (Amending WSR 90-14-019, filed 6/27/90, effective 7/28/90)

WAC 374-20-020 Definitions. Unless the context requires otherwise, the definitions in this section shall apply throughout this chapter.

(1) The terms ((~~"person,"~~)) "public record((~~,~~))" and "writing" have the same meanings as stated in RCW 42.17.-020.

(2) "Agency" means the pollution liability insurance agency established pursuant to chapters 70.148 and 70.149 RCW((~~. For purposes of WAC 374-20-030 through 374-20-100 inclusive, agency~~)) and shall also mean staff or employees of the pollution liability insurance agency.

(3) "Director" means the director of the agency.

(4) "Public records officer" means the designated records manager of the agency.

(5) "Designee" means the employee of the agency designated by the director or the public records officer to serve as the public records officer at the agency in the absence of the officer.

AMENDATORY SECTION (Amending WSR 90-14-019, filed 6/27/90, effective 7/28/90)

WAC 374-20-030 Description of organization. (1) The ((~~location of the principal offices and the~~)) agency's mailing address ((~~of the agency are~~)) is:

Pollution Liability Insurance Agency
State of Washington
((~~1015 - 10th Avenue, S.E.~~
~~Mailstop: EN-12~~
~~Olympia~~)) P.O. Box 40930
Olympia, Washington 98504-0930

The agency's office is located at:
300 Desmond Drive S.E.
Lacey, Washington ((~~98504~~)) 98503

(2) The principal administrative and appointing officer of the agency is the director. The director may designate other officers or employees of the agency to act ((~~in~~)) on his or her behalf in the director's absence ((~~or with respect to those matters~~)) in which so doing would enhance the efficiency of the agency's operations.

(3) The agency implements and administers the pollution liability insurance programs established by chapters 70.148, 70.149, and 70.340 RCW.

(4) Any person wishing to request access to public records of the agency, or seeking assistance in making such a request, should contact the public records officer of the pollution liability insurance agency using one of the following contact methods by mail:

PLIA Public Records Officer
P.O. Box 40930
Olympia, WA 98504-0930
Phone: 800-822-3905
Fax: 360-407-0509
Email: pliamail@plia.wa.gov.

A request form is available on the agency's web site at www.plia.wa.gov.

(5) The public records officer will oversee compliance with the Public Records Act, chapter 42.56 RCW. The agency will provide the fullest assistance to requestors; create and maintain an index to public records of the agency for use by the public and agency officials; 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 agency.

AMENDATORY SECTION (Amending WSR 90-14-019, filed 6/27/90, effective 7/28/90)

WAC 374-20-040 Public records available. (1) ((~~All~~)) **Times for inspection of records.** Public records ((~~of the agency~~)) are available for ((~~public~~)) inspection and copying ((~~pursuant to these rules and subject to subsections (2), (3), and (4) of this section~~)) during agency business hours of Monday through Friday, 8:00 a.m. to 5:00 p.m., excluding legal holidays. Records must be inspected at the office of the agency. Many public records are also available for inspection and copying on the agency's web site at any time, at no cost.

(2) ((~~Availability of public records is subject to the exemptions and requirements of RCW 42.17.310, 42.17.315, and 70.148.060.~~

~~(3) When a public record includes information the disclosure of which would lead to an unreasonable invasion of personal privacy, the agency shall delete such information before making the record available and the public records officer shall provide a written justification for the deletion.~~

~~(4) The agency shall, upon request for identifiable public records, make them promptly available to any person. If public records requested are not readily available for inspection, the agency shall notify the requester when and where the records will be available.~~)) **Records index.** An index of public records, as described in WAC 374-20-050, is available for use by members of the public. The index may be accessed online at www.plia.wa.gov.

(3) **Organization of records.** The agency will maintain its records in a reasonably organized manner. The agency will take reasonable actions to protect records from damage and disorganization. A requestor shall not take agency records from the agency's office without the permission of the public records officer or designee. A variety of records are available on the agency's web site at www.plia.wa.gov. Requestors are encouraged to view the documents available on the web site before submitting a records request.

(4) **No duty to create records.** The agency is under no obligation to create a new public record to satisfy a records request. Translating a record into an alternative electronic format at the request of a requestor does not constitute a new public record. Scanning paper copies to make electronic copies is a method of copying paper records and does not create a new public record.

AMENDATORY SECTION (Amending WSR 90-21-051, filed 10/15/90, effective 11/15/90)

WAC 374-20-050 Records indexes. (((~~(1) Effective July 1, 1990, the agency will maintain an index or indexes of:~~

~~(a) All records issued before July 1, 1990, for which the agency has maintained an index;~~

~~(b) Final orders entered after June 30, 1990, that are issued in adjudicative proceedings as defined in RCW 34.05.010(1) and that contain an analysis or decision of substantial importance to the agency in carrying out its duties;~~

~~(c) Declaratory orders entered after June 30, 1990, that are issued pursuant to RCW 34.05.240 and that contain an analysis or decision of substantial importance to the agency in carrying out its duties;~~

~~(d) Interpretive statements as defined in RCW 34.05.010(8) that were entered after June 30, 1990; and~~

~~(e) Policy statements as defined in RCW 34.05.010(14) that were entered after June 30, 1990.~~

~~(2) Each index shall list the records they contain by date of issue, number, addressee, subject matter, or other identifying information appropriate to the type of record.~~

~~(3) Each index shall be revised or updated no less frequently than quarterly.~~

~~(4) The indexes developed by or for the agency shall be available to all persons under the same rules and under the same conditions as are applied to public records available for inspection and shall be available at the offices of the agency.~~)) The records retention schedule established by the division of state archives of the office of the secretary of state serves as an index for the identification and location of the agency's records, including those described in RCW 42.56.070(5).

The records retention schedule indexes records according to the record series title. Each title is further identified by a statement of function or purpose, and the retention period. The records retention schedule is available to the public for inspection and copying. With the assistance of the public records officer or designee, any person can access the agency's public records using the records retention schedule.

Policy statements and interpretive statements entered after June 30, 1990, and as defined in RCW 34.05.010, are indexed by number and subject matter and are available on the agency's web site.

AMENDATORY SECTION (Amending WSR 90-14-019, filed 6/27/90, effective 7/28/90)

WAC 374-20-060 Making a request((~~s~~)) for public records. (((~~(1) All requests for inspection or copying made in person at the agency shall be made on a form substantially as follows:~~

~~REQUEST FOR PUBLIC RECORDS~~

~~Date . . . . . Time . . . . . .~~

~~Name . . . . . .~~

~~Address . . . . . .~~

~~. . . . . .~~

~~Representing . . . . . .~~

~~Description of Records:~~

~~. . . . . .~~

~~. . . . . .~~

~~. . . . . .~~

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

~~. . . . . .~~

~~Signature~~

~~Number of copies . . . . . .~~

~~Number of pages . . . . . .~~

~~Per page charge $ . . . . . .~~

~~Total charge $ . . . . . .~~

~~(2) All requests made in person may be made at the agency between the hours of 9:00 a.m. to 12:00 noon and 1:00 p.m. to 4:00 p.m. Monday through Friday, excluding legal holidays.~~

~~(3) A request for inspection or copying of public records may be made by mail in a letter containing the following information:~~

~~(a) The name and address of the person making the request;~~

~~(b) The organization or group that the person represents;~~

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

~~(d) A description of the public records requested;~~

~~(e) A statement whether access to copying equipment is desired;~~

~~(f) A phone number where the person can be reached in case the public records officer or designee needs to contact the person for further description of the material or any other reason;~~

~~(g) A statement that the record will not be used for commercial purposes.~~

~~(4) All requests by mail should be received at the agency at least three business days before the requested date of inspection to allow the public records officer or designee to make certain the requested records are available and not exempt and, if necessary, to contact the person requesting inspection.~~

~~(5) The agency may in its discretion fill requests made by telephone.~~)) (1) Any person wishing to inspect or copy public records of the agency must make the request in writing using the agency's request form, the agency's online portal, by letter, fax, or email addressed to the agency public records officer. The written request must include:

(a) Name of requestor;

(b) Address of requestor;

(c) Requestor's contact information, including telephone number and any email address;

(d) Identification of the requested public record(s) adequate for the public records officer or designee to locate the records;

(e) Whether the requestor is asking to inspect the record(s) or for copies;

(f) Whether the requestor would like an estimate of applicable charges before any copies are made; and

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

(2) A records request form is available for use by requestors at the office of the public records officer and online at www.plia.wa.gov.

(3) If the requestor refuses to identify themselves or provides insufficient contact information, the agency will respond to the extent feasible and consistent with the law.

AMENDATORY SECTION (Amending WSR 90-14-019, filed 6/27/90, effective 7/28/90)

WAC 374-20-070 Fees. ((~~No fee shall be charged for inspection of public records. The agency may charge a reasonable fee, determined from time to time by the director, for providing copies of typed, printed, or written material of a maximum size of 8 1/2" by 14". The fee shall be the amount necessary to reimburse the agency for its actual costs incident to such copying. Fees for copies of nonstandard printed material or public records in nonwritten form may not exceed the agency's actual costs incident to such copying.~~)) (1) No fee shall be charged for the inspection of public records, including inspecting records on the agency's web site.

(2) In order to avoid unduly burdensome fee calculations, the agency will implement a fee schedule consistent with the Public Records Act. The agency adopts the state legislature's approved fees and costs for most of the agency records, as authorized in RCW 42.56.120 and as published in the agency's fee schedule.

(3) The fee schedule is available at the agency's office and on the agency's web site at www.plia.wa.gov.

(4) The agency will charge for copies of records pursuant to the default fees in RCW 42.56.120 (2)(b) and (c). The agency will charge for customized services pursuant to RCW 42.56.120(3). Under RCW 42.56.130, the agency may charge other copy fees authorized by statutes outside of chapter 42.56 RCW. The agency may enter into a contract, memorandum of understanding, or other agreement with a requestor that provides an alternative fee arrangement to the charges, or in response to a voluminous or frequently occurring request as allowed by RCW 42.56.120(4).

(5) A requestor may ask the agency to provide a summary of the applicable charges before any copies are made or before processing a customized service. The requestor may revise the request to reduce the number of copies to be made and reduce the applicable charges.

(6) Requestors are required to pay for copies in advance of receiving records. Fee waivers are an exception and are available for some smaller requests. If a fee waiver is requested, the requestor must submit the fee waiver request in writing describing how the conditions are met. A determination by the public records officer to waive all or part of copying fees will be made on a case-by-case review of the fee waiver request.

(a) To request a fee waiver, the requestor must submit the request in writing to the agency, describing how at least one of the conditions set forth in (b) of this subsection are met. If the public records officer determines condition(s) for a fee waiver are met, that decision will be documented in writing.

(b) The public records officer may grant a fee waiver request under the following conditions:

(i) All of the records responsive to an entire request are paper copies only and are twenty-five or fewer pages;

(ii) All of the records for an entire request are electronic and can be provided in a single email with attachments of a size equivalent to up to one hundred printed pages; or

(iii) The records responsive to an entire request consists of a number of duplicate documents.

(c) Fee waivers are not applicable to records provided in installments.

(7) Before beginning to make the copies or processing a customized service, 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 agency does not charge sales tax when it makes copies of public records.

(8) All required fees must be paid in advance of release of the copies or an installment of copies. The agency will notify the requestor of when payment is due.

(9) The agency may also charge actual costs of mailing, including the costs of the shipping container.

(10) Payment should be made by check or money order to the pollution liability insurance agency. The agency prefers not to receive cash. For cash payments it is within the public record officer's discretion to determine the denomination of bills and coins that will be accepted.

(11) The agency 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.

NEW SECTION

WAC 374-20-075 Responses to public records requests. (1) The agency is prohibited by statute from disclosing lists of individuals for commercial purposes.

(2) Upon receipt of a request, the agency will assign a tracking number and record the request into the agency's public records request log.

(3) The public records officer or designee will evaluate the request according to the nature of the request, volume, and availability of requested records. The agency will process requests in the order that allows the largest number of requests to be processed in the most efficient manner.

(4) Following the initial evaluation of the request under subsection (3) of this section, 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 including:

(i) If copies are available on the agency's web site, providing the internet site or link to the specific records requested;

(ii) If copies are requested and the required fee is paid, send the copies to the requestor;

(b) Acknowledge receipt of the request and provide a reasonable estimate of when records or an installment of records will be available. The public records officer or designee may revise the estimate of when records will be available; or

(c) Acknowledge receipt of the request and ask the requestor to provide clarification for anything unclear, and provide to the greatest extent possible, a reasonable estimate of the time the agency will require to respond to the request if it is not clarified.

(i) Such clarification may be requested and provided by telephone, and recorded in writing;

(ii) If the requestor fails to respond to the agency's request for clarification and the entire request is unclear, the agency need not respond to it.

(d) The agency will respond to those portions of the request that are clear or deny the public record request.

(5) If the agency does not respond in writing within five business days of receipt of the request, then the requestor should contact the public records officer to determine the reason for the failure to respond.

(6) If the requested records contain information that may affect rights of others and are exempt from disclosure, then the public records officer may, prior to providing the records, give notice to the person with affected rights. This notice will include sufficient information so that the affected person(s) may contact the requestor and ask him or her to revise the request, or, if necessary, seek a court order to prevent or limit the disclosure. The notice to the affected person(s) will include a copy of the request.

(7) Some records are exempt from disclosure, in whole or in part. If the agency believes that a record is exempt from disclosure and should be withheld, the public records officer will state the specific exemption and provide a brief 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, the public records officer will redact the exempt portions, provide the nonexempt portions, and provide an explanation for the redaction.

(8) The agency shall provide a viewing area to inspect public records, provided that doing so does not unduly burden the operation of the agency. No member of the public may remove a document from the viewing area or disassemble or alter any document. The requestor will indicate which documents he or she wishes the agency to copy. The requestor must claim or review the assembled records within ten business days of the agency's issuance of the notice of availability. If the requestor or a representative of the requestor fails to claim or review the records within the ten business day period, the agency will 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 will be processed as a new request.

(a) After inspection is complete, the public records officer or designee shall make copies or arrange for copying. In accordance with the charge for copies set out in WAC 374-20-070, the requestor must pay the appropriate fee before the agency will release the copies.

(b) When the inspection of the requested records is complete and any requested copies are provided, the public records officer or designee will indicate in writing that the agency has conducted a reasonable search for the requested records, made the nonexempt records available for inspection, and closed the request.

(9) While not required, and with the consent of the requestor, the agency may decide to provide customized electronic access services and assess charges under RCW 42.56.-120 (2)(f). A customized service charge applies only if the agency estimates that the request would require the use of information technology expertise to prepare data compilations, or provide customized electronic access services when such compilations and customized access services are not used by the agency for other purposes. The agency may charge a fee consistent with RCW 42.56.120 (2)(f) for such customized access.

(10) When electronic records are requested, the agency will provide the nonexempt records or portions of such records that are reasonably locatable in an electronic format that is used by the agency and is generally commercially available, or at the agency's discretion, in a format that is reasonably translatable from the format in which the agency keeps the records. The agency is under no obligation to convert electronic records to a specific format identified by the requestor. When metadata is requested, the agency will provide the records in a native file format that preserves metadata where technically feasible. Metadata may be unavailable for records that require conversion to a nonnative format in order to apply exemptions.

(11) When it appears that the number of records responsive to a request may be large, that the process of locating, assembling, or reviewing the records may be lengthy, or that it is otherwise appropriate, the agency may provide records on an installment basis. The agency may wait to locate and assemble additional records in an installment until the requestor has claimed or inspected the previous installment. If an installment is not claimed or inspected within ten business days of the notice of availability, the agency may close the request.

(12) When the requestor: Withdraws the request, fails to clarify an entirely unclear request, fails to fulfill his or her obligations to inspect the records, or pay the deposit, the required fees for an installment, or make final payment for the requested copies, the public records officer will close the request. The agency will indicate to the requestor that the agency has closed the request unless the requestor received previous correspondence stating that the request would be closed under the above circumstances.

(13) If, after the agency has informed the requestor that it has provided all available records, the agency 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 these on an expedited basis.

NEW SECTION

WAC 374-20-076 Notice of availability. (1) Once record(s) responsive to a request or any installment thereof have been located, assembled, reviewed, and prepared for release, and any affected parties notified, the agency will notify the requestor that those record(s) are available for inspection or copying.

(2) If the request asked for inspection of the record(s), then upon receipt of a notice of availability, the requestor may inspect records by scheduling a viewing appointment with the public records officer or designee.

(3) If the requestor asked for copies of the record(s), then the notice of availability will state the costs required to be paid and any other allowable costs under WAC 374-20-070 or the Public Records Act, before release of copies of the records.

(4) If the requestor asked for a summary of applicable charges before any copies are made, then the notice of availability will state the estimated costs to make copies of the record(s) pursuant to WAC 374-20-070. The requestor must inform the agency if it would like copies of the identified record(s). The requestor may revise the request to reduce the number of copies to be made thus reducing the applicable charges.

(5) If, within ten business days of the agency's issuance of a notice of availability, the requestor fails to claim the records (or any installment thereof) by either scheduling a viewing appointment, making any required payment and picking up copies, or by requesting copies of the record(s), then the agency will close the request.

