FOURTEENTH DAY

MORNING SESSION

Senate Chamber, Olympia, Monday, May 9, 2011

The Senate was called to order at 11:00 a.m. by Senator Fraser. The Secretary called the roll and announced that all Senators were present with the exception of Senators Becker, McAuliffe and Shin.

Senator Prentice the President Pro Tempore assumed the chair.

The Sergeant at Arms Color Guard consisting of staff Judy Best and Alyssa McClure, presented the Colors. Senator Morton offered the prayer.

MOTION

On motion of Senator Eide, the reading of the Journal of the previous day was dispensed with and it was approved.

MOTION

On motion of Senator Eide, the Senate advanced to the third order of business.

MESSAGE FROM THE GOVERNOR
GUBERNATORIAL APPOINTMENTS

May 6, 2011

TO THE HONORABLE, THE SENATE OF THE STATE OF WASHINGTON
Ladies and Gentlemen:

I have the honor to submit the following appointment, subject to your confirmation.

JOSHUA BROWN, appointed April 28, 2011, for the term ending July 15, 2013, as Member of the Salmon Recovery Funding Board.

Sincerely,
CHRISTINE O. GREGOIRE, Governor

Referred to Committee on Natural Resources & Marine Waters.

May 9, 2011

TO THE HONORABLE, THE SENATE OF THE STATE OF WASHINGTON
Ladies and Gentlemen:

I have the honor to submit the following reappointment, subject to your confirmation.

ELIZABETH A. WILLIS, reappointed April 19, 2011, for the term ending April 3, 2015, as Member of the State Board for Community and Technical Colleges.

Sincerely,
CHRISTINE O. GREGOIRE, Governor

Referred to Committee on Higher Education & Workforce Development.

MOTION

On motion of Senator Eide, all appointees listed on the Gubernatorial Appointments report were referred to the committees as designated.

MOTION

On motion of Senator Eide, the Senate advanced to the fourth order of business.

MESSAGE FROM THE HOUSE

May 6, 2011

MR. PRESIDENT:
The Speaker has signed:
HOUSE CONCURRENT RESOLUTION NO. 4405,
and the same is herewith transmitted.

BARBARA BAKER, Chief Clerk

MOTION

At 11:10 a.m., on motion of Senator Eide, the Senate was declared to be at ease subject to the call of the President.

AFTERNOON SESSION

The Senate was called to order at 2:36 p.m. by the President Pro Tempore.

MOTION

On motion of Senator Eide, the Senate advanced to the sixth order of business.

MOTION

On motion of Senator Ericksen, Senator Becker was excused.

MOTION

On motion of Senator White, Senators Eide, McAuliffe and Shin were excused.

SECOND READING

SECOND ENGROSSED SECOND SUBSTITUTE HOUSE BILL NO. 1738, by House Committee on Ways & Means (originally sponsored by Representatives Cody and Jinkins)

Changing the designation of the medicaid single state agency.

The measure was read the second time.

MOTION

Senator Keiser moved that the following committee striking amendment by the Committee on Ways & Means be adopted:

Strike everything after the enacting clause and insert the following:

"NEW SECTION. **Sec. 1.** The legislature finds that:

(1) Washington state government must be organized to be efficient, cost-effective, and responsive to its residents;

(2) The cost of state-purchased health care continues to grow at an unsustainable rate, now representing nearly one-third of the state's budget and hindering our ability to invest in other essential services such as education and public safety;

(3) Responsibility for state health care purchasing is currently spread over multiple agencies, but successful interagency collaboration on quality and cost initiatives has helped demonstrate the benefits to the state of centralized health care purchasing;

(4) Consolidating the majority of state health care purchasing into a single state agency will best position the state to work with others, including private sector purchasers, health insurance carriers, health care providers, and consumers to increase the quality and affordability of health care for all state residents;

(5) The development and implementation of uniform state policies for all state-purchased health care is among the purposes for which the health care authority was originally created; and

(6) The state will be best able to take advantage of the opportunities and meet its obligations under the federal affordable care act, including establishment of a health benefit exchange and medicaid expansion, if primary responsibility for doing so rests with a single state agency.

The legislature therefore intends, where appropriate, to consolidate state health care purchasing within the health care authority, positioning the state to use its full purchasing power to get the greatest value for its money, and allowing other agencies to focus even more intently on their core missions.

Sec. 2. RCW 74.09.010 and 2010 1st sp.s. c 8 s 28 are each reenacted and amended to read as follows:

((~~As used in this chapter:~~)) The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

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

(2) "Children's health program" means the health care services program provided to children under eighteen years of age and in households with incomes at or below the federal poverty level as annually defined by the federal department of health and human services as adjusted for family size, and who are not otherwise eligible for medical assistance or the limited casualty program for the medically needy.

((~~(2) "Committee" means the children's health services committee created in section 3 of this act.~~))

(3) "County" means the board of county commissioners, county council, county executive, or tribal jurisdiction, or its designee. ((~~A combination of two or more county authorities or tribal jurisdictions may enter into joint agreements to fulfill the requirements of RCW 74.09.415 through 74.09.435.~~))

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

(5) "Department of health" means the Washington state department of health created pursuant to RCW 43.70.020.

(6) "Director" means the director of the Washington state health care authority.

(7) "Full benefit dual eligible beneficiary" means an individual who, for any month: Has coverage for the month under a medicare prescription drug plan or medicare advantage plan with part D coverage; and is determined eligible by the state for full medicaid benefits for the month under any eligibility category in the state's medicaid plan or a section 1115 demonstration waiver that provides pharmacy benefits.