AMENDATORY SECTION (Amending WSR 90-14-019, filed 6/27/90, effective 7/28/90)

WAC 374-20-080 Statement of reasons for denial of public records request. ((~~When the agency refuses, in whole or in 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.~~)) (1) When the agency denies, in whole or in part, a written records request, it shall cite the specific exemption authorizing the refusal and provide a brief explanation of how the exemption applies to the record withheld.

(2) The agency will maintain on its web site www.plia.wa.gov a list of the "other statute" exemptions from disclosure, outside those found in the Public Records Act, which may be applied to specific information or records of the agency. This list is for informational purposes only, and failure to list an exemption shall not affect the ability of any exemption used by the agency.

(3) The agency may deny a "bot" request, if the agency establishes that responding would cause excessive interference with other essential agency functions. A "bot" request is one of multiple records requests from a requestor to the agency within a twenty-four hour period which the agency reasonably believes was automatically generated by a computer program or script.

AMENDATORY SECTION (Amending WSR 90-14-019, filed 6/27/90, effective 7/28/90)

WAC 374-20-090 Reviews of denials of public records request. ((~~Upon denial of a request for inspection of a public record, in whole or in part, the public records officer or other staff member denying the request shall refer the denial to the director or the director's designee for review. The director or the director's designee shall immediately review the denial and either affirm or reverse it. Such review shall be deemed complete at the end of the second business day following the denial of inspection and shall constitute final agency action for the purpose of review. The final decision shall be sent to the person requesting inspection promptly following the decision.~~)) (1) **Petition for internal administrative review of denial of access.** Any requestor who objects to any denial of a records request may petition in writing to the public records officer for a review of that decision. The petition shall include a copy of, or reasonably identify, the written statement by the public records officer or designee denying the request.

(a) The public records officer shall promptly provide the petition and any other relevant information to the agency official designated by the director to conduct the review.

(b) The agency official will immediately consider the petition and either affirm or reverse the denial within two business days following the agency's receipt of the petition, or within such other time as the agency and the requestor mutually agree to.

(2) **Review by the attorney general's office.** Pursuant to RCW 42.56.530, if the agency 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.

(3) **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 19-20-125
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed October 2, 2019, 11:31 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 18-14-080 and 19-13-090.

Title of Rule and Other Identifying Information: The agency is amending or adding the following WAC sections in chapter 182-538 WAC, Managed care: WAC 182-538-040 Introduction, 182-538-050 Definitions, 182-538-060 Managed care choice and assignment, 182-538-067 Qualification to become a managed care organization (MCO), 182-538-068 Qualifications to become a primary care case manage-

ment (PCCM) provider, 182-538-070 Payments to managed care organizations (MCOs), 182-538-071 Payments for primary care case management (PCCM) providers, 182-538-095 Scope of care for managed care enrollees, 182-538-096 Scope of service for PCCM enrollees, 182-538-100 Managed care emergency services, 182-538-110 The grievance and appeal system and agency administrative hearing for managed care organization (MCO) enrollees, 182-538-111 The administrative hearing process for primary care case management (PCCM), 182-538-130 Exemptions and ending enrollment in managed care, 182-538-140 Quality of care and 182-538-150 Apple health foster care program; and new WAC 182-538-170 Notice requirements, 182-538-180 Rights and protections, and 182-538-190 Behavioral health services only (BHSO).

The agency is repealing the following sections of chapter 182-538A WAC, Washington apple health fully integrated managed care (FIMC): WAC 182-538A-040 Washington apple health fully integrated managed care, 182-538A-050 Definitions, 182-538A-060 Fully integrated managed care and choice, 182-538A-067, Qualifications to become a managed care organization (MCO) in fully integrated managed care (FIMC) regional service areas, 182-538A-068 Qualification to become a primary care case management (PCCM) provider in fully integrated managed care (FIMC) regional service areas, 182-538A-070 Payments to managed care organizations (MCOs) in fully integrated managed care (FIMC) regional service areas, 182-538A-071 Payments to primary care case management (PCCM) providers in fully integrated managed care (FIMC) regional service areas, 182-538A-095 Scope of care for fully integrated managed care (FIMC) and behavioral health services only (BHSO) enrollees, 182-538A-100 Managed care emergency services for fully integrated managed care (FIMC) enrollees, 182-538A-110 The grievance and appeal system, and agency administrative hearing for fully integrated managed care (FIMC) managed care organization (MCO) enrollees, 182-538A-111 The administrative hearing process for primary care case management (PCCM) enrollees in FIMC regional service areas, 182-538A-120 Fully integrated managed care (FIMC) enrollee request for a second medical opinion, 182-538A-130 Exemptions and ending enrollment in fully integrated managed care (FIMC), 182-538A-140 Fully integrated managed care (FIMC) qualify of care, 182-538A-150 Apple health foster care program in fully integrated managed care regional service areas, 182-538A-170 Notice requirements, 182-538A-180 Rights and protections, and 182-538A-190 Behavioral health services only (BHSO).

The agency is amending chapter 182-538B WAC, Behavioral health wraparound services.

The agency is amending and adding the following sections of chapter 182-538C WAC, Crisis and noncrisis behavioral health services: WAC 182-538C-040 Behavioral health services, 182-538C-050 Definitions, 182-538C-070 Payment, 182-538C-110 Grievance and appeal system and agency administrative hearing for behavioral health administrative services organizations (BH-ASOs), 182-538C-220 Covered crisis mental health services, and 182-538C-230 Covered substance use disorder detoxification services and new WAC 182-538C-252 Behavioral health administrative services organizations—Advisory board membership.

The agency is adding new chapter 182-538D WAC, Behavioral health services.

The agency is adding new chapter 182-100 WAC, Problem gambling.

Hearing Location(s): On November 5, 2019, at 10:00 a.m., at the Health Care Authority (HCA), Cherry Street Plaza, Sue Crystal Conference Room 106A, 626 8th Avenue, Olympia, WA 98504. Metered public parking is available street side around building. A map is available at https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling 360-725-1000.

Date of Intended Adoption: Not sooner than November 6, 2019.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by November 5, 2019.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication relay services 711, email amber.lougheed@hca.wa.gov, by October 25, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This rule making is required to comply with the requirements in 2ESHB 1388 which changed the designation of the state behavioral health authority from the department of social and health services to HCA, effective July 1, 2018. These rules currently operate under emergency filing WSR 19-13-057.

This rule making is also required to implement E2SSB 5432 which directs the agency to fully implement behavioral health integration for January 1, 2020, by: (1) Removing behavioral health organizations from law; (2) clarifying the roles and responsibilities among HCA, the department of social and health services, and the department of health; (3) clarifying the roles and responsibilities of behavioral health administrative services organizations and the medicaid managed care organizations; and (4) making technical corrections related to the behavioral health system.

This rule making is also needed to implement 2SSB 6312 concerning state purchasing of mental health and chemical dependency treatment services and the full integration of medical and behavioral health services by January 1, 2020.

Reasons Supporting Proposal: See purpose statement.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160; E2SSB 5432, 66th legislature, 2019 regular session; 2SSB 6312, 63rd legislature, 2104 [2014] regular session; and 2ESBH [2ESHB] 1388 (chapter 201, Laws of 2018).

Statute Being Implemented: RCW 41.05.021, 41.05.160; E2SSB 5432, 66th legislature, 2019 regular session; 2SSB 6312, 63rd legislature, 2104 [2014] regular session; and 2ESBH [2ESHB] 1388 (chapter 201, Laws of 2018).

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Amy Emerson, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1348; Implementation and Enforcement: Annette

Schuffenhauer, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1254.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The creation of, amendments to, and repeal of the WAC listed in the CR-102 do not impose additional compliance costs or requirements on providers.

October 2, 2019
Wendy Barcus
Rules Coordinator

Chapter 182-100 WAC

PROBLEM GAMBLING

NEW SECTION

WAC 182-100-0100 Problem gambling and gambling disorder treatment services. (1) Under RCW 41.05.750, the Washington state health care authority (HCA) administers a program to:

(a) Prevent and treat problem gambling and gambling disorder; and

(b) Train professionals to identify and treat problem gambling issues and gambling disorders. Training must be administered by a qualified person who has training and experience in treatment services for people experiencing a problem gambling issue or gambling disorder.

(2) To be eligible to receive treatment under this program, a person must participate in a behavioral health assessment process under WAC 246-341-0610 to determine that the person:

(a) Has a problem gambling issue or gambling disorder;

(b) Wants treatment and is willing to do the work necessary to undergo treatment; and

(c) Is unable to afford treatment.

(3) Family members of a person who has a problem gambling issue or gambling disorder may be eligible to receive treatment if they are unable to afford treatment.

(4) Treatment under this section is available only to the extent of the funds appropriated or otherwise made available to HCA for this purpose.

(5) Problem gambling and gambling disorder treatment services include diagnostic screening and assessment, and individual, group, couples, and family counseling and case management.

(6) An agency providing problem gambling and gambling disorder services must meet the behavioral health agency licensure, certification, administration, personnel, clinical, and outpatient requirements in WAC 246-341-0754 and 246-341-0300 through 246-341-0650.

(7) Definitions for the purposes of this section only.

(a) **"Gambling disorder"** means a mental disorder as defined in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* and is characterized by loss of control over gambling, progression in preoccupation with gambling and in obtaining money to gamble, and continuation of gambling despite adverse consequences;

(b) **"Problem gambling"** means at-risk behavior that compromises, disrupts, or damages family or personal relationships, or vocational pursuits.

AMENDATORY SECTION (Amending WSR 17-23-199, filed 11/22/17, effective 12/23/17)

WAC 182-538-040 Introduction. (1) This chapter governs services provided under the Washington apple health integrated managed care (IMC) contract((~~s. If a conflict exists between the requirements of this chapter and other rules, the requirements of this chapter take precedence~~)).

(2) IMC provides physical and behavioral health services to medicaid beneficiaries through managed care.

(3) IMC includes enrollees receiving behavioral health services only (BHSO).

(4) IMC medicaid services are available only through a contracted managed care organization (MCO) and its provider network, except as identified in this chapter.

(5) For nonmedicaid funded behavioral health wraparound services, see chapter 182-538B WAC.

(6) For crisis and crisis related behavioral health services, see chapter 182-538C WAC.

(7) For behavioral health services, also see chapter 182-538D WAC.

AMENDATORY SECTION (Amending WSR 17-23-199, filed 11/22/17, effective 12/23/17)

WAC 182-538-050 Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC((~~, Medical definitions,~~)) apply to this chapter. If conflict exists, this chapter takes precedence.

"Administrative hearing" means ((~~the agency's administrative hearing process~~)) an evidentiary adjudicative proceeding before an administrative law judge or presiding officer that is available to an enrollee under chapter 182-526 WAC ((~~for review of an adverse benefit determination in accordance with~~)) according to RCW 74.09.741.

"Adverse benefit determination" means one or more of the following:

(a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(b) The reduction, suspension, or termination of a previously authorized service;

(c) The denial, in whole or in part, of payment for a service;

(d) The failure to provide services in a timely manner, as defined by the state;

(e) The failure of a managed care organization (MCO) to act within the time frames provided in 42 C.F.R. Sec.

438.408 (a), (b)(1) and (2) for standard resolution of grievances and appeals; or

(f) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside the network under 42 C.F.R. Sec. 438.52 (b)(2)(ii).

"Agency" - See WAC 182-500-0010.

"Appeal" means a review by an MCO of an adverse benefit determination.

"Apple health foster care (AHFC)" means the managed care program developed by the agency and the department of social and health services to serve children and youth in foster care and adoption support and young adult alumni of the foster care program.

"Assign" or **"assignment"** means the agency selects an MCO to serve a client who has not selected an MCO.

"Auto enrollment" means the agency has automatically enrolled a client into an MCO in the client's area of residence.

"Behavioral health" - See WAC 182-538D-0200.

"Behavioral health administrative service organization (BH-ASO)" means an entity selected by the medicaid agency to administer behavioral health services and programs, including crisis services for all people in an integrated managed care regional service area. The BH-ASO administers crisis services for all people in its defined regional service area, regardless of a person's ability to pay.

"Behavioral health services only (BHSO)" means the program in which enrollees only receive behavioral health benefits through a managed care delivery system.

"Client" ((~~means, for the purposes of this chapter, a person eligible for any Washington apple health program, including managed care programs, but who is not enrolled with an MCO or PCCM provider~~)) - See WAC 182-500-0020.

"Disenrollment" - See "end enrollment."

"Emergency medical condition" means a condition meeting the definition in 42 C.F.R. Sec. 438.114(a).

"Emergency services" means services defined in 42 C.F.R. Sec. 438.114(a).

"End enrollment" means ending the enrollment of an enrollee for one of the reasons outlined in WAC 182-538-130.

"Enrollee" means a person eligible for any Washington apple health program enrolled in managed care with an MCO or PCCM provider that has a contract with the state.

"Enrollee's representative" means a person with a legal right or written authorization from the enrollee to act on behalf of the enrollee in making decisions.

"Enrollees with special health care needs" means enrollees having chronic and disabling conditions and the conditions:

(a) Have a biologic, psychologic, or cognitive basis;

(b) Have lasted or are virtually certain to last for at least one year; and

(c) Produce one or more of the following conditions stemming from a disease:

(i) Significant limitation in areas of physical, cognitive, or emotional function;

(ii) Dependency on medical or assistive devices to minimize limitation of function or activities; or

(iii) In addition, for children, any of the following:

(A) Significant limitation in social growth or developmental function;

(B) Need for psychological, educational, medical, or related services over and above the usual for the child's age; or

(C) Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.

"Exemption" means agency approval of a client's preenrollment request to remain in the fee-for-service delivery system for one of the reasons outlined in WAC 182-538-130.

"Fully integrated managed care (FIMC)" - See integrated managed care.

"Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination.

"Grievance and appeal system" means the processes the MCO implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them.

"Health care service" or **"service"** means a service or item provided for the prevention, cure, or treatment of an illness, injury, disease, or condition.

"Integrated managed care (IMC)" means the program under which a managed care organization provides:

(a) Physical health services funded by medicaid; and

(b) Behavioral health services funded by medicaid, and other available resources provided for in chapters 182-538B, 182-538C, and 182-538D WAC.

"Managed care" means a comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided through either an MCO or PCCM provider.

"Managed care contract" means the agreement between the agency and an MCO to provide prepaid contracted services to enrollees.

"Managed care organization" or **"MCO"** means an organization having a certificate of authority or certificate of registration from the office of insurance commissioner that contracts with the agency under a comprehensive risk contract to provide prepaid health care services to enrollees under the agency's managed care programs.

"Mandatory enrollment" means the agency's requirement that a client enroll in managed care.

"Mandatory service area" means a service area in which eligible clients are required to enroll in an MCO.

"Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity acting within their scope of practice and licensure that:

(a) Provides health care services to enrollees; and

(b) Does not have a written agreement with the managed care organization (MCO) to participate in the MCO's provider network.

"Participating provider" means a person, health care provider, practitioner, or entity acting within their scope of practice and licensure with a written agreement with the MCO to provide services to enrollees.

"Patient days of care" means all voluntary patients and involuntarily committed patients under chapter 71.05 RCW,

regardless of where in the state hospital the patients reside. Patients who are committed to the state hospital under chapter 10.77 RCW are not included in the patient days of care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the patient days of care until a petition for ninety days of civil commitment under chapter 71.05 RCW has been filed in court. Patients who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the patient days of care until the patient is civilly committed under chapter 71.05 RCW.

"Primary care case management" or **"PCCM"** means the health care management activities of a provider that contracts with the agency to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services.

"Primary care provider" or **"PCP"** means a person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), naturopath, or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care.

"Regional service area (RSA)" means a single county or multi-county grouping formed for the purpose of health care purchasing and designated by the agency and the department of social and health services.

"Timely" concerning the provision of services, means an enrollee has the right to receive medically necessary health care as expeditiously as the enrollee's health condition requires. Concerning authorization of services and grievances and appeals, "timely" means according to the agency's managed care program contracts and the time frames stated in this chapter.

"Wraparound with intensive services (WISe)" is a program that provides comprehensive behavioral health services and support to:

(a) Medicaid-eligible people age twenty or younger with complex behavioral health needs; and

(b) Their families.

AMENDATORY SECTION (Amending WSR 15-24-098, filed 12/1/15, effective 1/1/16)

WAC 182-538-060 Managed care choice and assignment. (1) ((~~Except as provided in subsection (2) of this section,~~)) The medicaid agency requires a client to enroll in integrated managed care (IMC) when that client:

(a) Is eligible for one of the Washington apple health programs for which enrollment is mandatory;

(b) Resides in an area where enrollment is mandatory; and

(c) Is not exempt from ((~~managed care~~)) IMC enrollment ((~~or~~)) and the agency has not ended the client's managed care enrollment, consistent with WAC 182-538-130.

(2) American Indian and Alaska native (AI/AN) clients and their descendants may choose one of the following:

(a) Enrollment with a managed care organization (MCO) available in their regional service area;

(b) Enrollment with a PCCM provider through a tribal clinic or urban Indian center available in their area; or

(c) The agency's fee-for-service system for physical health or behavioral health or both.