(((~~(7)~~))) (8) "Internal management" means the administration of medical assistance, medical care services, the children's health program, and the limited casualty program.

(((~~(8)~~))) (9) "Limited casualty program" means the medical care program provided to medically needy persons as defined under Title XIX of the federal social security act, and to medically indigent persons who are without income or resources sufficient to secure necessary medical services.

(((~~(9)~~))) (10) "Medical assistance" means the federal aid medical care program provided to categorically needy persons as defined under Title XIX of the federal social security act.

(((~~(10)~~))) (11) "Medical care services" means the limited scope of care financed by state funds and provided to disability lifeline benefits recipients, and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW.

(((~~(11)~~))) (12) "Nursing home" means nursing home as defined in RCW 18.51.010.

(((~~(12)~~))) (13) "Poverty" means the federal poverty level determined annually by the United States department of health and human services, or successor agency.

(((~~(13)~~))) (14) "Secretary" means the secretary of social and health services.

Sec. 3. RCW 74.09.035 and 2010 1st sp.s. c 8 s 29 and 2010 c 94 s 22 are each reenacted and amended to read as follows:

(1) To the extent of available funds, medical care services may be provided to recipients of disability lifeline benefits, persons denied disability lifeline benefits under RCW 74.04.005(5)(b) or 74.04.655 who otherwise meet the requirements of RCW 74.04.005(5)(a), and recipients of alcohol and drug addiction services provided under chapter 74.50 RCW, in accordance with medical eligibility requirements established by the ((~~department~~)) authority. To the extent authorized in the operating budget, upon implementation of a federal medicaid 1115 waiver providing federal matching funds for medical care services, these services also may be provided to persons who have been terminated from disability lifeline benefits under RCW 74.04.005(5)(h).

(2) Determination of the amount, scope, and duration of medical care services shall be limited to coverage as defined by the ((~~department~~)) authority, except that adult dental, and routine foot care shall not be included unless there is a specific appropriation for these services.

(3) The ((~~department~~)) authority shall enter into performance-based contracts with one or more managed health care systems for the provision of medical care services to recipients of disability lifeline benefits. The contract must provide for integrated delivery of medical and mental health services.

(4) The ((~~department~~)) authority shall establish standards of assistance and resource and income exemptions, which may include deductibles and co-insurance provisions. In addition, the ((~~department~~)) authority may include a prohibition against the voluntary assignment of property or cash for the purpose of qualifying for assistance.

(5) Residents of skilled nursing homes, intermediate care facilities, and intermediate care facilities for ((~~the mentally retarded~~)) persons with intellectual disabilities, as that term is described by federal law, who are eligible for medical care services shall be provided medical services to the same extent as provided to those persons eligible under the medical assistance program.

(6) Payments made by the ((~~department~~)) authority under this program shall be the limit of expenditures for medical care services solely from state funds.

(7) Eligibility for medical care services shall commence with the date of certification for disability lifeline benefits or the date of eligibility for alcohol and drug addiction services provided under chapter 74.50 RCW.

Sec. 4. RCW 74.09.037 and 2004 c 115 s 3 are each amended to read as follows:

Any card issued ((~~after December 31, 2005,~~)) by the ((~~department~~)) authority or a managed health care system to a person receiving services under this chapter, that must be presented to providers for purposes of claims processing, may not display an identification number that includes more than a four-digit portion of the person's complete social security number.

Sec. 5. RCW 74.09.050 and 2000 c 5 s 15 are each amended to read as follows:

(1) The ((~~secretary~~)) director shall appoint such professional personnel and other assistants and employees, including professional medical screeners, as may be reasonably necessary to carry out the provisions of this chapter. The medical screeners shall be supervised by one or more physicians who shall be appointed by the ((~~secretary~~)) director or his or her designee. The ((~~secretary~~)) director shall appoint a medical director who is licensed under chapter 18.57 or 18.71 RCW.

(2) Whenever the director's authority is not specifically limited by law, he or she has complete charge and supervisory powers over the authority. The director is authorized to create such administrative structures as deemed appropriate, except as otherwise specified by law. The director has the power to employ such assistants and personnel as may be necessary for the general administration of the authority. Except as elsewhere specified, such employment must be in accordance with the rules of the state civil service law, chapter 41.06 RCW.

Sec. 6. RCW 74.09.055 and 2006 c 24 s 1 are each amended to read as follows:

The ((~~department~~)) authority is authorized to establish copayment, deductible, or coinsurance, or other cost-sharing requirements for recipients of any medical programs defined in RCW 74.09.010, except that premiums shall not be imposed on children in households at or below two hundred percent of the federal poverty level.

Sec. 7. RCW 74.09.075 and 1979 c 141 s 337 are each amended to read as follows:

The department or authority, as appropriate, shall provide ((~~(a)~~)) (1) for evaluation of employability when a person is applying for public assistance representing a medical condition as a basis for need, and ((~~(b)~~)) (2) for medical reports to be used in the evaluation of total and permanent disability. It shall further provide for medical consultation and assistance in determining the need for special diets, housekeeper and attendant services, and other requirements as found necessary because of the medical condition under the rules promulgated by the secretary or director.

Sec. 8. RCW 74.09.080 and 1979 c 141 s 338 are each amended to read as follows:

In carrying out the administrative responsibility of this chapter, the department or authority, as appropriate:

(1) May contract with an individual or a group, may utilize existing local state public assistance offices, or establish separate welfare medical care offices on a county or multicounty unit basis as found necessary; and

(2) Shall determine both financial and functional eligibility for persons applying for long-term care services under chapter 74.39 or 74.39A RCW as a unified process in a single long-term care organizational unit.