(3) To enroll with an MCO or PCCM provider, a client may:

(a) Enroll online via the Washington Healthplanfinder at https://www.wahealthplanfinder.org;

(b) Call the agency's toll-free enrollment line at 800-562-3022; or

(c) Go to the ProviderOne client portal at https://www.waproviderone.org/client and follow the instructions((~~;~~

~~(d) Mail a postage-paid completed managed care enrollment form (HCA 13-862) to the agency's unit responsible for managed care enrollment; or~~

~~(e) Fax the managed care enrollment form (HCA 13-862) to the agency at the number located on the enrollment form~~)).

(4) ((~~A client~~)) An enrollee in IMC must enroll with an MCO available in the regional service area where the ((~~client~~)) enrollee resides.

(5) All family members will be enrolled with the same MCO, except family members of an enrollee placed in the patient review and coordination (PRC) program under WAC 182-501-0135 need not enroll in the same MCO as the family member placed in the PRC program.

(6) ((~~A client~~)) An enrollee may be placed into the PRC program by the ((~~client's~~)) MCO or the agency. ((~~The client~~)) An enrollee placed in the PRC program must follow the enrollment requirements of the program as stated in WAC 182-501-0135.

(7) When a client requests enrollment with an MCO or PCCM provider, the agency enrolls a client effective the earliest possible date given the requirements of the agency's enrollment system.

(8) The agency assigns a client who does not choose an MCO or PCCM provider as follows:

(a) If the client was enrolled with an MCO or PCCM provider within the previous six months, the client is reenrolled with the same MCO or PCCM provider;

(b) If (a) of this subsection does not apply and the client has a family member enrolled with an MCO, the client is enrolled with that MCO;

(c) The client is reenrolled within the previous six months with their prior MCO plan if:

(i) The agency identifies the prior MCO and the program is available; and

(ii) The client does not have a family member enrolled with an agency-contracted MCO or PCCM provider.

(d) If the client has a break in eligibility of less than two months, the client will be automatically reenrolled with his or her previous MCO or PCCM provider and no notice will be sent; or

(e) If the client cannot be assigned according to (a), (b), (c), or (d) of this subsection, the agency assigns the client according to agency policy.

(f) If the client cannot be assigned according to (a) or (b) of this subsection, the agency assigns the client as follows:

(i) If a client who is not ((~~AI or AN~~)) AI/AN does not choose an MCO, the agency assigns the client to an MCO available in the area where the client resides. The MCO is responsible for primary care provider (PCP) choice and assignment.

(ii) For clients who are newly eligible or who have had a break in eligibility of more than six months, the agency sends a written notice to each household of one or more clients who are assigned to an MCO. The assigned client has ten calendar days to contact the agency to change the MCO assignment before enrollment is effective. The notice includes:

(A) The agency's toll-free number;

(B) The toll-free number and name of the MCO to which each client has been assigned;

(C) The effective date of enrollment; and

(D) The date by which the client must respond in order to change the assignment.

(((~~iii) If the client has a break in eligibility of less than six months, the client will be automatically reenrolled with his or her previous MCO and no notice will be sent.~~

~~(9) Upon request, the agency will assist clients in identifying an MCO with which their provider participates.~~

~~(10)~~)) (9) An MCO enrollee's selection of a PCP or assignment to a PCP occurs as follows:

(a) An MCO enrollee may choose:

(i) A PCP or clinic that is in the enrollee's MCO and accepting new enrollees; or

(ii) A different PCP or clinic participating with the enrollee's MCO for different family members.

(b) The MCO assigns a PCP or clinic that meets the access standards set forth in the relevant managed care contract if the enrollee does not choose a PCP or clinic.

(c) An MCO enrollee may change PCPs or clinics in an MCO for any reason, with the change becoming effective no later than the beginning of the month following the enrollee's request.

(d) An MCO enrollee may file a grievance with the MCO if the MCO does not approve an enrollee's request to change PCPs or clinics.

(e) MCO enrollees required to participate in the agency's PRC program may be limited in their right to change PCPs (see WAC 182-501-0135).

AMENDATORY SECTION (Amending WSR 15-24-098, filed 12/1/15, effective 1/1/16)

WAC 182-538-067 Qualifications to become a managed care organization (MCO) in integrated managed care. (1) To provide physical or behavioral health services under the IMC medicaid contract:

(a) An MCO must contract with the agency.

(b) MCO must also contract with an agency-contracted behavioral health administrative service organization (BH-ASO) that maintains an adequate provider network to deliver services to clients in IMC regional service areas.

(2) A managed care organization (MCO) must meet the following qualifications to be eligible to contract with the medicaid agency:

(a) Have a certificate of registration from the Washington state office of the insurance commissioner (OIC) that allows the MCO to provide health care services under a risk-based contract;

(b) Accept the terms and conditions of the agency's managed care contract;

(c) Be able to meet the network and quality standards established by the agency; and

(d) Pass a readiness review, including an on-site visit conducted by the agency.

(((~~(2)~~))) (3) At its discretion, the agency awards a contract to an MCO through a competitive process or an application process available to all qualified providers.

(((~~(3)~~))) (4) The agency reserves the right not to contract with any otherwise qualified MCO.

AMENDATORY SECTION (Amending WSR 15-24-098, filed 12/1/15, effective 1/1/16)

WAC 182-538-068 Qualifications to become a primary care case management (PCCM) provider in integrated managed care regional service areas. A primary care case management (PCCM) provider or the individual providers in a PCCM group or clinic must:

(1) Have a core provider agreement with the medicaid agency;

(2) Be a recognized urban Indian health center or tribal clinic;

(3) Accept the terms and conditions of the agency's PCCM contract;

(4) Be able to meet the quality standards established by the agency; and

(5) Accept the case management rate paid by the agency.

AMENDATORY SECTION (Amending WSR 18-08-035, filed 3/27/18, effective 4/27/18)

WAC 182-538-070 Payments ((~~to~~)) and sanctions for managed care organizations (MCOs) in integrated managed care regional service areas. (1) The medicaid agency pays apple health managed care organizations (MCOs) monthly capitated premiums that:

(a) Have been developed using generally accepted actuarial principles and practices;

(b) Are appropriate for the populations to be covered and the services to be furnished under the MCO contract;

(c) Have been certified by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board;

(d) Are based on analysis of historical cost, rate information, or both; and

(e) Are paid based on legislative allocations.

(2) The MCO is solely responsible for payment of MCO-contracted health care services. The agency will not pay for a service that is the MCO's responsibility, even if the MCO has not paid the provider for the service.

(3) The agency pays MCOs a service-based enhancement rate for wraparound with intensive services (WISe) administered by a certified WISe provider who holds a current behavioral health agency license issued by the department of health under chapter 246-341 WAC.

(4) For crisis services, the MCO must determine whether the person receiving the services is eligible for Washington apple health or if the person has other insurance coverage.

(5) The MCO pays a reimbursement for each patient day of care that exceeds the MCO daily allocation of state hospital beds based on a quarterly calculation of the bed usage.

(a) The agency bills the MCO quarterly for state hospital patient days of care exceeding the MCO daily allocation of state hospital beds and the established rate of reimbursement.

(b) An MCO using fewer patient days of care than its quarterly allocation of state hospital beds receives a portion of the reimbursement collected proportional to its share of the total number of patient days of care that were not used at the appropriate state hospital.

(6) The agency may:

(a) Impose intermediate sanctions under 42 C.F.R. Sec. 438.700 and corrective action for substandard rates of clinical performance measures and for deficiencies found in audits and on-site visits;

(b) Require corrective action for findings for noncompliance with any contractual, state, or federal requirements;

(c) Impose sanctions for noncompliance with any contractual, state, or federal requirements not corrected; and

(d) Apply a monthly penalty assessment associated with poor performance on selected behavioral health performance measures.

(7) The agency pays an enhancement rate for each MCO enrollee assigned to a federally qualified health center (FQHC) or rural health clinic (RHC) according to chapters 182-548 and 182-549 WAC.

(((~~(4)~~))) (8) The agency pays MCOs a delivery case rate, separate from the capitation payment, when an enrollee delivers a child(ren) and the MCO pays for any part of labor and delivery.

AMENDATORY SECTION (Amending WSR 15-24-098, filed 12/1/15, effective 1/1/16)

WAC 182-538-071 Payments for primary care case management (PCCM) providers in the integrated managed care for regional service areas. (1) The medicaid agency pays PCCM providers a monthly case management fee according to contracted terms and conditions.

(2) The agency pays PCCM providers for health care services under the fee-for-service health care delivery system.

AMENDATORY SECTION (Amending WSR 15-24-098, filed 12/1/15, effective 1/1/16)

WAC 182-538-095 Scope of care for integrated managed care enrollees and managed care organization benefit administration requirements.

Scope of Care.

(1) ((~~A managed care~~)) An enrollee in integrated managed care (IMC) is eligible only for the scope of services ((~~in WAC 182-501-0060 for categorically needy clients.~~

(~~a~~))) that are covered based on the apple health program (eligibility program) in which they are enrolled.

(a) See the chart in WAC 182-501-0060 for category of covered services that are covered based on enrollee's apple health eligibility program, and the program rules to determine which specific services are covered. See WAC 182-501-0065 for a description of the category of covered services.

(b) The apple health eligibility programs for IMC includes the alternative benefit plan (ABP), categorically needy (CN), and medically needy (MN) programs.

(2) The managed care organization (MCO) covers the services included ((~~in the contract for its enrollees.~~

~~(i) MCOs may, at their discretion, cover services not required under the MCO contract.~~

(~~ii~~))) under the IMC medicaid contract for IMC enrollees based on their apple health eligibility program.

(3) If an IMC enrollee is enrolled in behavioral health services only (BHSO):

(a) The MCO will only cover the behavioral health benefit included in the IMC medicaid contract.

(b) The MCO is not responsible for coverage of the physical health benefit in the IMC contract.

(c) See WAC 182-538-190 regarding additional rules related to BHSO.

(4) The agency ((~~cannot~~)) does not require the MCO to cover any services outside the scope of covered services in the MCO's contract with the agency. At its discretion, an MCO may cover services not required under the IMC medicaid contract.

(((~~(b) The agency covers services identified as covered for categorically needy clients in WAC 182-501-0060 and described in WAC 182-501-0065 that are excluded from coverage in the MCO contract.~~

~~(2) The following services are not covered by the MCO:~~)) (5) Services included in enrollees' medicaid eligibility program, and identified as covered based on program rules, may be excluded from coverage by the agency under the managed care contract. These excluded services that are covered based on program rules are available on a fee-for-service basis.

(6) The MCO is not required to authorize or pay for covered services if:

(a) Services ((~~that~~)) are determined to be not medically necessary as defined in WAC 182-500-0070.

(b) Services ((~~not included in the categorically needy scope of services~~)) are excluded from coverage under the managed care contract.

(c) Services received in a hospital emergency department for nonemergency medical conditions, except for a screening exam as described in WAC 182-538-100.

(d) Services received from a participating provider that require prior authorization from the MCO, but were not authorized by the MCO.

(e) All nonemergency services covered under the MCO contract and received from nonparticipating providers that were not prior authorized by the MCO.

(((~~(3) A provider may bill an enrollee for noncovered services as described in subsection (2) of this section, if the requirements of WAC 182-502-0160 are met.~~))

MCO Benefit Administration Requirements.

(((4))) (7) For services covered by the agency through contracts with MCOs:

(a) The agency requires the MCO to subcontract with enough providers to deliver the scope of contracted services in a timely manner((~~. Except for emergency services,~~));

(b) The agency requires MCOs to provide new enrollees with written information about how enrollees may obtain covered services;

(c) MCOs provide covered services to enrollees through their participating providers((~~;~~

~~(b) The agency requires MCOs to provide new enrollees with written information about how enrollees may obtain covered services;~~

~~(c)~~)), unless an exception applies. An MCO covers services from a nonparticipating provider when an enrollee obtains:

(i) Emergency services; or

(ii) Authorization from the MCO to receive services from a nonparticipating provider.

(d) For nonemergency services, MCOs may require:

(i) The enrollee to obtain a referral from the primary care provider (PCP)((~~, and/or~~)); or

(ii) The provider to obtain authorization from the MCO, according to the requirements of the MCO contract;

(((~~d~~))) (e) MCOs and their contracted providers determine which services are medically necessary given the enrollee's condition, according to the requirements included in the MCO contract;

(((~~e~~))) (f) The agency requires the MCO to coordinate benefits with other insurers in a manner that does not reduce benefits to the enrollee or result in costs to the enrollee;

(((~~f~~))) (g) A managed care enrollee does not need a PCP referral to receive women's health care services, as described in RCW 48.42.100, from any women's health care provider participating with the MCO. Any covered services ordered or prescribed by a women's health care provider must meet the MCO's service authorization requirements for the specific service;

(((~~g~~))) (h) For enrollees outside their MCO services area, the MCO must cover enrollees for emergency care and medically necessary covered benefits that cannot wait until the enrollees return to their MCO services area.

(((~~5~~))) (8)(a) An MCO enrollee may obtain specific services described in the managed care contract from either an MCO-contracted provider or a provider with a separate agreement with the agency without a referral from the PCP or MCO. These services are communicated to enrollees by the agency and MCOs as described in (b) of this subsection.

(b) The agency sends each enrollee written information about covered services when the client must enroll in managed care and any time there is a change in covered services. The agency requires MCOs to provide new enrollees with written information about covered services.

(((~~6~~))) (9) An enrollee is entitled to timely access to covered services that are medically necessary as defined in WAC 182-500-0070.

(((~~7~~))) (10) All nonemergency services covered under the MCO contract and received from nonparticipating providers require prior authorization from the MCO.

(11) A provider may bill an enrollee for services only if the requirements of WAC 182-502-0160 are met.

AMENDATORY SECTION (Amending WSR 15-24-098, filed 12/1/15, effective 1/1/16)

WAC 182-538-096 Scope of service for PCCM enrollees. (1) An enrollee is entitled to timely access to covered services that are medically necessary.

(2) A primary care case management (PCCM) enrollee is eligible for the scope of services ((~~in~~)) that are covered based on the enrollee's apple health eligibility program. See WAC 182-501-0060 and 182-501-0065((~~. An enrollee is entitled to timely access to covered services that are medically necessary~~)) for categories of services that are covered and program rules for specific services that are covered.

(((~~a~~))) (3) The agency covers services through the fee-for-service system for enrollees with a primary care case management (PCCM) provider. ((~~Except for emergencies,~~))

(a) The PCCM provider must either provide the covered services or refer the enrollee to other providers who are contracted with the agency for covered services, except for emergency services.

(b) The PCCM provider is responsible for explaining to the enrollee how to obtain the services for which the PCCM provider is referring the enrollee.

(c) Services that require PCCM provider referral are described in the PCCM contract.

(((~~b~~))) (d) The agency sends each enrollee written information about covered services when the client enrolls in managed care and when there is a change in covered services. This information describes covered services, which services are covered by the agency, and how to access services through the PCCM provider.

(((~~(2) For services covered by the agency through PCCM contracts for managed care:~~

~~(a) The agency covers medically necessary services included in the categorically needy scope of care and furnished by providers who have a current core provider agreement with the agency to provide the requested service;~~

~~(b) The agency may require the PCCM provider to obtain authorization from the agency for coverage of nonemergency services;~~

~~(c) The PCCM provider determines which services are medically necessary;~~

~~(d) Services referred by the PCCM provider require an authorization number to receive payment from the agency; and~~

~~(e) An enrollee may request a hearing for review of PCCM provider or agency coverage decisions (see WAC 182-538-110).~~

~~(3)~~)) (4) The agency will not authorize or pay for the following services ((~~are not covered~~)):

(a) Services that are not medically necessary as defined in WAC 182-500-0070.

(b) Services not included in the ((~~categorically needy~~)) scope of covered services for the client's apple health eligibility program.

(c) Services((~~, other than a screening exam as described in WAC 182-538-100(3),~~)) received in a hospital emergency department for nonemergency medical conditions((~~.~~

~~(d) Services that require a referral from the PCCM provider as described in the PCCM contract, but were not referred by the PCCM provider~~)), other than a screening exam as described in WAC 182-538-100(3).

AMENDATORY SECTION (Amending WSR 15-24-098, filed 12/1/15, effective 1/1/16)

WAC 182-538-100 Managed care emergency services. (1) A managed care enrollee may obtain emergency services for emergency medical conditions from any qualified medicaid provider.

(a) The managed care organization (MCO) covers emergency services for MCO enrollees.

(b) The agency covers emergency services for primary care case management (PCCM) enrollees.

(2) Emergency services for emergency medical conditions do not require prior authorization by the MCO, primary care provider (PCP), PCCM provider, or the agency.

(3) MCOs must cover all emergency services provided to an enrollee by a provider who is qualified to furnish medicaid services, without regard to whether the provider is a participating or nonparticipating provider.

(4) An enrollee who requests emergency services may receive an exam to determine if the enrollee has an emergency medical condition. What constitutes an emergency medical condition may not be limited on the basis of diagnosis or symptoms.

(5) The MCO must cover emergency services provided to an enrollee when:

(a) The enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition; and

(b) The plan provider or other MCO representative instructs the enrollee to seek emergency services.

(6) In any disagreement between a hospital and the MCO about whether the enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails.