Sec. 9. RCW 74.09.120 and 2010 c 94 s 23 are each amended to read as follows:

((~~The department shall purchase necessary physician and dentist services by contract or "fee for service."~~)) (1) The department shall purchase nursing home care by contract and payment for the care shall be in accordance with the provisions of chapter 74.46 RCW and rules adopted by the department ((~~under the authority of RCW 74.46.800~~)). No payment shall be made to a nursing home which does not permit inspection by the authority and the department ((~~of social and health services~~)) of every part of its premises and an examination of all records, including financial records, methods of administration, general and special dietary programs, the disbursement of drugs and methods of supply, and any other records the authority or the department deems relevant to the regulation of nursing home operations, enforcement of standards for resident care, and payment for nursing home services.

(2) The department may purchase nursing home care by contract in veterans' homes operated by the state department of veterans affairs and payment for the care shall be in accordance with the provisions of chapter 74.46 RCW and rules adopted by the department under the authority of RCW 74.46.800.

(3) The department may purchase care in institutions for persons with intellectual disabilities, also known as intermediate care facilities for persons with intellectual disabilities. The department shall establish rules for reasonable accounting and reimbursement systems for such care. Institutions for persons with intellectual disabilities include licensed nursing homes, public institutions, licensed boarding homes with fifteen beds or less, and hospital facilities certified as intermediate care facilities for persons with intellectual disabilities under the federal medicaid program to provide health, habilitative, or rehabilitative services and twenty-four hour supervision for persons with intellectual disabilities or related conditions and includes in the program "active treatment" as federally defined.

(4) The department may purchase care in institutions for mental diseases by contract. The department shall establish rules for reasonable accounting and reimbursement systems for such care. Institutions for mental diseases are certified under the federal medicaid program and primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases, including medical attention, nursing care, and related services.

(5) Both the department and the authority may each purchase all other services provided under this chapter by contract or at rates established by the department or the authority respectively.

Sec. 10. RCW 74.09.160 and 1991 c 103 s 1 are each amended to read as follows:

Each vendor or group who has a contract and is rendering service to eligible persons as defined in this chapter shall submit such charges as agreed upon between the department or authority, as appropriate, and the individual or group no later than twelve months from the date of service. If the final charges are not presented within the twelve-month period, they shall not be a charge against the state. Said twelve-month period may also be extended by regulation, but only if required by applicable federal law or regulation, and to no more than the extension of time so required. ((~~For services rendered prior to July 28, 1991, final charges shall not be a charge against the state unless they are presented within one hundred twenty days from the date of service.~~))

Sec. 11. RCW 74.09.180 and 1997 c 236 s 1 are each amended to read as follows:

(1) The provisions of this chapter shall not apply to recipients whose personal injuries are occasioned by negligence or wrong of another: PROVIDED, HOWEVER, That the ((~~secretary~~)) director may furnish assistance, under the provisions of this chapter, for the results of injuries to or illness of a recipient, and the ((~~department~~)) authority shall thereby be subrogated to the recipient's rights against the recovery had from any tort feasor or the tort feasor's insurer, or both, and shall have a lien thereupon to the extent of the value of the assistance furnished by the ((~~department~~)) authority. To secure reimbursement for assistance provided under this section, the ((~~department~~)) authority may pursue its remedies under ((~~RCW 43.20B.060~~)) section 95 of this act.

(2) The rights and remedies provided to the ((~~department~~)) authority in this section to secure reimbursement for assistance, including the ((~~department's~~)) authority's lien and subrogation rights, may be delegated to a managed health care system by contract entered into pursuant to RCW 74.09.522. A managed health care system may enforce all rights and remedies delegated to it by the ((~~department~~)) authority to secure and recover assistance

provided under a managed health care system consistent with its agreement with the ((~~department~~)) authority.

Sec. 12. RCW 74.09.185 and 1995 c 34 s 6 are each amended to read as follows:

To the extent that payment for covered expenses has been made under medical assistance for health care items or services furnished to an individual, in any case where a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services. Recovery pursuant to the subrogation rights, assignment, or enforcement of the lien granted to the ((~~department~~)) authority by this section shall not be reduced, prorated, or applied to only a portion of a judgment, award, or settlement, except as provided in ((~~RCW 43.20B.050 and 43.20B.060~~)) sections 94 and 95 of this act. The doctrine of equitable subrogation shall not apply to defeat, reduce, or prorate recovery by the ((~~department~~)) authority as to its assignment, lien, or subrogation rights.

Sec. 13. RCW 74.09.190 and 1979 c 141 s 342 are each amended to read as follows:

Nothing in this chapter shall be construed as empowering the secretary or director to compel any recipient of public assistance and a medical indigent person to undergo any physical examination, surgical operation, or accept any form of medical treatment contrary to the wishes of said person who relies on or is treated by prayer or spiritual means in accordance with the creed and tenets of any well recognized church or religious denomination.

Sec. 14. RCW 74.09.200 and 1979 ex.s. c 152 s 1 are each amended to read as follows:

The legislature finds and declares it to be in the public interest and for the protection of the health and welfare of the residents of the state of Washington that a proper regulatory and inspection program be instituted in connection with the providing of medical, dental, and other health services to recipients of public assistance and medically indigent persons. In order to effectively accomplish such purpose and to assure that the recipient of such services receives such services as are paid for by the state of Washington, the acceptance by the recipient of such services, and by practitioners of reimbursement for performing such services, shall authorize the secretary ((~~of the department of social and health services~~)) or ((~~his designee~~)) director, to inspect and audit all records in connection with the providing of such services.

Sec. 15. RCW 74.09.210 and 1989 c 175 s 146 are each amended to read as follows:

(1) No person, firm, corporation, partnership, association, agency, institution, or other legal entity, but not including an individual public assistance recipient of health care, shall, on behalf of himself or others, obtain or attempt to obtain benefits or payments under this chapter in a greater amount than that to which entitled by means of:

(a) A willful false statement;

(b) By willful misrepresentation, or by concealment of any material facts; or

(c) By other fraudulent scheme or device, including, but not limited to:

(i) Billing for services, drugs, supplies, or equipment that were unfurnished, of lower quality, or a substitution or misrepresentation of items billed; or

(ii) Repeated billing for purportedly covered items, which were not in fact so covered.

(2) Any person or entity knowingly violating any of the provisions of subsection (1) of this section shall be liable for repayment of any excess benefits or payments received, plus interest at the rate and in the manner provided in RCW 43.20B.695. Such person or other entity shall further, in addition to any other penalties provided by law, be subject to civil penalties. The secretary or director, as appropriate, may assess civil penalties in an amount not to exceed three times the amount of such excess benefits or payments: PROVIDED, That these civil penalties shall not apply to any acts or omissions occurring prior to September 1, 1979. RCW 43.20A.215 governs notice of a civil fine and provides the right to an adjudicative proceeding.

(3) A criminal action need not be brought against a person for that person to be civilly liable under this section.

(4) In all proceedings under this section, service, adjudicative proceedings, and judicial review of such determinations shall be in accordance with chapter 34.05 RCW, the administrative procedure act.

(5) Civil penalties shall be deposited in the general fund upon their receipt.

Sec. 16. RCW 74.09.240 and 1995 c 319 s 1 are each amended to read as follows:

(1) Any person, including any corporation, that solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind

(a) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this chapter, or

(b) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this chapter,

shall be guilty of a class C felony; however, the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

(2) Any person, including any corporation, that offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person

(a) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under this chapter, or

(b) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under this chapter,

shall be guilty of a class C felony; however, the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

(3)(a) Except as provided in 42 U.S.C. 1395 nn, physicians are prohibited from self-referring any client eligible under this chapter for the following designated health services to a facility in which the physician or an immediate family member has a financial relationship:

(i) Clinical laboratory services;

(ii) Physical therapy services;

(iii) Occupational therapy services;

(iv) Radiology including magnetic resonance imaging, computerized axial tomography, and ultrasound services;

(v) Durable medical equipment and supplies;

(vi) Parenteral and enteral nutrients equipment and supplies;

(vii) Prosthetics, orthotics, and prosthetic devices;

(viii) Home health services;

(ix) Outpatient prescription drugs;

(x) Inpatient and outpatient hospital services;

(xi) Radiation therapy services and supplies.

(b) For purposes of this subsection, "financial relationship" means the relationship between a physician and an entity that includes either:

(i) An ownership or investment interest; or

(ii) A compensation arrangement.

For purposes of this subsection, "compensation arrangement" means an arrangement involving remuneration between a physician, or an immediate family member of a physician, and an entity.

(c) The department or authority, as appropriate, is authorized to adopt by rule amendments to 42 U.S.C. 1395 nn enacted after July 23, 1995.

(d) This section shall not apply in any case covered by a general exception specified in 42 U.S.C. Sec. 1395 nn.

(4) Subsections (1) and (2) of this section shall not apply to:

(a) A discount or other reduction in price obtained by a provider of services or other entity under this chapter if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this chapter((,)); and

(b) Any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(5) Subsections (1) and (2) of this section, if applicable to the conduct involved, shall supersede the criminal provisions of chapter 19.68 RCW, but shall not preclude administrative proceedings authorized by chapter 19.68 RCW.

Sec. 17. RCW 74.09.260 and 1991 sp.s. c 8 s 7 are each amended to read as follows:

Any person, including any corporation, that knowingly:

(1) Charges, for any service provided to a patient under any medical care plan authorized under this chapter, money or other consideration at a rate in excess of the rates established by the department ((~~of social and health services~~)) or authority, as appropriate; or

(2) Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under such plan, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient):

(a) As a precondition of admitting a patient to a hospital or nursing facility; or

(b) As a requirement for the patient's continued stay in such facility,

when the cost of the services provided therein to the patient is paid for, in whole or in part, under such plan, shall be guilty of a class C felony: PROVIDED, That the fine, if imposed, shall not be in an amount more than twenty-five thousand dollars, except as authorized by RCW 9A.20.030.

Sec. 18. RCW 74.09.280 and 1979 ex.s. c 152 s 9 are each amended to read as follows:

The secretary ((~~of social and health services~~)) or director may by rule require that any application, statement, or form filled out by suppliers of medical care under this chapter shall contain or be verified by a written statement that it is made under the penalties of perjury and such declaration shall be in lieu of any oath otherwise required, and each such paper shall in such event so state. The making or subscribing of any such papers or forms containing any false or misleading information may be prosecuted and punished under chapter 9A.72 RCW.