(7) Under 42 C.F.R. 438.114, the enrollee's MCO must cover and pay for:

(a) Emergency services provided to enrollees by an emergency room provider, hospital or ((~~fiscal agent~~)) provider outside the managed care system; and

(b) Any screening and treatment the enrollee requires after the provision of the emergency services.

AMENDATORY SECTION (Amending WSR 17-23-199, filed 11/22/17, effective 12/23/17)

WAC 182-538-110 The grievance and appeal system and agency administrative hearing for managed care organization (MCO) enrollees. (1) **Introduction.** This section contains information about the grievance and appeal system and the right to an agency administrative hearing for MCO enrollees. See WAC 182-538-111 for information about PCCM enrollees.

(2) **Statutory basis and framework.**

(a) Each MCO must have a grievance and appeal system in place for enrollees.

(b) Once an MCO enrollee has completed the MCO appeals process, the MCO enrollee has the option of requesting an agency administrative hearing regarding any adverse benefit determination upheld by the MCO. See chapter 182-526 WAC.

(3) **MCO grievance and appeal system - General requirements.**

(a) The MCO grievance and appeal system must include:

(i) A process for addressing complaints about any matter that is not an adverse benefit determination, which is a grievance;

(ii) An appeal process to address enrollee requests for review of an MCO adverse benefit determination; and

(iii) Access to the agency's administrative hearing process for review of an MCO's resolution of an appeal.

(b) MCOs must provide information describing the MCO's grievance and appeal system to all providers and subcontractors.

(c) An MCO must have agency approval for written materials sent to enrollees regarding the grievance and appeal system and the agency's administrative hearing process under chapter 182-526 WAC.

(d) MCOs must inform enrollees in writing within fifteen calendar days of enrollment about enrollees' rights with instructions on how to use the MCO's grievance and appeal system and the agency's administrative hearing process.

(e) An MCO must give enrollees any reasonable assistance in completing forms and other procedural steps for grievances and appeals (e.g., interpreter services and toll-free numbers).

(f) An MCO must allow enrollees and their authorized representatives to file grievances and appeals orally as well as in writing ((~~including~~)).

(g) Methods to file either a grievance or appeal include, but are not limited to, U.S. mail, commercial delivery services, hand delivery, fax, and email.

(h) MCOs may not require enrollees to provide written follow-up for a grievance ((~~or an appeal~~)) the MCO received orally.

(((~~(g)~~))) (i) The MCO must resolve each grievance and appeal and provide notice of the resolution as expeditiously as the enrollee's health condition requires, and within the time frames identified in this section.

(((~~(h)~~))) (j) The MCO must ensure that the people who make decisions on grievances and appeals:

(i) Neither were involved in any previous level of review or decision making, nor a subordinate of any person who was so involved; and

(ii) Are health care professionals with appropriate clinical expertise in treating the enrollee's condition or disease if deciding any of the following:

(A) An appeal of an adverse benefit determination concerning medical necessity;

(B) A grievance concerning denial of an expedited resolution of an appeal; or

(C) A grievance or appeal that involves any clinical issues.

(iii) Take into account all comments, documents, records, and other information submitted by the enrollee or the enrollee's representative without regard to whether the information was submitted or considered in the initial adverse benefit determination.

(4) **The MCO grievance process.**

(a) Only an enrollee or enrollee's authorized representative may file a grievance with the MCO. A provider may not file a grievance on behalf of an enrollee without the enrollee's written consent.

(b) The MCO must acknowledge receipt of each grievance within two business days. Acknowledgment may be orally or in writing.

(c) The MCO must complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the enrollee's health condition requires, but no later than forty-five days after receiving the grievance.

(d) The MCO must notify enrollees of the resolution of grievances within five business days of determination.

(i) Notices of resolution of grievances not involving clinical issues can be oral or in writing.

(ii) Notices of resolution of grievances for clinical issues must be in writing.

(e) Enrollees do not have a right to an agency administrative hearing to dispute the resolution of a grievance unless the MCO fails to adhere to the notice and timing requirements for grievances.

(f) If the MCO fails to adhere to the notice and timing requirements for grievances, the enrollee is deemed to have completed the MCO's appeals process and may initiate an agency administrative hearing.

(5) **MCO's notice of adverse benefit determination.**

(a) **Language and format requirements.** The notice of adverse benefit determination must be in writing in the enrollee's primary language, and in an easily understood format, in accordance with 42 C.F.R. Sec. 438.404.

(b) **Content of notice.** The notice of MCO adverse benefit determination must explain:

(i) The adverse benefit determination the MCO has made or intends to make, and any pertinent effective date;

(ii) The reasons for the adverse benefit determination, including citation to rules or regulations and the MCO criteria that were the basis of the decision;

(iii) The enrollee's right to receive upon request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination, including medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;

(iv) The enrollee's right to file an appeal of the MCO adverse benefit determination, including information on the MCO appeal process and the right to request an agency administrative hearing;

(v) The procedures for exercising the enrollee's rights;

(vi) The circumstances under which an appeal can be expedited and how to request it;

(vii) The enrollee's right to have benefits continued pending resolution of an appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) **Timing of notice.** The MCO must mail the notice of adverse benefit determination within the following time frames:

(i) For termination, suspension, or reduction of previously authorized services, at least ten calendar days prior to the effective date of the adverse benefit determination in accordance with 42 C.F.R. Sec. 438.404 and 431.211. This time period does not apply if the criteria in 42 C.F.R. Sec. 431.213 or 431.214 are met. This notice must be mailed by a method that certifies receipt and assures delivery within three calendar days.

(ii) For denial of payment, at the time of any adverse benefit determination affecting the claim. This applies only when the enrollee can be held liable for the costs associated with the adverse benefit determination.

(iii) For standard service authorization decisions that deny or limit services, as expeditiously as the enrollee's health condition requires not to exceed fourteen calendar days following receipt of the request for service. An extension of up to fourteen additional days may be allowed if:

(A) The enrollee or enrollee's provider requests the extension.

(B) The MCO determines and justifies to the agency upon request, a need for additional information and that the extension is in the enrollee's interest.

(iv) If the MCO extends the time frame for standard service authorization decisions, the MCO must:

(A) Give the enrollee written notice of the reason for the decision to extend and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision; and

(B) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(v) For expedited authorization decisions:

(A) In cases involving mental health drug authorization decisions, or where the provider indicates or the MCO determines that following the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice no later than seventy-two hours after receipt of the request for service.

(B) The MCO may extend the seventy-two-hour time frame up to fourteen calendar days if:

(I) The enrollee requests the extension; or

(II) The MCO determines and justifies to the agency, upon request, there is a need for additional information and it is in the enrollee's interest.

(6) **The MCO appeal process.**

(a) **Authority to appeal.** An enrollee, the enrollee's authorized representative, or the provider acting with the enrollee's written consent may appeal an adverse benefit determination from the MCO.

(b) **Oral appeals.** An MCO must treat oral inquiries about appealing an adverse benefit determination as an appeal to establish the earliest possible filing date for the appeal. The oral appeal must be confirmed in writing by the

MCO, unless the enrollee or provider requests an expedited resolution.

(c) **Acknowledgment letter.** The MCO must acknowledge in writing receipt of each appeal to both the enrollee and the requesting provider within five calendar days of receiving the appeal request. The appeal acknowledgment letter sent by the MCO serves as written confirmation of an appeal filed orally by an enrollee.

(d) **Standard service authorization - Sixty-day deadline.** For appeals involving standard service authorization decisions, an enrollee must file an appeal within sixty calendar days of the date on the MCO's notice of adverse benefit determination. This time frame also applies to a request for an expedited appeal.

(e) **Previously authorized service - Ten-day deadline.** For appeals of adverse benefit determinations involving termination, suspension, or reduction of a previously authorized service, and the enrollee is requesting continuation of the service, the enrollee must file an appeal within ten calendar days of the MCO mailing notice of the adverse benefit determination.

(f) **Untimely service authorization decisions.** When the MCO does not make a **service authorization decision** within required time frames, it is considered a denial. In this case, the MCO sends a formal notice of adverse benefit determination, including the enrollee's right to an appeal.

(g) **Appeal process requirements.** The MCO appeal process must:

(i) Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law, in person, by telephone, or in writing. The MCO must inform the enrollee of the limited time available for this in the case of expedited resolution;

(ii) Provide the enrollee and the enrollee's representative opportunity before and during the appeal process to examine the enrollee's case file, including medical records, other relevant documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in this section; and

(iii) Include as parties to the appeal:

(A) The enrollee and the enrollee's representative; or

(B) The legal representative of the deceased enrollee's estate.

(h) **Level of appeal.** There will only be one level of review in the MCO appeals process.

(i) Time frames for resolution of appeals and notice to the enrollee. MCOs must resolve each appeal and provide notice as expeditiously as the enrollee's health condition requires, and within the following time frames:

(i) For standard resolution of appeals, including notice to the affected parties, no longer than thirty calendar days from the day the MCO receives the appeal. This includes appeals involving termination, suspension, or reduction of previously authorized services.

(ii) For expedited resolution of appeals, including notice to the affected parties, no longer than seventy-two hours after the MCO receives the appeal. The MCO may extend the seventy-two-hour time frame up to fourteen calendar days if:

(A) The enrollee requests the extension; or

(B) The MCO determines and shows to the satisfaction of the agency, upon request, there is a need for additional information and it is in the enrollee's interest.

(iii) If the MCO fails to adhere to the notice and timing requirements for appeals, the enrollee is deemed to have completed the MCO's appeals process and may request an agency administrative hearing.

(j) **Language and format requirements - Notice of resolution of appeal.**

(i) The notice of the resolution of the appeal must be in writing in the enrollee's primary language and in an easily understood format, in accordance with 42 C.F.R. Sec. 438.10.

(ii) The notice of the resolution of the appeal must be sent to the enrollee and the requesting provider.

(iii) For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.

(k) **Content of resolution of appeal.**

(i) The notice of resolution must include the results of the resolution process and the date it was completed;

(ii) For appeals not resolved wholly in favor of the enrollee, the notice of resolution must include:

(A) The right to request an agency administrative hearing under RCW 74.09.741 and chapter 182-526 WAC, and how to request the hearing;

(B) The right to request and receive benefits while an agency administrative hearing is pending, and how to make the request in accordance with subsection (9) of this section and the agency's administrative hearing rules in chapter 182-526 WAC;

(C) That the enrollee may be held liable for the cost of those benefits received for the first sixty days after the agency or the office of administrative hearings (OAH) receives an agency administrative hearing request, if the hearing decision upholds the MCO's adverse benefit determination. See RCW 74.09.741 (5)(g).

(7) **MCO expedited appeal process.**

(a) Each MCO must establish and maintain an expedited appeal process when the MCO determines or the provider indicates that taking the time for a standard resolution of an appeal could seriously jeopardize the enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

(b) The enrollee may file an expedited appeal either orally, according to WAC 182-526-0095, or in writing. No additional follow-up is required of the enrollee.

(c) The MCO must make a decision on the enrollee's request for expedited appeal and provide written notice as expeditiously as the enrollee's health condition requires and no later than two calendar days after the MCO receives the appeal. The MCO must also make reasonable efforts to orally notify the enrollee of the decision.

(d) The MCO may extend the time frame for decision on the enrollee's request for an expedited appeal up to fourteen calendar days if:

(i) The enrollee requests the extension; or

(ii) The MCO determines and shows to the satisfaction of the agency, upon its request, that there is a need for additional information and the delay is in the enrollee's interest.

(e) The MCO must make reasonable efforts to provide the enrollee prompt verbal notice and provide written notice for any extension not requested by the enrollee with the reason for the delay.

(f) If the MCO grants an expedited appeal, the MCO must issue a decision as expeditiously as the enrollee's physical or mental health condition requires, but not later than seventy-two hours after receiving the appeal. The MCO may extend the time frame for a decision and to provide notice to the enrollee for an expedited appeal, up to fourteen days, if:

(i) The enrollee requests the extension; or

(ii) The MCO determines and shows to the satisfaction of the agency, upon its request, that there is a need for additional information and the delay is in the enrollee's interest.

(g) The MCO must provide written notice for any extension not requested by the enrollee within two calendar days of the decision and inform the enrollee of the reason for the delay and the enrollee's right to file a grievance.

(h) If the MCO denies a request for expedited resolution of an appeal, it must:

(i) Process the appeal based on the time frame for standard resolution;

(ii) Make reasonable efforts to give the enrollee prompt oral notice of the denial; and

(iii) Provide written notice within two calendar days.

(i) The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(8) **The right to an agency administrative hearing for managed care (MCO) enrollees.**

(a) **Authority to file.** Only an enrollee, the enrollee's authorized representative, or a provider with the enrollee's or authorized representative's written consent may request an administrative hearing. See RCW 74.09.741, WAC 182-526-0090, and 182-526-0155.

(b) **Right to agency administrative hearing.** If an enrollee has completed the MCO appeal process and does not agree with the MCO's resolution of the appeal, the enrollee may file a request for an agency administrative hearing based on the rules in this section and the agency administrative hearing rules in chapter 182-526 WAC.

(c) **Deadline - One hundred twenty days.** An enrollee's request for an agency administrative hearing must be filed no later than one hundred twenty calendar days from the date of the written notice of resolution of appeal from the MCO.

(d) **Independent party.** The MCO is an independent party and responsible for its own representation in any agency administrative hearing, appeal to the board of appeals, and any subsequent judicial proceedings.

(e) **Applicable rules.** The agency's administrative hearing rules in chapter 182-526 WAC apply to agency administrative hearings requested by enrollees to review the resolution of an enrollee appeal of an MCO adverse benefit determination.

(9) **Continuation of previously authorized services.**

(a) The MCO must continue the enrollee's services if all of the following apply:

(i) The enrollee, or enrollee's authorized representative, or provider with written consent files the appeal on or before the later of the following:

(A) Within ten calendar days of the MCO mailing the notice of adverse benefit determination; or

(B) The intended effective date of the MCO's proposed adverse benefit determination.

(ii) The appeal involves the termination, suspension, or reduction of previously authorized services;

(iii) The services were ordered by an authorized provider; and

(iv) The original period covered by the original authorization has not expired.

(b) If the MCO continues or reinstates the enrollee's services while the appeal is pending at the enrollee's request, the services must be continued until one of the following occurs:

(i) The enrollee withdraws the MCO appeal;

(ii) The enrollee fails to request an agency administrative hearing within ten calendar days after the MCO sends the notice of an adverse resolution to the enrollee's appeal;

(iii) The enrollee withdraws the request for an agency administrative hearing; or

(iv) The office of administrative hearings (OAH) issues a hearing decision adverse to the enrollee.

(c) If the final resolution of the appeal upholds the MCO's adverse benefit determination, the MCO may recover from the enrollee the amount paid for the services provided to the enrollee for the first sixty calendar days after the agency or the office of administrative hearings (OAH) received a request for an agency administrative hearing, to the extent that services were provided solely because of the requirement for continuation of services.

(10) **Effect of reversed resolutions of appeals.**

(a) **Services not furnished while an appeal is pending.** If the MCO or a final order entered by the HCA board of appeals, as defined in chapter 182-526 WAC, or an independent review organization (IRO) reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, but not later than seventy-two hours from the date it receives notice reversing the determination.

(b) **Services furnished while the appeal is pending.** If the MCO reverses a decision to deny authorization of services or the denial is reversed through an IRO or a final order of OAH or the board of appeals and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services.

AMENDATORY SECTION (Amending WSR 15-24-098, filed 12/1/15, effective 1/1/16)

WAC 182-538-111 The administrative hearing process for primary care case management (PCCM). (((~~(1) This section contains information about the administrative hearing process for primary care case management (PCCM) enrollees. See WAC 182-538-110 for information about the grievance system for managed care organization (MCO) enrollees.~~

~~(2)~~)) PCCM enrollees follow the same administrative hearing rules and processes as fee-for-service clients under chapter 182-526 WAC.

AMENDATORY SECTION (Amending WSR 16-23-021, filed 11/4/16, effective 1/1/17)

WAC 182-538-130 Exemptions and ending enrollment in managed care. (((~~1~~))) The medicaid agency enrolls clients into integrated managed care (IMC) based on the rules in WAC 182-538-060. IMC is mandatory in all regional service areas.

(1) **Authority to request.** The following people may request that the agency approve an exemption or end enrollment in managed care:

(a) A client or enrollee;

(b) A client or enrollee's authorized representative under WAC 182-503-0130; or

(c) A client or enrollee's representative as defined in RCW 7.70.065.

(2) **Standards to exempt or end enrollment.**

(a) The agency ((~~approves a request to exempt a client from enrollment or to~~)) exempts or ends enrollment from mandatory managed care when any of the following apply:

(((~~a~~))) (i) The client or enrollee is eligible for medicare;

(((~~b~~))) (ii) The client or enrollee is not eligible for managed care enrollment, for Washington apple health programs, or both((~~; or~~

~~(c) A request for exemption or to end enrollment is received and approved by the agency as described in this section.~~

~~(i) If a client requests exemption within the notice period stated in WAC 182-538-060, the client is not enrolled until the agency approves or denies the request.~~

~~(ii) If an enrollee request to end enrollment is received after the enrollment effective date, the enrollee remains enrolled pending the agency's decision, unless continued enrollment creates loss of access to providers for medically necessary care.~~

~~(2)(a) The following people may request the agency to approve an exemption or end enrollment in managed care:~~

~~(i) A client or enrollee;~~

~~(ii) A client or enrollee's authorized representative under WAC 182-503-0130; or~~

~~(iii) A client or enrollee's representative as defined in RCW 7.70.065~~)).