Sec. 19. RCW 74.09.290 and 1994 sp.s. c 9 s 749 are each amended to read as follows:

The secretary ((~~of the department of social and health services~~)) or ((~~his authorized representative~~)) director shall have the authority to:

(1) Conduct audits and investigations of providers of medical and other services furnished pursuant to this chapter, except that the Washington state medical quality assurance commission shall generally serve in an advisory capacity to the secretary or director in the conduct of audits or investigations of physicians. Any overpayment discovered as a result of an audit of a provider under this authority shall be offset by any underpayments discovered in that same audit sample. In order to determine the provider's actual, usual, customary, or prevailing charges, the secretary or director may examine such random representative records as necessary to show accounts billed and accounts received except that in the conduct of such examinations, patient names, other than public assistance applicants or recipients, shall not be noted, copied, or otherwise made available to the department or authority. In order to verify costs incurred by the department or authority for treatment of public assistance applicants or recipients, the secretary or director may examine patient records or portions thereof in connection with services to such applicants or recipients rendered by a health care provider, notwithstanding the provisions of RCW 5.60.060, 18.53.200, 18.83.110, or any other statute which may make or purport to make such records privileged or confidential: PROVIDED, That no original patient records shall be removed from the premises of the health care provider, and that the disclosure of any records or information by the department ((~~of social and health services~~)) or the authority is prohibited and shall be punishable as a class C felony according to chapter 9A.20 RCW, unless such disclosure is directly connected to the official purpose for which the records or information were obtained: PROVIDED FURTHER, That the disclosure of patient information as required under this section shall not subject any physician or other health services provider to any liability for breach of any confidential relationship between the provider and the patient, but no evidence resulting from such disclosure may be used in any civil, administrative, or criminal proceeding against the patient unless a waiver of the applicable evidentiary privilege is obtained: PROVIDED FURTHER, That the secretary or director shall destroy all copies of patient medical records in their possession upon completion of the audit, investigation or proceedings;

(2) Approve or deny applications to participate as a provider of services furnished pursuant to this chapter;

(3) Terminate or suspend eligibility to participate as a provider of services furnished pursuant to this chapter; and

(4) Adopt, promulgate, amend, and repeal administrative rules, in accordance with the administrative procedure act, chapter 34.05 RCW, to carry out the policies and purposes of RCW 74.09.200 through 74.09.290.

Sec. 20. RCW 74.09.300 and 1979 ex.s. c 152 s 11 are each amended to read as follows:

Whenever the secretary ((~~of the department of social and health services~~)) or director imposes a civil penalty under RCW 74.09.210, or terminates or suspends a provider's eligibility under RCW 74.09.290, he or she shall, if the provider is licensed pursuant to Titles 18, 70, or 71 RCW, give written notice of such imposition, termination, or suspension to the appropriate licensing agency or disciplinary board.

Sec. 21. RCW 74.09.470 and 2009 c 463 s 2 are each amended to read as follows:

(1) Consistent with the goals established in RCW 74.09.402, through the apple health for kids program authorized in this section, the ((~~department~~)) authority shall provide affordable health care coverage to children under the age of nineteen who reside in Washington state and whose family income at the time of enrollment is not greater than two hundred fifty percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services, and effective January 1, 2009, and only to the extent that funds are specifically appropriated therefor, to children whose family income is not greater than three hundred percent of the federal poverty level. In administering the program, the ((~~department~~)) authority shall take such actions as may be necessary to ensure the receipt of federal financial participation under the medical assistance program, as codified at Title XIX of the federal social security act, the state

children's health insurance program, as codified at Title XXI of the federal social security act, and any other federal funding sources that are now available or may become available in the future. The ((~~department~~)) authority and the caseload forecast council shall estimate the anticipated caseload and costs of the program established in this section.

(2) The ((~~department~~)) authority shall accept applications for enrollment for children's health care coverage; establish appropriate minimum-enrollment periods, as may be necessary; and determine eligibility based on current family income. The ((~~department~~)) authority shall make eligibility determinations within the time frames for establishing eligibility for children on medical assistance, as defined by RCW 74.09.510. The application and annual renewal processes shall be designed to minimize administrative barriers for applicants and enrolled clients, and to minimize gaps in eligibility for families who are eligible for coverage. If a change in family income results in a change in the source of funding for coverage, the ((~~department~~)) authority shall transfer the family members to the appropriate source of funding and notify the family with respect to any change in premium obligation, without a break in eligibility. The ((~~department~~)) authority shall use the same eligibility redetermination and appeals procedures as those provided for children on medical assistance programs. The ((~~department~~)) authority shall modify its eligibility renewal procedures to lower the percentage of children failing to annually renew. The ((~~department~~)) authority shall manage its outreach, application, and renewal procedures with the goals of: (a) Achieving year by year improvements in enrollment, enrollment rates, renewals, and renewal rates; (b) maximizing the use of existing program databases to obtain information related to earned and unearned income for purposes of eligibility determination and renewals, including, but not limited to, the basic food program, the child care subsidy program, federal social security administration programs, and the employment security department wage database; (c) streamlining renewal processes to rely primarily upon data matches, online submissions, and telephone interviews; and (d) implementing any other eligibility determination and renewal processes to allow the state to receive an enhanced federal matching rate and additional federal outreach funding available through the federal children's health insurance program reauthorization act of 2009 by January 2010. The department shall advise the governor and the legislature regarding the status of these efforts by September 30, 2009. The information provided should include the status of the department's efforts, the anticipated impact of those efforts on enrollment, and the costs associated with that enrollment.

(3) To ensure continuity of care and ease of understanding for families and health care providers, and to maximize the efficiency of the program, the amount, scope, and duration of health care services provided to children under this section shall be the same as that provided to children under medical assistance, as defined in RCW 74.09.520.

(4) The primary mechanism for purchasing health care coverage under this section shall be through contracts with managed health care systems as defined in RCW 74.09.522, subject to conditions, limitations, and appropriations provided in the biennial appropriations act. However, the ((~~department~~)) authority shall make every effort within available resources to purchase health care coverage for uninsured children whose families have access to dependent coverage through an employer-sponsored health plan or another source when it is cost-effective for the state to do so, and the purchase is consistent with requirements of Title XIX and Title XXI of the federal social security act. To the extent allowable under federal law, the ((~~department~~)) authority shall require families to enroll in available employer-sponsored coverage, as a condition of participating in the program established under this section, when it is cost-effective for the state to do so. Families who enroll in available employer-sponsored coverage under this section shall be accounted for separately in the annual report required by RCW 74.09.053.

(5)(a) To reflect appropriate parental responsibility, the ((~~department~~)) authority shall develop and implement a schedule of premiums for children's health care coverage due to the ((~~department~~)) authority from families with income greater than two hundred percent of the federal poverty level. For families with income greater than two hundred fifty percent of the federal poverty level, the premiums shall be established in consultation with the senate majority and minority leaders and the speaker and minority leader of the house of representatives. Premiums shall be set at a reasonable level that does not pose a barrier to enrollment. The amount of the premium shall be based upon family income and shall not exceed the premium limitations in Title XXI of the federal social security act. Premiums shall not be imposed on children in households at or below two hundred percent of the federal poverty level as articulated in RCW 74.09.055.

(b) Beginning no later than January 1, 2010, the ((~~department~~)) authority shall offer families whose income is greater than three hundred percent of the federal poverty level the opportunity to purchase health care coverage for their children through the programs administered under this section without an explicit premium subsidy from the state. The design of the health benefit package offered to these children should provide a benefit package substantially similar to that offered in the apple health for kids program, and may differ with respect to cost-sharing, and other appropriate elements from that provided to children under subsection (3) of this section including, but not limited to, application of preexisting conditions, waiting periods, and other design changes needed to offer affordable coverage. The amount paid by the family shall be in an amount equal to the rate paid by the state to the managed health care system for coverage of the child, including any associated and administrative costs to the state of providing coverage for the child. Any pooling of the program enrollees that results in state fiscal impact must be identified and brought to the legislature for consideration.

(6) The ((~~department~~)) authority shall undertake and continue a proactive, targeted outreach and education effort with the goal of enrolling children in health coverage and improving the health literacy of youth and parents. The ((~~department~~)) authority shall collaborate with the department of social and health services, department of health, local public health jurisdictions, the office of the superintendent of public instruction, the department of early learning, health educators, health care providers, health carriers, community-based organizations, and parents in the design and development of this effort. The outreach and education effort shall include the following components:

(a) Broad dissemination of information about the availability of coverage, including media campaigns;

(b) Assistance with completing applications, and community-based outreach efforts to help people apply for coverage. Community-based outreach efforts should be targeted to the populations least likely to be covered;

(c) Use of existing systems, such as enrollment information from the free and reduced-price lunch program, the department of early learning child care subsidy program, the department of health's women, infants, and children program, and the early childhood education and assistance program, to identify children who may be eligible but not enrolled in coverage;

(d) Contracting with community-based organizations and government entities to support community-based outreach efforts to help families apply for coverage. These efforts should be targeted to the populations least likely to be covered. The ((~~department~~)) authority shall provide informational materials for use by government entities and community-based organizations in their

outreach activities, and should identify any available federal matching funds to support these efforts;

(e) Development and dissemination of materials to engage and inform parents and families statewide on issues such as: The benefits of health insurance coverage; the appropriate use of health services, including primary care provided by health care practitioners licensed under chapters 18.71, 18.57, 18.36A, and 18.79 RCW, and emergency services; the value of a medical home, well-child services and immunization, and other preventive health services with linkages to department of health child profile efforts; identifying and managing chronic conditions such as asthma and diabetes; and the value of good nutrition and physical activity;

(f) An evaluation of the outreach and education efforts, based upon clear, cost-effective outcome measures that are included in contracts with entities that undertake components of the outreach and education effort;

(g) An implementation plan to develop online application capability that is integrated with the ((~~department's~~)) automated client eligibility system, and to develop data linkages with the office of the superintendent of public instruction for free and reduced-price lunch enrollment information and the department of early learning for child care subsidy program enrollment information.

(7) The ((~~department~~)) authority shall take action to increase the number of primary care physicians providing dental disease preventive services including oral health screenings, risk assessment, family education, the application of fluoride varnish, and referral to a dentist as needed.

(8) The department shall monitor the rates of substitution between private-sector health care coverage and the coverage provided under this section ((~~and shall report to appropriate committees of the legislature by December 2010~~)).

Sec. 22. RCW 74.09.480 and 2009 c 463 s 4 are each amended to read as follows:

(1) The ((~~department~~)) authority, in collaboration with the department of health, department of social and health services, health carriers, local public health jurisdictions, children's health care providers including pediatricians, family practitioners, and pediatric subspecialists, community and migrant health centers, parents, and other purchasers, shall establish a concise set of explicit performance measures that can indicate whether children enrolled in the program are receiving health care through an established and effective medical home, and whether the overall health of enrolled children is improving. Such indicators may include, but are not limited to:

(a) Childhood immunization rates;

(b) Well child care utilization rates, including the use of behavioral and oral health screening, and validated, structured developmental screens using tools, that are consistent with nationally accepted pediatric guidelines and recommended administration schedule, once funding is specifically appropriated for this purpose;

(c) Care management for children with chronic illnesses;

(d) Emergency room utilization;

(e) Visual acuity and eye health;

(f) Preventive oral health service utilization; and

(g) Children's mental health status. In defining these measures the ((~~department~~)) authority shall be guided by the measures provided in RCW 71.36.025.

Performance measures and targets for each performance measure must be established and monitored each biennium, with a goal of achieving measurable, improved health outcomes for the children of Washington state each biennium.