(b) The agency grants a request to exempt or to end enrollment in managed care when the client or enrollee:

(i) Is American Indian or Alaska native or is a descendant of an AI/AN client and requests not to be in managed care;

(ii) Lives in an area or is enrolled in a Washington apple health program in which participation in managed care is voluntary; or

(iii) Requires care that meets the criteria in subsection (3) of this section for case-by-case clinical exemptions or to end enrollment.

(3) **Case-by-case clinical criteria** ((~~to authorize an exemption or to~~)), Clinical criteria for an enrollee or client to be exempted or end enrollment in IMC.

(a) The agency may approve a request for exemption or to end enrollment when the following criteria are met:

(i) The care must be medically necessary;

(ii) ((~~That~~)) The medically necessary care at issue is covered under the agency's managed care contracts and is not a benefit under the behavioral health services only (BHSO) program;

(iii) The client is receiving the medically necessary care at issue from an established provider or providers who are not available through any contracted MCO; and

(iv) It is medically necessary to continue that care from the established provider or providers.

(b) If a client requests exemption prior to enrollment, the client is not enrolled until the agency approves or denies the request.

(c) If an enrollee request to end enrollment is received after the enrollment effective date, the enrollee remains enrolled pending the agency's decision.

(4) **Approved request.**

(a) When the agency approves a request for exemption or to end enrollment, the agency will notify the client or enrollee of its decision by telephone or in writing.

(b) For clients who are not AI/AN, the following rules apply:

(i) If the agency approves the request for a limited time, the client or enrollee is notified of the time limitation and the process for renewing the exemption.

(((~~c~~))) (ii) The agency limits the period of time based on the circumstances or how long the conditions described are expected to exist.

(iii) The agency may periodically review those circumstances or conditions to determine if they continue to exist.

(iv) Any authorized exemption will continue only until the client can be enrolled in managed care.

(5) **BHSO.**

(a) When a client is exempt from mandatory IMC or their enrollment in the mandatory IMC program ends, the exemption is for the physical health benefit only. The client remains enrolled in behavioral health services only (BHSO) for the behavioral health benefit.

(b) AI/AN clients are an exception in that they can choose to receive their behavioral health benefit on a fee-for-service basis.

(6) **Denied request.** When the agency denies a request for exemption or to end enrollment((~~, the~~)):

(a) The agency will notify the client or enrollee of its decision by telephone or in writing and confirms a telephone notification in writing.

(b) When a client or enrollee is limited-English proficient, the written notice must be available in the client's or enrollee's primary language under 42 C.F.R. 438.10.

(c) The written notice must contain all the following information:

(i) The agency's decision;

(ii) The reason for the decision;

(iii) The specific rule or regulation supporting the decision; and

(iv) The right to request an agency administrative hearing.

(((~~(4)~~))) (7) **Administrative hearing request.** If a client or enrollee does not agree with the agency's decision regarding a request for exemption or to end enrollment, the client or enrollee may file a request for an agency administrative hearing based on RCW 74.09.741, the rules in this chapter, and the agency hearing rules in chapter 182-526 WAC.

(((~~(5)~~))) (8) **MCO request.** The agency will grant a request from an MCO to end enrollment of an enrollee ((~~on a case-by-case basis~~)) when the request is submitted to the agency in writing and includes sufficient documentation for the agency to determine that the criteria to end enrollment in this subsection is met.

(a) All of the following criteria must be met to end enrollment:

(i) The enrollee puts the safety or property of the contractor or the contractor's staff, providers, patients, or visitors at risk and the enrollee's conduct presents the threat of imminent harm to others, except for enrollees described in (c) of this subsection;

(ii) A clinically appropriate evaluation was conducted to determine whether there was a treatable problem contributing to the enrollee's behavior and there was not a treatable problem or the enrollee refused to participate;

(iii) The enrollee's health care needs have been coordinated as contractually required and the safety concerns cannot be addressed; and

(iv) The enrollee has received written notice from the MCO of its intent to request to end enrollment of the enrollee, unless the requirement for notification has been waived by the agency because the enrollee's conduct presents the threat of imminent harm to others. The MCO's notice to the enrollee includes the enrollee's right to use the MCO's grievance process to review the request to end enrollment.

(b) The agency will not approve a request to end enrollment when the request is solely due to any of the following:

(i) An adverse change in the enrollee's health status;

(ii) The cost of meeting the enrollee's health care needs or because of the enrollee's utilization of services;

(iii) The enrollee's diminished mental capacity; or

(iv) Uncooperative or disruptive behavior resulting from the enrollee's special needs or behavioral health condition, except when continued enrollment in the MCO or PCCM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees.

(c) The agency will not approve a request to end enrollment of an enrollee's behavioral health services. The agency may determine to transition the enrollee to behavioral health services only (BHSO).

(d) When the agency receives a request from an MCO to end enrollment of an enrollee, the agency reviews each request on a case-by-case basis. The agency will respond to the MCO in writing with the decision. If the agency grants the request to end enrollment:

(i) The MCO will notify the enrollee in writing of the decision. The notice must include:

(A) The enrollee's right to use the MCO's grievance system as described in WAC 182-538-110; and

(B) The enrollee's right to use the agency's hearing process (see WAC 182-526-0200 for the hearing process for enrollees).

(ii) The agency will send a written notice to the enrollee at least ten calendar days in advance of the effective date that enrollment will end. The notice to the enrollee includes the information in subsection (3)(c) of this section.

(((~~(d)~~))) (e) The MCO will continue to provide services to the enrollee until the date the ((~~individual~~)) person is no longer enrolled.

(((~~(6)~~))) (f) The agency may exempt the client for the period of time the circumstances ((~~or conditions described in this section~~)) are expected to exist. The agency may periodically review those circumstances ((~~or conditions~~)) to determine if they continue to exist. Any authorized exemption will continue only until the client can be enrolled in ((~~managed care~~)) IMC.

AMENDATORY SECTION (Amending WSR 17-23-199, filed 11/22/17, effective 12/23/17)

WAC 182-538-140 Quality of care. (1) To assure that managed care enrollees receive quality health care services, the agency requires managed care organizations (MCOs) to comply with quality improvement standards detailed in the agency's managed care contract. MCOs must:

(a) Have a clearly defined quality organizational structure and operation, including a fully operational quality assessment, measurement, and improvement program;

(b) Have effective means to detect ((~~over~~)) overutilization and underutilization of services;

(c) Maintain a system for provider and practitioner credentialing and recredentialing;

(d) Ensure that MCO subcontracts and the delegation of MCO responsibilities align with agency standards;

(e) Ensure MCO oversight of delegated entities responsible for any delegated activity to include:

(i) A delegation agreement with each entity describing the responsibilities of the MCO and the entity;

(ii) Evaluation of the entity before delegation;

(iii) An annual evaluation of the entity; and

(iv) Evaluation or regular reports and follow-up on issues that are not compliant with the delegation agreement or the agency's managed care contract specifications.

(f) Cooperate with an agency-contracted, qualified independent external quality review organization (EQRO) conducting review activities as described in 42 C.F.R. Sec. 438.358;

(g) Have an effective mechanism to assess the quality and appropriateness of care furnished to enrollees with special health care needs;

(h) Assess and develop individualized treatment plans for enrollees with special health care needs which ensure integration of clinical and nonclinical disciplines and services in the overall plan of care;

(i) Submit annual reports to the agency on performance measures as specified by the agency;

(j) Maintain a health information system that:

(i) Collects, analyzes, integrates, and reports data as requested by the agency;

(ii) Provides information on utilization, grievances and appeals, enrollees ending enrollment for reasons other than

the loss of medicaid eligibility, and other areas as defined by the agency;

(iii) Retains enrollee grievance and appeal records described in 42 C.F.R. Sec. 438.416, base data as required by 42 C.F.R. Sec. 438.5(c), MLR reports as required by 42 C.F.R. Sec. 438.8(k), and the data, information, and documentation specified in 42 C.F.R. Secs. 438.604, 438.606, 438.408, and 438.610 for a period of no less than ten years;

(iv) Collects data on enrollees, providers, and services provided to enrollees through an encounter data system, in a standardized format as specified by the agency; and

(v) Ensures data received from providers is adequate and complete by verifying the accuracy and timeliness of reported data and screening the data for completeness, logic, and consistency.

(k) Conduct performance improvement projects designed to achieve significant improvement, sustained over time, in clinical care outcomes and services, and that involve the following:

(i) Measuring performance using objective quality indicators;

(ii) Implementing system changes to achieve improvement in service quality;

(iii) Evaluating the effectiveness of system changes;

(iv) Planning and initiating activities for increasing or sustaining performance improvement;

(v) Reporting each project status and the results as requested by the agency; and

(vi) Completing each performance improvement project timely so as to generally allow aggregate information to produce new quality of care information every year.

(l) Ensure enrollee access to health care services;

(m) Ensure continuity and coordination of enrollee care;

(n) Maintain and monitor availability of health care services for enrollees;

(o) Perform client satisfaction surveys; and

(p) Obtain and maintain national committee on quality assurance (NCQA) accreditation.

(2) The agency may:

(a) Impose intermediate sanctions under 42 C.F.R. Sec. 438.700 and corrective action for substandard rates of clinical performance measures and for deficiencies found in audits and on-site visits;

(b) Require corrective action for findings for noncompliance with any contractual state or federal requirements; and

(c) Impose sanctions for noncompliance with any contractual, state, or federal requirements not corrected.

AMENDATORY SECTION (Amending WSR 16-23-021, filed 11/4/16, effective 1/1/17)

WAC 182-538-150 Apple health foster care program. (1) Unless otherwise stated in this section, all of the provisions of chapter 182-538 WAC apply to apple health foster care (AHFC).

(2) The following sections of chapter 182-538 WAC do not apply to AHFC:

(a) WAC 182-538-068;

(b) WAC 182-538-071;

(c) WAC 182-538-096; and

(d) WAC 182-538-111.

(3)(a) Enrollment in AHFC is voluntary for eligible ((~~individuals~~)) people.

(b) The agency will enroll eligible ((~~individuals~~)) people in the single MCO that serves children and youth in foster care and adoption support, and young adult alumni of the foster care system.

(((~~(b)~~)) (c) An AHFC enrollee may request to end enrollment in AHFC without cause if the client is in the adoption support or young adult alumni programs. WAC 182-538-130 does not apply to these requests as enrollment in AHFC is voluntary.

(4) ((~~In addition to the scope of medical care services in WAC 182-538-095,~~)) AHFC coordinates health care services for enrollees. This includes services with the department of social and health services community mental health system and other health care systems as needed.

(5) The agency sends written information about covered services when the ((~~individual~~)) person becomes eligible to enroll in AHFC and at any time there is a change in covered services. In addition, the agency requires MCOs to provide new enrollees with written information about:

(a) Covered services;

(b) The right to grievances and appeals through the MCO; and

(c) Hearings through the agency.

NEW SECTION

WAC 182-538-170 Notice requirements. The notice requirements in chapter 182-518 WAC apply to integrated managed care (IMC).

NEW SECTION

WAC 182-538-180 Rights and protections. (1) People have medicaid-specific rights when applying for, eligible for, or receiving medicaid-funded health care services.

(2) All applicable statutory and constitutional rights apply to all medicaid people including, but not limited to:

(a) The participant rights under WAC 246-341-0600;

(b) Applicable necessary supplemental accommodation services including, but not limited to:

(i) Arranging for or providing help to complete and submit forms to the agency;

(ii) Helping people give or get the information the agency needs to decide or continue eligibility;

(iii) Helping to request continuing benefits;

(iv) Explaining the reduction in or ending of benefits;

(v) Assisting with requests for administrative hearings; and

(vi) On request, reviewing the agency's decision to terminate, suspend, or reduce benefits.

(c) Receiving the name, address, telephone number, and any languages offered other than English of providers in a managed care organization (MCO);

(d) Receiving information about the structure and operation of the MCO and how health care services are delivered;

(e) Receiving emergency care, urgent care, or crisis services;

(f) Receiving poststabilization services after receiving emergency care, urgent care, or crisis services that result in admittance to a hospital;

(g) Receiving age-appropriate and culturally appropriate services;

(h) Being provided a qualified interpreter and translated material at no cost to the person;

(i) Receiving requested information and help in the language or format of choice;

(j) Having available treatment options and explanation of alternatives;

(k) Refusing any proposed treatment;

(l) Receiving care that does not discriminate against a person;

(m) Being free of any sexual exploitation or harassment;

(n) Making an advance directive that states the person's choices and preferences for health care services under 42 C.F.R. Sec. 489 Subpart I;

(o) Choosing a contracted health care provider;

(p) Requesting and receiving a copy of health care records;

(q) Being informed the cost for copying, if any;

(r) Being free from retaliation;

(s) Requesting and receiving policies and procedures of the MCO as they relate to health care rights;

(t) Receiving services in an accessible location;

(u) Receiving medically necessary services in accordance with the early and periodic screening, diagnosis, and treatment (EPSDT) program under WAC 182-534-0100, if the person is age twenty or younger;

(v) Being treated with dignity, privacy, and respect;

(w) Receiving treatment options and alternatives in a manner that is appropriate to a person's condition;

(x) Being free from seclusion and restraint;

(y) Receiving a second opinion from a qualified health care professional within an MCO provider network at no cost or having one arranged outside the network at no cost, as provided in 42 C.F.R. Sec. 438.206 (b)(3);

(z) Receiving medically necessary health care services outside of the MCO if those services cannot be provided adequately and timely within the MCO;

(aa) Filing a grievance with the MCO if the person is not satisfied with a service;

(bb) Receiving a notice of action so that a person may appeal any decision by the MCO that:

(i) Denies or limits authorization of a requested service;

(ii) Reduces, suspends, or terminates a previously authorized service; or

(iii) Denies payment for a service, in whole or in part.

(cc) Filing an appeal if the MCO fails to provide health care services in a timely manner as defined by the state or act within the time frames in 42 C.F.R. Sec. 438.408(b); and

(dd) Requesting an administrative hearing if an appeal is not resolved in a person's favor.

NEW SECTION

WAC 182-538-190 Behavioral health services only (BHSO). This section applies to enrollees receiving behavioral health services only (BHSO) under the integrated managed care (IMC) medicaid contract.

(1) IMC is mandatory for clients in eligible programs, but the agency may end enrollment or exempt clients from IMC based on WAC 182-538-130.

(2) If the agency ends enrollment or exempts a client from IMC, the client is required to enroll in behavioral health services only (BHSO). An exception to this requirement exists for American Indian and Alaskan native (AI/AN) clients. IMC including BHSO is optional for AI/AN clients.

(3) For BHSO enrollees, the MCO covers the behavioral health benefits included in the IMC medicaid contract, and the agency covers physical health services on a fee-for-service basis.

(4) The agency assigns the BHSO enrollee to an MCO available in the area where the client resides.

(5) A BHSO enrollee may change MCOs for any reason with the change becoming effective according to the agency's managed care policy.

REPEALER

The following chapter of the Washington Administrative Code is repealed:

WAC 182-538A-040	Washington apple health fully integrated managed care.
WAC 182-538A-050	Definitions.
WAC 182-538A-060	Fully integrated managed care and choice.
WAC 182-538A-067	Qualifications to become a managed care organization (MCO) in fully integrated managed care (FIMC) regional service areas.
WAC 182-538A-068	Qualifications to become a primary care case management (PCCM) provider in fully integrated managed care (FIMC) regional service areas.
WAC 182-538A-070	Payments to managed care organizations (MCOs) in fully integrated managed care (FIMC) regional service areas.
WAC 182-538A-071	Payments to primary care case management (PCCM) providers in fully integrated managed care (FIMC) regional service areas.
WAC 182-538A-095	Scope of care for fully integrated managed care (FIMC) and behavioral health services only (BHSO) enrollees.
WAC 182-538A-100	Managed care emergency services for fully integrated managed care (FIMC) enrollees.

WAC 182-538A-110	The grievance and appeal system, and agency administrative hearing for fully integrated managed care (FIMC) managed care organization (MCO) enrollees.
WAC 182-538A-111	The administrative hearing process for primary care case management (PCCM) enrollees in FIMC regional service areas.
WAC 182-538A-120	Fully integrated managed care (FIMC) enrollee request for a second medical opinion.
WAC 182-538A-130	Exemptions and ending enrollment in fully integrated managed care (FIMC).
WAC 182-538A-140	Fully integrated managed care (FIMC) quality of care.
WAC 182-538A-150	Apple health foster care program in fully integrated managed care regional service areas.
WAC 182-538A-170	Notice requirements.
WAC 182-538A-180	Rights and protections.
WAC 182-538A-190	Behavioral health services only (BHSO).

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538B-040 Behavioral health wraparound services. (1) This chapter governs nonmedicaid funded behavioral health services provided under the medicaid agency's behavioral health services wraparound contract. See also chapter 182-538D WAC for rules applicable to nonmedicaid behavioral health services.