(2) Beginning in calendar year 2009, targeted provider rate increases shall be linked to quality improvement measures established under this section. The ((~~department~~)) authority, in conjunction with those groups identified in subsection (1) of this section, shall develop parameters for determining criteria for increased payment, alternative payment methodologies, or other incentives for those practices and health plans that incorporate evidence-based practice and improve and achieve sustained improvement with respect to the measures.

(3) The department shall provide a report to the governor and the legislature related to provider performance on these measures, beginning in September 2010 for 2007 through 2009 and the authority shall provide the report biennially thereafter. ((~~The department shall advise the legislature as to its progress towards developing this biennial reporting system by September 30, 2009.~~))

Sec. 23. RCW 74.09.490 and 2007 c 359 s 5 are each amended to read as follows:

(1)(((~~(a)~~))) The ((~~department~~)) authority, in consultation with the evidence-based practice institute established in RCW 71.24.061, shall develop and implement policies to improve prescribing practices for treatment of emotional or behavioral disturbances in children, improve the quality of children's mental health therapy through increased use of evidence-based and research-based practices and reduced variation in practice, improve communication and care coordination between primary care and mental health providers, and prioritize care in the family home or care which integrates the family where out-of-home placement is required.

(((~~(b)~~))) (2) The ((~~department~~)) authority shall identify those children with emotional or behavioral disturbances who may be at high risk due to off-label use of prescription medication, use of multiple medications, high medication dosage, or lack of coordination among multiple prescribing providers, and establish one or more mechanisms to evaluate the appropriateness of the medication these children are using, including but not limited to obtaining second opinions from experts in child psychiatry.

(((~~(c)~~))) (3) The ((~~department~~)) authority shall review the psychotropic medications of all children under five and establish one or more mechanisms to evaluate the appropriateness of the medication these children are using, including but not limited to obtaining second opinions from experts in child psychiatry.

(((~~(d)~~))) (4) The ((~~department~~)) authority shall track prescriptive practices with respect to psychotropic medications with the goal of reducing the use of medication.

(((~~(e)~~))) (5) The ((~~department~~)) authority shall encourage the use of cognitive behavioral therapies and other treatments which are empirically supported or evidence-based, in addition to or in the place of prescription medication where appropriate.

((~~(2) The department shall convene a representative group of regional support networks, community mental health centers, and managed health care systems contracting with the department under RCW 74.09.522 to:~~

~~(a) Establish mechanisms and develop contract language that ensures increased coordination of and access to medicaid mental health benefits available to children and their families, including ensuring access to services that are identified as a result of a developmental screen administered through early periodic screening, diagnosis, and treatment;~~

~~(b) Define managed health care system and regional support network contractual performance standards that track access to and utilization of services; and~~

~~(c) Set standards for reducing the number of children that are prescribed antipsychotic drugs and receive no outpatient mental health services with their medication.~~

~~(3) The department shall submit a report on progress and any findings under this section to the legislature by January 1, 2009.~~))

Sec. 24. RCW 74.09.500 and 1979 c 141 s 343 are each amended to read as follows:

There is hereby established a new program of federal-aid assistance to be known as medical assistance to be administered by the ((~~state department of social and health services~~)) authority. The ((~~department of social and health services~~)) authority is authorized to comply with the federal requirements for the medical assistance program provided in the social security act and particularly Title XIX of Public Law (89-97), as amended, in order to secure federal matching funds for such program.

Sec. 25. RCW 74.09.510 and 2010 c 94 s 24 are each amended to read as follows:

Medical assistance may be provided in accordance with eligibility requirements established by the ((~~department~~)) authority, as defined in the social security Title XIX state plan for mandatory categorically needy persons and:

(1) Individuals who would be eligible for cash assistance except for their institutional status;

(2) Individuals who are under twenty-one years of age, who would be eligible for medicaid, but do not qualify as dependent children and who are in (a) foster care, (b) subsidized adoption, (c) a nursing facility or an intermediate care facility for persons with intellectual disabilities, or (d) inpatient psychiatric facilities;

(3) Individuals who:

(a) Are under twenty-one years of age;

(b) On or after July 22, 2007, were in foster care under the legal responsibility of the department or a federally recognized tribe located within the state; and

(c) On their eighteenth birthday, were in foster care under the legal responsibility of the department or a federally recognized tribe located within the state;

(4) Persons who are aged, blind, or disabled who: (a) Receive only a state supplement, or (b) would not be eligible for cash assistance if they were not institutionalized;

(5) Categorically eligible individuals who meet the income and resource requirements of the cash assistance programs;

(6) Individuals who are enrolled in managed health care systems, who have otherwise lost eligibility for medical assistance, but who have not completed a current six-month enrollment in a managed health care system, and who are eligible for federal financial participation under Title XIX of the social security act;

(7) Children and pregnant women allowed by federal statute for whom funding is appropriated;

(8) Working individuals with disabilities authorized under section 1902(a)(10)(A)(ii) of the social security act for whom funding is appropriated;

(9) Other individuals eligible for medical services under RCW 74.09.035 and 74.09.700 for whom federal financial participation is available under Title XIX of the social security act;

(10) Persons allowed by section 1931 of the social security act for whom funding is appropriated; and

(11) Women who: (a) Are under sixty-five years of age; (b) have been screened for breast and cervical cancer under the national breast and cervical cancer early detection program administered by the department of health or tribal entity and have been identified as needing treatment for breast or cervical cancer; and (c) are not otherwise covered by health insurance. Medical assistance provided under this subsection is limited to the period during which the woman requires treatment for breast or cervical cancer, and is subject to any conditions or limitations specified in the omnibus appropriations act.