(2) Washington apple health ((~~fully~~)) integrated managed care ((~~(FIMC)~~)) (IMC) behavioral health wraparound services are available only through a managed care organization (MCO) contracted to provide ((~~FIMC~~)) IMC services ((~~or behavioral health services only (BHSO)~~)).

(3) The MCO provides contracted nonmedicaid funded behavioral health wraparound services to medicaid enrollees in an ((~~FIMC~~)) IMC regional service area:

(a) Within available resources;

(b) Based on medical necessity; and

(c) In order of priority to populations as identified by state and federal authorities.

(4) When nonmedicaid funding is exhausted, behavioral health wraparound services are no longer paid for and cannot be authorized regardless of medical necessity.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538B-050 Definitions. The following definitions and those found in chapters 182-500((~~,~~)) and 182-538((~~, and 182-538A~~)) WAC apply to this chapter, unless otherwise stated.

"Action" means the denial or limited authorization of a service covered under the behavioral health services wraparound contract based on medical necessity.

"Available resources" means funds appropriated for the purpose of providing behavioral health wraparound services.

(a) This includes:

(i) Federal funds, except those provided according to Title XIX of the Social Security Act; and

(ii) State funds appropriated by the legislature for the purpose of providing services under the behavioral health administrative services organization contract.

(b) This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

"Integrated managed care (IMC)" See WAC 182-538-050.

AMENDATORY SECTION (Amending WSR 17-23-199, filed 11/22/17, effective 12/23/17)

WAC 182-538B-110 Grievance and appeal system and agency administrative hearing. (1) **Introduction.** This section contains information about the managed care organization (MCO) grievance and appeal system and the agency's administrative hearing process for enrollees under the behavioral health services wraparound contract in ((~~fully~~)) integrated managed care ((~~(FIMC)~~)) (IMC) regional service areas.

(a) The MCO must have a grievance and appeal system and access to an agency administrative hearing to allow enrollees to file grievances and seek review of an MCO action as defined in this chapter.

(b) The agency's administrative hearing rules in chapter 182-526 WAC apply to agency administrative hearings requested by an enrollee to review the resolution of an enrollee's appeal of an MCO action.

(c) If a conflict exists between the requirements of this chapter and other rules, the requirements of this chapter take precedence.

(d) The MCO's policies and procedures regarding the grievance system must be approved by the agency.

(2) **MCO grievance and appeal system.** The MCO grievance and appeal system includes:

(a) A grievance process for addressing complaints about any matter that is not an action;

(b) An appeals process to address an enrollee's request for review of an MCO action;

(c) Access to an independent review by an independent review organization (IRO) under RCW 48.43.535 and WAC 182-526-0200;

(d) Access to the agency's administrative hearing process for review of an MCO's resolution of an appeal; and

(e) Allowing enrollees and the enrollee's authorized representatives to file grievances and appeals orally or in writing. An MCO cannot require enrollees to provide written follow-up for a grievance or an appeal the MCO received orally.

(3) **The MCO grievance process.**

(a) An enrollee or enrollee's authorized representative may file a grievance with an MCO. A provider may not file a grievance on behalf of an enrollee without the enrollee's written consent.

(b) An enrollee does not have a right to an agency administrative hearing in regards to the resolution of a grievance.

(c) The MCO must acknowledge receipt of each grievance either orally or in writing within two business days.

(d) The MCO must notify enrollees of the resolution of grievances within five business days of determination.

(4) **The MCO appeals process.**

(a) An enrollee, the enrollee's authorized representative, or a provider acting on behalf of the enrollee with the enrollee's written consent may appeal an MCO action.

(b) An MCO treats oral inquiries about appealing an action as an appeal to establish the earliest possible filing date for the appeal. The MCO confirms the oral appeal in writing.

(c) An MCO must acknowledge in writing receipt of each appeal to both the enrollee and the requesting provider within five calendar days of receiving the appeal request. The appeal acknowledgment letter sent by the MCO serves as written confirmation of an appeal filed orally by an enrollee.

(d) The enrollee must file an appeal of an MCO action within sixty calendar days of the date on the MCO's notice of action.

(e) The MCO is not obligated to continue services pending the results of an appeal or subsequent agency administrative hearing.

(f) The MCO appeal process:

(i) Provides the enrollee a reasonable opportunity to present evidence and allegations of fact or law, both in person and in writing;

(ii) Provides the enrollee and the enrollee's representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the action. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in this section; and

(iii) Includes as parties to the appeal:

(A) The enrollee and the enrollee's authorized representative; and

(B) The legal representative of the deceased enrollee's estate.

(g) The MCO ensures that the people making decisions on appeals:

(i) Were not involved in any previous level of review or decision making; and

(ii) Are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease if deciding either of the following:

(A) An appeal of an action involving medical necessity; or

(B) An appeal that involves any clinical issues.

(h) Time frames for resolution of appeals.

(i) An MCO resolves each appeal and provides notice as expeditiously as the enrollee's health condition requires and no longer than seventy-two hours after the day the MCO receives the appeal.

(ii) The MCO may extend the time frame by an additional fourteen calendar days if:

(A) The enrollee requests the extension; or

(B) The MCO determines additional information is needed and delay is in the interests of the enrollee.

(i) Notice of resolution of appeal. The notice of the resolution of the appeal must:

(i) Be in writing and be sent to the enrollee and the requesting provider;

(ii) Include the results of the resolution of the appeal process and the date it was completed; and

(iii) Include information on the enrollee's right to request an agency administrative hearing and how to do so as provided in the agency hearing rules in WAC 182-526-0200, if the appeal is not resolved wholly in favor of the enrollee.

(j) **Deemed completion of the appeals process**. If the MCO fails to adhere to the notice and timing requirements for appeals, the enrollee is deemed to have completed the MCO's appeals process and may request an agency administrative hearing under WAC 182-526-0200.

(5) **Agency administrative hearing.**

(a) Only an enrollee or enrollee's authorized representative may request an agency administrative hearing. A provider may not request a hearing on behalf of an enrollee.

(b) If an enrollee does not agree with the MCO's resolution of an appeal and has completed the MCO appeal process, the enrollee may file a request for an agency administrative hearing based on the rules in this section and the agency hearing rules in WAC 182-526-0200. The enrollee must request an agency administrative hearing within ninety calendar days of the notice of resolution of appeal.

(c) An MCO is an independent party and responsible for its own representation in any agency administrative hearing, independent review, appeal to the board of appeals, and any subsequent judicial proceedings.

(6) **Effect of reversed resolutions of appeals.** If an MCO, a final order as defined in chapter 182-526 WAC, or an independent review organization (IRO) reverses a decision to deny or limit services, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires.

(7) **Available resources exhausted.** When available resources are exhausted, any appeals process, independent review, or agency administrative hearing process related to a request to authorize a service will be terminated, since services cannot be authorized without funding regardless of medical necessity.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538B-170 Notice requirements. Chapter 182-518 WAC applies to notice requirements in ((~~fully~~)) integrated managed care ((~~(FIMC)~~)) (IMC) regional service areas.

AMENDATORY SECTION (Amending WSR 17-23-200, filed 11/22/17, effective 12/23/17)

WAC 182-538C-040 Behavioral health services. (1) This chapter governs crisis-related and other behavioral health services provided under the medicaid agency's behavioral health administrative services organization (BH-ASO) contract. See also chapter 182-538D WAC for rules applicable to nonmedicaid behavioral health services.

(2) The BH-ASO contracts with the agency to provide behavioral health services within ((~~a fully~~)) an integrated managed care (((~~FIMC~~))) (IMC) regional service area.

(a) The BH-ASO provides the following services to all people, regardless of insurance status, income level, ability to pay, and county of residence:

(i) Mental health crisis services; ((~~and~~))

(ii) Operation of a behavioral health ombuds (ombudsman); and

(iii) Implementation of the Involuntary Treatment Act for both mental health and substance use disorders.

(b) The BH-ASO may provide substance use disorder crisis services within available resources to all people, regardless of the person's insurance status, income level, ability to pay, and county of residence.

(c) The BH-ASO provides the following services to people who are not eligible for medicaid coverage and are involuntarily or voluntarily detained under chapter 71.05, 71.24, or 71.34 RCW, ((~~RCW 70.96A.140,~~)) or a less restrictive alternative (LRA) court order:

(i) Evaluation and treatment services;

(ii) Substance use disorder residential treatment services; and

(iii) Outpatient behavioral services, under an LRA court order.

(d) To be eligible to contract with the agency, the BH-ASO must:

(i) Accept the terms and conditions of the agency's contracts; and

(ii) Be able to meet the network and quality standards established by the agency.

(e) Services related to the administration of chapters 71.05, 71.24, and 71.34 RCW ((~~and RCW 70.96A.140~~)).

(3) The BH-ASO may provide contracted noncrisis behavioral health services to people in an ((~~FIMC~~)) IMC regional service area:

(a) Within available resources;

(b) Based on medical necessity; and

(c) In order of priority to populations as identified by state and federal authorities.

(4) Within an ((~~FIMC~~)) IMC regional service area, the BH-ASO is a subcontractor with all ((~~FIMC~~)) IMC managed care organizations (MCOs) to provide crisis services for medicaid enrollees and the administration of involuntary treatment acts under ((~~RCW 70.96A.140 or~~)) chapter 71.05, 71.24, or 71.34 RCW.

(5) For medicaid-funded services subcontracted for by ((~~FIMC~~)) IMC managed care organizations (MCOs) to the BH-ASO:

(a) Grievances and appeals must be filed with the ((~~FIMC~~)) IMC MCO; and

(b) The grievance and appeal system and the agency's administrative hearing rules in chapter 182-538 WAC apply instead of the grievance and appeal system and hearing rules in this chapter.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538C-050 Definitions. The definitions ((~~and abbreviations~~)) in this section and those found in chapters 182-500 and 182-538 WAC apply to this chapter. ((~~If conflict exists, this chapter takes precedence.~~))

"Action" means the denial or limited authorization of a service covered under the behavioral health administrative services organization (BH-ASO) contract based on medical necessity.

"Available resources" means funds appropriated for the purpose of providing community behavioral health programs.

(a) This includes:

(i) Federal funds, except those provided according to Title XIX of the Social Security Act; and

(ii) State funds appropriated by the legislature for the purpose of providing services under the BH-ASO contract.

(b) This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

"Behavioral health" ((~~means mental health and substance use disorder conditions and related benefits~~)) - See WAC 182-538-050.

"Behavioral health administrative services organization (BH-ASO)" ((~~means an entity selected by the medicaid agency to administer behavioral health programs, including crisis services for individuals in a fully integrated managed care regional service area. The BH-ASO administers crisis services for all individuals in its defined regional service area, regardless of an individual's ability to pay~~)) - See WAC 182-538-050.

"Complaint" - See "grievance."

"Crisis" ((~~means an actual or perceived urgent or emergent situation that occurs when:~~

~~(a) An individual's stability or functioning is disrupted; and~~

~~(b) There is an immediate need to resolve the situation to prevent:~~

~~(i) A serious deterioration in the individual's mental or physical health; or~~

~~(ii) The need for referral to a significantly higher level of care.~~

~~"Fully integrated managed care (FIMC)"~~ ~~means the program under which a managed care organization provides:~~

~~(a) Physical health services funded by medicaid; and~~

~~(b) Behavioral health services funded by other available resources as defined in this chapter.~~

~~"Grievance"~~ ~~means an expression of dissatisfaction made by or on behalf of an individual and referred to a behavioral health administrative services organization (BH-ASO) about any matter other than an action~~)) - See WAC 182-538D-0200.

"Grievance" - See WAC 182-538-050.

"Integrated managed care (IMC)" - See WAC 182-538-050.

"Less restrictive alternative (LRA)" means court-ordered outpatient treatment in a setting less restrictive than total confinement.

"Noncrisis services" means services funded by non-medicaid funding sources that are provided to ((~~individuals~~)) people who are not enrolled in Washington apple health or otherwise eligible for medicaid. These services may be provided at the discretion of the behavioral health administrative services organization (BH-ASO) within available resources, such as:

(a) Crisis stabilization;

(b) Outpatient mental health or substance use disorder services; and

(c) Withdrawal management.

"Patient days of care" ((~~means all voluntary patients and involuntarily committed patients under chapter 71.05 RCW, regardless of where in the state hospital the patients reside. Patients who are committed to the state hospital under chapter 10.77 RCW are not included in the patient days of care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the patient days of care until a petition for ninety days of civil commitment under chapter 71.05 RCW has been filed in court. Patients who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the patient days of care until the patient is civilly committed under chapter 71.05 RCW.~~

~~"Regional service area"~~ ~~means a single county or multi-county grouping formed for the purpose of health care purchasing and designated by the agency and the department of social and health services~~)) - See WAC 182-538-050.

"Regional service area" - See WAC 182-538-050.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538C-070 Payment. (1) For crisis services, the behavioral health administrative services organization (BH-ASO) must determine whether the ((~~individual~~)) person receiving the services is eligible for Washington apple health or if the ((~~individual~~)) person has any other form of insurance coverage.

(2) For ((~~individuals~~)) people receiving crisis services who do not have other insurance coverage, the BH-ASO is responsible for the cost of those services.

(3) The BH-ASO administers and pays for the evaluation of involuntary detention or involuntary treatment under chapters 71.05, 71.24, and 71.34 RCW ((~~and RCW 70.96A.140~~)).

(4) The BH-ASO pays a reimbursement for each state hospital patient day of care that exceeds the BH-ASO daily allocation of state hospital beds based on a quarterly calculation of the bed usage by the BH-ASO.

(a) The medicaid agency bills the BH-ASO quarterly for state hospital patient days of care exceeding the BH-ASO daily allocation of state hospital beds and the established rate of reimbursement.

(b) The BH-ASO using fewer patient days of care than its quarterly allocation of state hospital beds will receive a portion of the reimbursement collected proportional to its share of the total number of patient days of care that were not used at the appropriate state hospital.

AMENDATORY SECTION (Amending WSR 17-23-200, filed 11/22/17, effective 12/23/17)

WAC 182-538C-110 Grievance and appeal system and agency administrative hearing for behavioral health administrative services organizations (BH-ASOs). (1) **General.** This section applies to the behavioral health administrative service organization (BH-ASO) grievance system for people within ((~~fully~~)) integrated managed care (((~~FIMC~~))) (IMC) regional service areas.

(a) The BH-ASO must have a grievance and appeal system to allow a person to file a grievance and request a review of a BH-ASO action as defined in this chapter.

(b) The agency's administrative hearing rules in chapter 182-526 WAC apply to agency administrative hearings requested by a person to review the resolution of an appeal of a BH-ASO action.

(c) If a conflict exists between the requirements of this chapter and other rules, the requirements of this chapter take precedence.

(d) The BH-ASO must maintain records of grievances and appeals.

(e) The BH-ASO is not obligated to continue services pending the results of an appeal or subsequent agency administrative hearing.

(2) **The BH-ASO grievance and appeal system.** The BH-ASO grievance system includes:

(a) A process for addressing complaints about any matter that is not an action;

(b) An appeal process to address a person's request for a review of a BH-ASO action as defined in this chapter; and

(c) Access to the agency's administrative hearing process for a person to request a review of a BH-ASO's resolution of an appeal.

(3) **The BH-ASO grievance process.**

(a) A person or a person's authorized representative may file a grievance with a BH-ASO. A provider may not file a grievance on behalf of a person without the written consent of the person or the person's authorized representative.

(b) There is no right to an agency administrative hearing regarding the BH-ASO's decision on a grievance, since a grievance is not an action.

(c) The BH-ASO must notify a person of the decision regarding the person's grievance within five business days of the decision.

(4) **The BH-ASO appeal process.**

(a) Parties to the appeal include:

(i) The person and the person's authorized or legal representative; or

(ii) The authorized representative of the deceased person's estate.

(b) A person, the person's authorized representative, or the provider acting with the person's written consent may appeal a BH-ASO action.

(c) A BH-ASO must treat oral inquiries about appealing an action as an appeal in order to establish the earliest possible filing date for the appeal.

(d) The BH-ASO must confirm any oral appeal in writing to the person or provider acting on behalf of the person.

(e) The person or provider acting on behalf of the person must file an appeal, either orally or in writing, within sixty calendar days of the date on the BH-ASO's notice of action.

(f) The BH-ASO must acknowledge receipt of each appeal to both the person and the provider requesting the service within three calendar days of receipt. ((~~The appeal acknowledgment letter sent by the BH-ASO serves as written confirmation of an appeal filed orally by a person.~~))

(g) If the person requests an expedited appeal for a crisis-related service, the BH-ASO must make a decision on whether to grant the person's request for expedited appeal and provide written notice as expeditiously as the person's health condition requires, within three calendar days after the BH-ASO receives the appeal. The BH-ASO must make reasonable efforts to provide oral notice.

(h) The BH-ASO appeal process:

(i) Provides the person a reasonable opportunity to present evidence and allegations of fact or law in writing.

(ii) Provides the person and the person's authorized representative opportunity before and during the appeals process to examine the person's case file, including medical records and any other documents and records considered during the appeal process free of charge.

(iii) If the person requests an expedited appeal, the BH-ASO must inform the person that it may result in the person having limited time to review records and prepare for the appeal.

(i) The BH-ASO ensures the staff making decisions on appeals:

(i) Were not involved in any previous level of review or decision making; and

(ii) Are health care professionals with appropriate clinical expertise in treating the person's condition or disease if deciding any of the following:

(A) An appeal of an action; or

(B) An appeal that involves any clinical issues.

(j) Time frames for standard resolution of appeals.

(i) For appeals involving termination, suspension, or reduction of previously authorized noncrisis services, the BH-ASO must make a decision within fourteen calendar days after receipt of the appeal.

(ii) If the BH-ASO cannot resolve an appeal within fourteen calendar days, the BH-ASO must notify the person that an extension is necessary to complete the appeal.

(k) Time frames for expedited appeals for crisis-related services ((~~or behavioral health prescription drug authorization decisions~~)).

(i) The BH-ASO must resolve the expedited appeal and provide notice of the decision no later than three calendar days after the BH-ASO receives the appeal.

(ii) The BH-ASO may extend the time frame by fourteen additional calendar days if:

(A) The person requests the extension; or

(B) The BH-ASO determines additional information is needed and the delay is in the interests of the person.

(iii) If the BH-ASO denies a request for expedited resolution of a noncrisis related service appeal, it must:

(A) Process the appeal based on the time frame for standard resolution;

(B) Make reasonable efforts to give the person prompt oral notice of the denial; and

(C) Follow-up within two calendar days of the oral notice with a written notice of denial.

(l) Extension of a standard resolution or expedited appeal not requested by the person.

(i) The BH-ASO must notify the person in writing of the reason for the delay, if not requested by that person.

(ii) The extension cannot delay the decision beyond twenty-eight calendar days of the request for appeal, without the informed written consent of the person.

(m) Notice of resolution of appeal. The notice of the resolution of the appeal must:

(i) Be in writing and be sent to the person and the provider requesting the services;

(ii) Include the results of the resolution process and the date it was completed; and

(iii) Include notice of the right to request an agency administrative hearing and how to do so as provided in the agency hearing rules in chapter 182-526 WAC, if the appeal is not resolved wholly in favor of the person.

(5) **Agency administrative hearings.**

(a) Only a person or a person's authorized representative may request an agency administrative hearing. A provider may not request a hearing on behalf of a person.

(b) If a person does not agree with the BH-ASO's resolution of an appeal, the person may file a request for an agency administrative hearing based on this section and the agency hearing rules in chapter 182-526 WAC.

(c) The BH-ASO is an independent party and responsible for its own representation in any agency administrative hearing, appeal to the board of appeals, and any subsequent judicial proceedings.

(6) **Effect of reversed resolutions of appeals.** If the BH-ASO's decision not to provide services is reversed on appeal by the BH-ASO or through a final order from the agency administrative hearing process, the BH-ASO must authorize or provide the disputed services promptly and as expeditiously as the person's health condition requires.

(7) **Available resources exhausted.** When available resources are exhausted, any appeals or administrative hearing process related to a request for authorization of a noncrisis service will be terminated, since noncrisis services cannot be authorized without funding, regardless of medical necessity.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538C-220 Covered crisis mental health services. (1) Crisis mental health services are intended to stabilize ((~~an individual~~)) a person in crisis to:

(a) Prevent further deterioration;

(b) Provide immediate treatment and intervention in a location best suited to meet the needs of the ((~~individual~~)) person; and

(c) Provide treatment services in the least restrictive environment available.

(2) Crisis mental health services include:

(a) Crisis telephone support ((~~under WAC 388-877A-0230~~));

(b) Crisis outreach services ((~~under WAC 388-877A-0240~~));

(c) Crisis stabilization services ((~~under WAC 388-877A-0260~~));

(d) Crisis peer support services ((~~under WAC 388-877A-0270~~)); and

(e) Emergency involuntary detention services ((~~under WAC 388-877A-0280~~)).

(3) A facility providing any crisis mental health service to ((~~an individual~~)) a person must:

(a) Be licensed by the department of ((~~social and~~)) health ((~~services~~)) as a behavioral health agency;

(b) Be certified by the department of ((~~social and~~)) health ((~~services~~)) to provide crisis mental health services;

(c) Have policies and procedures to support and implement the:

(i) Program-specific requirements ((~~in WAC 388-877A-0230 through 388-877A-0280~~)) for each crisis mental health service provided; and

(ii) Department of corrections access to confidential mental health information requirements in WAC ((~~388-865-0600 through 388-865-0640~~)) 182-538D-0600 through 182-538D-0640.

(4) A BH-ASO or its subcontractor providing crisis mental health services only is not required to meet the initial assessment, individual service plan, and clinical record requirements in WAC ((~~388-877-0610, 388-877-0620, and 388-877-0640~~)) 246-341-0610, 246-341-0620, and 246-341-0640.

(5) A BH-ASO or its subcontractor must ensure crisis mental health services:

(a) Are, with the exception of stabilization services, available twenty-four hours a day, seven days a week;

(b) Include family members, significant others, and other relevant treatment providers, as necessary, to provide support to the ((~~individual~~)) person in crisis; and

(c) Are provided in a setting that is safe for the ((~~individual~~)) person and staff members of the BH-ASO and its subcontractor.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538C-230 Covered substance use disorder detoxification services. (1) Chemical dependency detoxification services are provided to ((~~an individual~~)) a person to assist in the process of withdrawal from psychoactive substances in a safe and effective manner.

(2) A facility providing detoxification services to ((~~an individual~~)) a person must:

(a) Be a facility licensed by the department of health under one of the following:

(i) Chapter 246-320 WAC;

(ii) Chapter 246-322 WAC;

(iii) Chapter 246-324 WAC; or

(iv) Chapter 246-337 WAC.

(b) Be licensed by the department of ((~~social and~~)) health ((~~services~~)) as a behavioral health agency;

(c) Meet the applicable behavioral health agency licensure, certification, administration, personnel, clinical requirements, and behavioral health services administrative requirements; and

(d) Have policies and procedures to support and implement the applicable requirements in WAC ((~~388-877B-0110 through 388-877B-0130~~)) 246-341-1100 and 246-341-1102.

(3) A BH-ASO or its subcontractor agency must:

(a) Provide counseling to each ((~~individual~~)) person that addresses the ((~~individual's~~)) person's:

(i) Chemical dependency and motivation; and

(ii) Continuing care needs and need for referral to other services.

(b) Maintain a list of resources and referral options that can be used by staff members to refer ((~~an individual~~)) a person to appropriate services.

(c) Post any rules and responsibilities for ((~~individuals~~)) people receiving treatment, including information on potential use of increased motivation interventions or sanctions, in a public place in the facility.

(d) Provide tuberculosis screenings to ((~~individuals~~)) people for the prevention and control of tuberculosis.

(e) Provide HIV/AIDS information and include a brief risk intervention and referral as indicated.

NEW SECTION

WAC 182-538C-252 Behavioral health administrative services organizations—Advisory board membership. (1) A behavioral health administrative services organization (BH-ASO) must appoint advisory board members and maintain an advisory board in order to:

(a) Promote active engagement with people with behavioral health disorders, their families, and behavioral health agencies; and

(b) Solicit and use the advisory board members input to improve service delivery and outcome.

(2) The BH-ASO must appoint advisory board members and maintain an advisory board that:

(a) Broadly represents the demographic character of the service area;

(b) Is composed of at least fifty-one percent representation of one or more of the following:

(i) People with lived experience;

(ii) Parents or legal guardians of people with lived experience; or

(iii) Self-identified as people in recovery from a behavioral health disorder.

(c) Includes law enforcement representation; and

(d) Includes tribal representation, upon request of a tribe.

(3) When the BH-ASO is not a function of county government, the advisory board must include no more than four county elected officials.

(4) The advisory board:

(a) May have members who are employees of subcontracted agencies, as long as there are written rules that address potential conflicts of interest.

(b) Has the discretion to set rules in order to meet the requirements of this section.

(c) Membership is limited to three years per term for time served, per each advisory board member. Multiple terms may be served by a member if the advisory board rules allow it.

(5) The advisory board independently reviews and provides comments to the BH-ASO, on plans, budgets, and policies developed by the BH-ASO to implement the requirements of this section, chapters 71.05, 71.24, 71.34 RCW, and applicable federal laws.

Chapter 182-538D WAC

BEHAVIORAL HEALTH SERVICES

NEW SECTION

WAC 182-538D-0200 Behavioral health services—Definitions. The following definitions and those found in chapters 182-500, 182-538, and 182-538C WAC apply to this chapter. If conflict exists, this chapter takes precedence.

"Adult" means a person age eighteen or older. For purposes of the medicaid program, people age eighteen through age twenty have the early and periodic screening, diagnostic and treatment (EPSDT) benefit described in chapter 182-534 WAC. In the medicaid program, EPSDT is available until a person reaches age twenty-one.

"Assessment" means the process of obtaining all pertinent bio-psychosocial information, as identified by the person, and family and collateral sources, for determining a diagnosis and to plan individualized services and supports.

"Behavioral health" means the prevention, treatment of, and recovery from substance use disorders, mental health disorders or problem and pathological gambling disorders.

"Behavioral health administrative service organization (BH-ASO)" See WAC 182-538-050.

"Behavioral health agency" means an entity licensed by the department of health to provide behavioral health services, including services for mental health disorders and substance use disorders.

"Chemical dependency professional" or **"CDP"** means a person credentialed by the department of health as a chemical dependency professional (CDP) with primary responsibility for implementing an individualized service plan for substance use disorder services.

"Child" means a person under the age of eighteen. For the purposes of the medicaid program, people age eighteen through age twenty have the early and periodic screening, diagnostic and treatment (EPSDT) benefit described in chapter 182-534 WAC. In the medicaid program, EPSDT is available until a person reaches age twenty-one.

"Clinical record" means a paper or electronic file that is maintained by the provider and contains pertinent psychological, medical, and clinical information for each person served.

"Community support services" means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available twenty-four hours, seven days a week; prescreening determinations for people who are mentally ill being considered for placement in nursing homes as required by federal law; screening for patients being considered for admission to residential services; diagnosis and treatment for children who are mentally or severely emotionally disturbed discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment (EPSDT) program; investigation, legal, and other nonresidential services under chapter 71.05 RCW; case management services; psychiatric treatment including medication supervision; counseling; psychotherapy; assuring transfer of relevant patient information between service providers; recovery services; and other services determined by behavioral health administrative service organizations and managed care organizations.

"Complaint" See "grievance" in WAC 182-538-050.

"Consent" means agreement given by a person after the person is provided with a description of the nature, character, anticipated results of proposed treatments and the recognized serious possible risks, complications, and anticipated benefits, including alternatives and nontreatment. Informed consent must be provided in a terminology that the person can reasonably be expected to understand.

"Consultation" means the clinical review and development of recommendations regarding activities, or decisions of, clinical staff, contracted employees, volunteers, or students by people with appropriate knowledge and experience to make recommendations.

"Crisis" means an actual or perceived urgent or emergent situation that occurs when a person's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the person's mental or physical health, or to prevent the need for referral to a significantly higher level of care.

"Cultural competence" or **"culturally competent"** means the ability to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of culturally competent care include striving to overcome cultural, language, and communications barriers, providing an environment in which people from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options, encouraging people to express their spiritual beliefs and cultural practices, and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans.

"Designated crisis responder (DCR)" means a mental health professional appointed by the county, or an entity appointed by the county, to perform the duties described in chapter 71.05 RCW.

"Disability" means a physical or mental impairment that substantially limits one or more major life activities of a person and the person:

(a) Has a record of such an impairment; or

(b) Is regarded as having such impairment.

"Ethnic minority" or **"racial/ethnic groups"** means, for the purposes of this chapter, any of the following general population groups:

(a) African American;

(b) An American Indian or Alaskan native, which includes:

(i) A person who is a member or considered to be a member in a federally recognized tribe;

(ii) A person determined eligible to be found Indian by the secretary of interior;

(iii) An Eskimo, Aleut, or other Alaskan native; and

(iv) An unenrolled Indian meaning a person considered Indian by a federally or nonfederally recognized Indian tribe or off-reservation Indian/Alaskan native community organization.

(c) Asian/Pacific Islander; or

(d) Hispanic.

"Housing services" means the active search and promotion of individual access to, and choice in, safe and affordable housing that is appropriate to the person's age, culture, and needs.

"Integrated managed care (IMC)" See WAC 182-538-050.

"Less restrictive alternative (LRA)" See WAC 182-538C-050.

"Mental health professional" means a person who meets the following:

(a) A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner (ARNP), psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;

(b) A person who is licensed by the department of health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate; or

(c) A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university who has at least two years of experience in direct treatment of people with mental illness or emotional disturbance, experience that was gained under the supervision of a mental health professional recognized by the department of health or attested to by the licensed behavioral health agency.

"Mental health specialist" means:

(a) A **"child mental health specialist"** is defined as a mental health professional with the following education and experience:

(i) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and

(ii) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(b) A **"geriatric mental health specialist"** is defined as a mental health professional who has the following education and experience:

(i) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of people age sixty and older; and

(ii) The equivalent of one year of full-time experience in the treatment of people age sixty and older, under the supervision of a geriatric mental health specialist.

(c) An **"ethnic minority mental health specialist"** is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

(i) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

(ii) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minorities.

(d) A **"disability mental health specialist"** is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, "disabled" means a person with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(i) If the consumer is deaf, the specialist must be a mental health professional with:

(A) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

(B) Ability to communicate fluently in the preferred language system of the consumer.

(ii) The specialist for people with developmental disabilities must be a mental health professional who:

(A) Has at least one year experience working with people with developmental disabilities; or

(B) Is a developmental disabilities professional as defined in RCW 71.05.020.

"Peer counselor" means a person recognized by medicaid agency as a person who:

(a) Is a self-identified consumer of behavioral health services who:

(i) Has applied for, is eligible for, or has received behavioral health services; or

(ii) Is the parent or legal guardian of a person who has applied for, is eligible for, or has received behavioral health services;

(b) Is a counselor credentialed under chapter 18.19 RCW;

(c) Has completed specialized training provided by or contracted through the medicaid agency. If the person was trained by trainers approved by the department of social and health services before October 1, 2004, and has met the requirements in (a), (b) and (d) of this subsection by January 31, 2005, the person is exempt from completing this specialized training;

(d) Has successfully passed an examination administered by the medicaid agency or an authorized contractor; and

(e) Has received a written notification letter from the medicaid agency stating that the medicaid agency recognizes the person as a "peer counselor."

"Quality plan" means an overarching system and/or process whereby quality assurance and quality improvement

activities are incorporated and infused into all aspects of a behavioral health administrative service organization's (BH-ASO's) or managed care organization's (MCO's) operations.

"Residential services" means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for people who are acutely mentally ill, adults who are chronically mentally ill, children who are severely emotionally disturbed, or adults who are seriously disturbed and determined by the behavioral health organization to be at risk of becoming acutely or chronically mentally ill.

"Resource management services" means the planning, coordination, and authorization of residential services and community support services for people who are:

(a) Adults and children who are acutely mentally ill;

(b) Adults who are chronically mentally ill;

(c) Children who are severely emotionally disturbed; or

(d) Adults who are seriously disturbed and determined solely by a behavioral health organization to be at risk of becoming acutely or chronically mentally ill.

"Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that a person continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances.

"Supervision" means the regular monitoring of the administrative, clinical, or clerical work performance of a staff member, trainee, student, volunteer, or employee on contract by a person with the authority to give direction and require change.

"Youth" means a person who is age seventeen or younger.

NEW SECTION

WAC 182-538D-0234 Behavioral health administrative service organizations—When the medicaid agency administers regional behavioral health services. (1) If a currently operating behavioral health administrative service organization (BH-ASO) chooses to stop functioning as a BH-ASO, fails to perform contract requirements and fails to correct the issue to the medicaid agency's satisfaction when corrective action is issued, or does not meet the requirements under RCW 71.24.045, the following is implemented:

(a) Under RCW 71.24.035(16), the director of the medicaid agency:

(i) Is designated as the BH-ASO until a new BH-ASO is designated; and

(ii) Assumes the duties assigned to the region without a participating BH-ASO.

(b) The medicaid agency:

(i) Administers behavioral health services within the region without a participating BH-ASO; and

(ii) Continues to apply the BH-ASO requirements in chapter 182-538C WAC.

(2) A person who resides within the service area of a region without a participating BH-ASO may receive services, within available resources as defined in RCW 71.24.025(2), from any provider of behavioral health services that is contracted with the medicaid agency and licensed by the department of health.

NEW SECTION

WAC 182-538D-0246 Behavioral health administrative service organizations and managed care organizations—Public awareness of behavioral health services. A behavioral health administrative service organization (BH-ASO), or a managed care organization (MCO), or a BH-ASO's or MCO's designee must provide public information on the availability of mental health and substance use disorder services. The BH-ASO or MCO must:

(1) Maintain information on available services, including crisis services and the recovery help line in telephone directories, public web sites, and other public places in easily accessible formats; and

(2) Publish and disseminate brochures and other materials or methods for describing services and hours of operation that are appropriate for all people, including those who may be visually impaired, limited-English proficient, or unable to read.

NEW SECTION

WAC 182-538D-0254 Behavioral health administrative service organizations and managed care organizations—Voluntary and involuntary inpatient evaluation and treatment services. (1) A behavioral health administrative service organization (BH-ASO) and managed care organization (MCO) must develop and implement age and culturally competent behavioral health services that are consistent with chapters 71.24, 71.05, and 71.34 RCW.

(2) For involuntary evaluation and treatment services, the BH-ASO or MCO:

(a) Must ensure that people in their regional service area have access to involuntary inpatient care; and

(b) Is responsible for coordinating discharge planning with the treating inpatient facility.

NEW SECTION

WAC 182-538D-0258 Behavioral health administrative service organizations—Administration of the Mental Health Involuntary Treatment Act and Substance Use Disorders Involuntary Treatment Act. Behavioral health administrative service organizations (BH-ASOs) are responsible for administration of the Mental Health Involuntary Treatment Act and Substance Use Disorders Involuntary Treatment Act, including investigation, detention, transportation for people not eligible for medicaid, due process and other court-related services, and other services required by chapters 71.05, 71.24, and 71.34 RCW. This includes:

(1) BH-ASOs ensuring that designated crisis responders (DCRs) perform the duties of involuntary investigation and detention in accordance with the requirements of chapters 71.05, 71.24, and 71.34 RCW.

(2) BH-ASOs and managed care organizations documenting the person's compliance with the conditions of mental health less restrictive alternative court orders by:

(a) Ensuring periodic evaluation of each committed person for release from or continuation of an involuntary treatment order. Evaluations must be recorded in the clinical record, and must occur at least monthly for ninety-day commitments and one hundred eighty-day commitments.

(b) Notifying the DCR if noncompliance with the less restrictive alternative order impairs the person sufficiently to warrant detention or evaluation for detention and petitioning for revocation of the less restrictive alternative court order.

NEW SECTION

WAC 182-538D-0262 Behavioral health administrative service organizations and managed care organizations—Behavioral health ombuds office. (1) A behavioral health administrative service organization (BH-ASO) must provide unencumbered access to and maintain the independence of the behavioral health ombuds. Managed care organizations (MCOs) must ensure the BH-ASO provides access to omsbuds for medicaid managed care enrollees.

(2) Behavioral health ombuds must be current consumers of the mental health or substance use disorder system, or past consumers or family members of past consumers.

(3) The BH-ASO must maintain a behavioral health ombuds office that:

(a) Is reflective of the age and demographic character of the region and assists and advocates for people with resolving issues at the lowest possible level;

(b) Is independent of the BH-ASO, MCO, medicaid agency, and the provider network, unless by written exception from the medicaid agency;

(c) Supports people, family members, and other interested parties regarding issues, grievances, and appeals;

(d) Is accessible to people, including having a toll-free, independent phone line for access;

(e) Is able to access provider sites and records relating to people with appropriate releases so that it can reach out to people and help to resolve issues, grievances, and appeals;

(f) Receives training and adheres to confidentiality consistent with this chapter and chapters 71.05, 71.24, and 71.34 RCW;

(g) Involves other people, at the person's request;

(h) Supports people in the pursuit of a formal resolution;

(i) If necessary, continues to assist the person through the administrative hearing process;

(j) Coordinates and collaborates with allied services to improve the effectiveness of advocacy and to reduce duplication when serving the same person;

(k) Provides information on grievances to the BH-ASO;

(l) Provides reports and formalized recommendations at least biennially to the BH-ASO and local consumer and family advocacy groups; and

(m) Posts and makes information available to people regarding the behavioral health ombuds office consistent with WAC 182-538D-0262, and local advocacy organizations that may assist people in understanding their rights.

NEW SECTION

WAC 182-538D-0264 Behavioral health administrative service organizations and managed care organizations—Quality plan. A behavioral health administrative service organization (BH-ASO) and managed care organization (MCO) must have a quality plan for continuous quality improvement in the delivery of culturally competent behavioral health services. See WAC 182-538-140 for MCOs and WAC 182-538C-040 for BH-ASOs.

NEW SECTION

WAC 182-538D-0380 Managed care organization—Choice of primary behavioral health provider. The managed care organization (MCO) must:

(1) Ensure that each person receiving nonemergency behavioral health rehabilitation services has a primary behavioral health provider who is responsible to carry out the individual service plan; and

(2) Allow people, parents of people age twelve and younger, and guardians of people of all ages to select a primary behavioral health provider from the available primary behavioral health provider staff within the MCO.

(3) Assign a primary behavioral health provider not later than fifteen working days after the person requests services if the person does not select a primary behavioral health provider.

(4) Allow a person to change primary behavioral health providers at any time for any reason. The person must notify the MCO or its designee of the request for a change, and inform the MCO or designee of the name of the new primary behavioral health provider.

DEPARTMENT OF CORRECTIONS ACCESS TO CONFIDENTIAL MENTAL HEALTH INFORMATION

NEW SECTION

WAC 182-538D-0600 Purpose. In order to enhance and facilitate the department of corrections' ability to carry out its responsibility of planning and ensuring community protection, mental health records and information, as defined in this section, that are otherwise confidential shall be released by any mental health service provider to the department of corrections personnel for whom the information is necessary to carry out the responsibilities of their office as authorized in RCW 71.05.445. Department of corrections personnel must use records only for the stated purpose and must assure that records remain confidential and subject to the limitations on disclosure outlined in chapter 71.05 RCW, except as provided in RCW 72.09.585.

NEW SECTION

WAC 182-538D-0620 Scope. Many records and reports are updated on a regular or as needed basis. The scope of the records and reports to be released to the department of corrections are dependent upon the reason for the request.

(1) For the purpose of a presentence investigation release only the most recently completed or received records of those completed or received within the twenty-four-month period before the date of the request; or

(2) For all other purposes including risk assessments release all versions of records and reports that were completed or received within the ten year period prior to the date of the request that are still available.

NEW SECTION

WAC 182-538D-0630 Time frame. The mental health service provider will provide the requested relevant records, reports and information to the authorized department of corrections person in a timely manner, according to the purpose of the request:

(1) Presentence investigation - Within seven days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the seven-day-period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(2) All other purposes - Within thirty days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the thirty-day period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(3) Emergent situation requests - When an offender subject has failed to report for department of corrections supervision or in an emergent situation that poses a significant risk to the public, the mental health provider shall upon request, release information related to mental health services delivered to the offender and, if known, information regarding the whereabouts of the offender. Requests if oral must be subsequently confirmed in writing the next working day, which includes email or facsimile so long as the requesting person at the department of corrections is clearly defined. The request must specify the information being requested. Disclosure of the information requested does not require the consent of consumer.

Information that can be released is limited to:

(a) A statement as to whether the offender is or is not being treated by the mental health services provider; and

(b) Address or information about the location or whereabouts of the offender.

NEW SECTION

WAC 182-538D-0640 Written requests. The written request for relevant records, reports and information must include:

(1) Verification that the person for whom records, reports and information are being requested is under the authority of the department of corrections, per chapter 9.94A RCW, and the expiration date of that authority;

(2) Sufficient information to identify the person for whom records, reports and information are being requested including name and other identifying data;

(3) Specification as to which records and reports are being requested and the purpose for the request;

(4) Specification as to what relevant information is requested and the purpose for the request;

(5) Identification of the department of corrections person to whom the records, reports and information shall be sent, including the person's name, title and address;

(6) Name, title and signature of the requestor and date of the request.

WSR 19-20-126

PROPOSED RULES

PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed October 2, 2019, 11:51 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-13-068.

Title of Rule and Other Identifying Information: WAC 181-86-145 Appeal procedure—Informal SPI review.

Hearing Location(s): On November 15, 2019, at 8:30 a.m., at the Heathman Lodge, 7801 N.E. Greenwood Drive, Vancouver, WA 98662.

Date of Intended Adoption: November 15, 2019.

Submit Written Comments to: The Professional Educator Standards Board (PESB), 600 Washington Street S.E., Room 400, Olympia, WA 98504, email pesb@k12.wa.us, by November 10, 2019.

Assistance for Persons with Disabilities: Contact PESB, phone 360-725-6275, email rulespesb@k12.wa.us, by November 10, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Amend WAC to clarify timeline for notification in certification appeals.

Reasons Supporting Proposal: The language currently is unclear regarding notification in certification appeals. There needs to be clear language allowing for operations of both the certification office and the office of professional practice.

Statutory Authority for Adoption: Chapter 28A.410 RCW.

Statute Being Implemented: Chapter 28A.410 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: PESB, governmental.

Name of Agency Personnel Responsible for Drafting: Maren Johnson, 600 Washington Street S.E., Olympia, WA 98504, 360-725-6275; Implementation and Enforcement: PESB, 600 Washington Street S.E., Olympia, WA 98504, 360-725-6275.

A school district fiscal impact statement is not required under RCW 28A.305.135.

October 2, 2019
Justin Montermini
Rules Coordinator

AMENDATORY SECTION (Amending WSR 18-01-022, filed 12/8/17, effective 1/8/18)

WAC 181-86-145 Appeal procedure—Informal SPI review. Any person who appeals the decision or order to deny his or her application, the issuance of a reprimand, or the order to suspend or revoke his or her certificate must file a written notice with the superintendent of public instruction within thirty calendar days following the date of postmarked mailing or other notification, whichever is earlier, from the section of the superintendent of public instruction's office responsible for certification of the decision or order.

The written notice must set forth the reasons why the appellant believes his or her application should have been granted or why his or her certificate should not be suspended or revoked, or why the reprimand should not be issued whichever is applicable.

Following timely notice of appeal, the superintendent of public instruction shall appoint a review officer who shall proceed as follows:

(1) If the appeal does not involve good moral character, personal fitness, or unprofessional conduct, the review officer shall review the application and appeal notice and may request further written information including, but not limited to, an explanation from the person or persons who initially reviewed the application of the reason(s) why the application was denied. If the review officer deems it advisable, he or she shall schedule an informal meeting with the appellant, the person or persons who denied the application, and any other interested party designated by the review officer to receive oral information concerning the application. Any such meeting must be held within thirty calendar days of the date of receipt by the superintendent of public instruction of the timely filed appeal notice.

(2) If the appeal involves good moral character, personal fitness, or acts of unprofessional conduct, the review officer shall schedule an informal meeting of the applicant or certificate holder and/or counsel for the applicant or certificate holder with the admissions and professional conduct advisory committee. Such meeting shall be scheduled in accordance with the calendar of meetings of the advisory committee: Provided, That notice of appeal must be received at least fifteen calendar days in advance of a scheduled meeting.

(3) Send by certified mail a written decision (i.e., findings of fact and conclusions of law) on the appeal within thirty calendar days from the date of post-marked mailing the timely filed appeal notice or informal meeting, whichever is later. The review officer may uphold, reverse, or modify the decision to deny the application, the order to reprimand, or the order to suspend or revoke the certificate.

(4) The timelines stated herein may be extended by the review officer for cause.

(5) Provided, That in the case of an action for suspension or revocation of a certificate, the review officer, if so requested by an appellant, shall delay any review under this section until all quasi-judicial administrative or judicial proceedings (i.e., criminal and civil actions), which the review officer and the appellant agree are factually related to the suspension or revocation proceeding, are completed, including appeals, if the appellant signs the agreement stated in WAC 181-86-160. In requesting such delay, the appellant shall disclose fully all pending quasi-judicial administrative proceedings in which the appellant is involved.

WSR 19-20-127
PROPOSED RULES
PROFESSIONAL EDUCATOR STANDARDS BOARD

[Filed October 2, 2019, 11:54 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 19-13-070.

Title of Rule and Other Identifying Information: WAC 181-78A-232.

Hearing Location(s): On November 15, 2019, at 8:30 a.m., at the Heathman Lodge, 7801 N.E. Greenwood Drive, Vancouver, WA 98662.

Date of Intended Adoption: November 15, 2019.

Submit Written Comments to: The Professional Educator Standards Board (PESB), 600 Washington Street S.E., Room 400, Olympia, WA 98504, email pesb@k12.wa.us, by November 10, 2019.

Assistance for Persons with Disabilities: Contact PESB, phone 360-725-6275, email rulespesb@k12.wa.us, by November 10, 2019.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Amend WAC to incorporate social and emotional learning (SEL) standards into teacher and principal preparation program standards.

Reasons Supporting Proposal: This proposal is the result of recent changes in RCW regarding educator SEL standards.

Statutory Authority for Adoption: Chapter 28A.410 RCW.

Statute Being Implemented: Chapter 28A.410 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: PESB, governmental.

Name of Agency Personnel Responsible for Drafting: Maren Johnson, 600 Washington Street S.E., Olympia, WA 98504, 360-725-6275; Implementation and Enforcement: PESB, 600 Washington Street S.E., Olympia, WA 98504, 360-725-6275.

A school district fiscal impact statement is not required under RCW 28A.305.135.

October 2, 2019
Justin Montermini
Rules Coordinator

AMENDATORY SECTION (Amending WSR 19-15-144, filed 7/24/19, effective 8/24/19)

WAC 181-78A-232 Teacher, principal, career and technical education director, superintendent, and program administrator—Specific program approval domain standard—Candidate knowledge, skills, and cultural responsiveness. Knowledge, skills, and cultural responsiveness. Providers prepare candidates who demonstrate the knowledge, skills and cultural responsiveness required for

the particular certificate and areas of endorsement, which reflect the state's approved standards.

(1) Providers demonstrate effective, culturally responsive pedagogy using multiple instructional methods, formats, and assessments.

(a) Qualified faculty use multiple instructional strategies, pedagogies, and assessments to address students' academic language ability levels and cultural and linguistic backgrounds.

(b) Providers create opportunities for faculty members and program personnel to pursue, apply, and practice ongoing professional learning to improve their knowledge, skill, effectiveness, and cultural responsiveness.

(c) Faculty within the program and the unit collaborate among one another, with content specialists, P-12 schools, members of the broader professional community, and diverse members of local communities for continuous program improvement.

(d) Faculty members and program leaders systematically and comprehensively evaluate faculty's effectiveness in teaching and learning.

(2) Providers ensure that completers demonstrate the necessary subject matter knowledge for success as educators in schools.

(a) Candidates demonstrate knowledge and competence relative to the national standards related to the role, which were adopted by the board. Providers ensure that candidates in teacher preparation programs demonstrate most recently published InTASC Standards, candidates in principal programs demonstrate most recently published NELP - Building Level Standards, and candidates in superintendent programs demonstrate most recently published NELP - District Level Standards, and candidates in career and technical education educator preparation programs demonstrate and document the career and technical education standards approved by the professional educator standards board.

(b) Teacher candidates must take a board approved basic skills assessment prior to program admission and take an endorsement assessment prior to beginning student teaching. Endorsement assessments are not required for teacher candidates in career and technical education business and industry route programs.

(c) Teacher candidates apply content knowledge as reflected in board approved endorsement standards.

(d) Teacher candidates engage with the since time immemorial curriculum focused on history, culture, and government of American Indian peoples as prescribed in WAC 181-78A-300.

(e) Providers ensure that educator candidates complete a course on issues of abuse as required by RCW 28A.410.035 and WAC 181-79A-030.

(3) Providers ensure that candidates demonstrate pedagogical knowledge and skill relative to the national professional standards adopted by the board for the role for which candidates are being prepared.

(a) Candidates demonstrate knowledge and competence relative the national standards related to the role, which were adopted by the board. Providers ensure that candidates in teacher preparation programs demonstrate most recently published InTASC Standards, candidates in principal programs demonstrate most recently published NELP - Building Level Standards, candidates in superintendent programs demonstrate most recently published NELP - District Level Standards, and candidates in career and technical education educator preparation programs demonstrate and document the career and technical education standards approved by the professional educator standards board.

(b) Faculty and mentors provide regular and ongoing feedback to candidates regarding field based performance that is actionable and leads to improvement in candidates' practice.

(c) Providers demonstrate through structured observation, discussion, surveys, and/or artifacts that program completers effectively apply the professional knowledge, skills, and dispositions that the preparation program was designed to achieve.

(d) Providers ensure that teacher candidates achieve passing scores on the teacher performance assessment, also known as the pedagogy assessment, approved by the board. The teacher performance assessment is not required for teacher candidates in career and technical education business and industry route programs.

(e) Providers ensure that all educator candidates demonstrate knowledge of the paraeducator standards of practice, as published by the paraeducator board.

(f) Providers of career and technical educator preparation programs provide candidates all necessary guidance to document, demonstrate, and submit for approval the required hours of occupational experience.

(g) Providers ensure that teacher and principal candidates can recognize signs of emotional or behavioral distress in students and appropriately refer students for assistance and support. The guidance provided to candidates must include the social-emotional learning standards, benchmarks, and related competencies described in RCW 28A.410.270.

(4) Providers ensure that candidates are well prepared to exhibit the knowledge and skills of culturally responsive educators.

(a) Providers offer all candidates meaningful, reflective opportunities to interact with racially and culturally diverse colleagues, faculty, P-12 practitioners, and P-12 students and families.

(b) Providers prepare candidates to adapt their practices based on students' prior experiences, cultural knowledge, and frames of reference to make learning encounters more relevant and effective.

(c) Providers ensure course work explicitly focuses on cultural responsiveness and integrates components of culturally responsive education within and throughout all courses.

(d) Faculty explicitly model equity pedagogy in course work and practica in ways that enable candidates to integrate their own cultural and linguistic backgrounds into classroom activities.