Sec. 26. RCW 74.09.515 and 2007 c 359 s 8 are each amended to read as follows:

(1) The ((~~department~~)) authority shall adopt rules and policies providing that when youth who were enrolled in a medical assistance program immediately prior to confinement are released from confinement, their medical assistance coverage will be fully reinstated on the day of their release, subject to any expedited review of their continued eligibility for medical assistance coverage that is required under federal or state law.

(2) The ((~~department~~)) authority, in collaboration with the department, county juvenile court administrators, and regional support networks, shall establish procedures for coordination between department field offices, juvenile rehabilitation administration institutions, and county juvenile courts that result in prompt reinstatement of eligibility and speedy eligibility determinations for youth who are likely to be eligible for medical assistance services upon release from confinement. Procedures developed under this subsection must address:

(a) Mechanisms for receiving medical assistance services' applications on behalf of confined youth in anticipation of their release from confinement;

(b) Expeditious review of applications filed by or on behalf of confined youth and, to the extent practicable, completion of the review before the youth is released; and

(c) Mechanisms for providing medical assistance services' identity cards to youth eligible for medical assistance services immediately upon their release from confinement.

(3) For purposes of this section, "confined" or "confinement" means detained in a facility operated by or under contract with the department of social and health services, juvenile rehabilitation administration, or detained in a juvenile detention facility operated under chapter 13.04 RCW.

(4) The ((~~department~~)) authority shall adopt standardized statewide screening and application practices and forms designed to facilitate the application of a confined youth who is likely to be eligible for a medical assistance program.

Sec. 27. RCW 74.09.520 and 2007 c 3 s 1 are each amended to read as follows:

(1) The term "medical assistance" may include the following care and services subject to rules adopted by the authority or department: (a) Inpatient hospital services; (b) outpatient hospital services; (c) other laboratory and X- ray services; (d) nursing facility services; (e) physicians' services, which shall include prescribed medication and instruction on birth control devices; (f) medical care, or any other type of remedial care as may be established by the secretary or director; (g) home health care services; (h) private duty nursing services; (i) dental services; (j) physical and occupational therapy and related services; (k) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (l) personal care services, as provided in this section; (m) hospice services; (n) other diagnostic, screening, preventive, and rehabilitative services; and (o) like services when furnished to a child by a school district in a manner consistent with the requirements of this chapter. For the purposes of this section, neither the authority nor the department may ((~~not~~)) cut off any prescription medications, oxygen supplies, respiratory services, or other life-sustaining medical services or supplies.

"Medical assistance," notwithstanding any other provision of law, shall not include routine foot care, or dental services delivered by any health care provider, that are not mandated by Title XIX of the social security act unless there is a specific appropriation for these services.

(2) ((~~The department shall amend the state plan for medical assistance under Title XIX of the federal social security act to include personal care services, as defined in 42 C.F.R. 440.170(f), in the categorically needy program.~~

~~(3)~~)) The department shall adopt, amend, or rescind such administrative rules as are necessary to ensure that Title XIX personal care services are provided to eligible persons in conformance with federal regulations.

(a) These administrative rules shall include financial eligibility indexed according to the requirements of the social security act providing for medicaid eligibility.

(b) The rules shall require clients be assessed as having a medical condition requiring assistance with personal care tasks. Plans of care for clients requiring health-related consultation for assessment and service planning may be reviewed by a nurse.

(c) The department shall determine by rule which clients have a health-related assessment or service planning need requiring registered nurse consultation or review. This definition may include clients that meet indicators or protocols for review, consultation, or visit.

(((~~(4)~~))) (3) The department shall design and implement a means to assess the level of functional disability of persons eligible for personal care services under this section. The personal care services benefit shall be provided to the extent funding is available according to the assessed level of functional disability. Any reductions in services made necessary for funding reasons should be accomplished in a manner that assures that priority for maintaining services is given to persons with the greatest need as determined by the assessment of functional disability.

(((~~(5)~~))) (4) Effective July 1, 1989, the ((~~department~~)) authority shall offer hospice services in accordance with available funds.

(((~~(6)~~))) (5) For Title XIX personal care services administered by aging and disability services administration of the department, the department shall contract with area agencies on aging:

(a) To provide case management services to individuals receiving Title XIX personal care services in their own home; and

(b) To reassess and reauthorize Title XIX personal care services or other home and community services as defined in RCW 74.39A.009 in home or in other settings for individuals consistent with the intent of this section:

(i) Who have been initially authorized by the department to receive Title XIX personal care services or other home and community services as defined in RCW 74.39A.009; and

(ii) Who, at the time of reassessment and reauthorization, are receiving such services in their own home.

(((~~(7)~~))) (6) In the event that an area agency on aging is unwilling to enter into or satisfactorily fulfill a contract or an individual consumer's need for case management services will be met through an alternative delivery system, the department is authorized to:

(a) Obtain the services through competitive bid; and

(b) Provide the services directly until a qualified contractor can be found.

(((~~(8)~~))) (7) Subject to the availability of amounts appropriated for this specific purpose, ((~~effective July 1, 2007,~~)) the ((~~department~~)) authority may offer medicare part D prescription drug copayment coverage to full benefit dual eligible beneficiaries.

Sec. 28. RCW 74.09.521 and 2009 c 388 s 1 are each amended to read as follows:

(1) To the extent that funds are specifically appropriated for this purpose the ((~~department~~)) authority shall revise its medicaid healthy options managed care and fee-for-service program standards under medicaid, Title XIX of the federal social security act to improve access to mental health services for children who do not meet the regional support network access to care standards. ((~~Effective July 1, 2008, the~~)) The program standards shall be revised to allow outpatient therapy services to be provided by licensed mental health professionals, as defined in RCW 71.34.020, or by a mental health professional regulated under Title 18 RCW who is under the direct supervision of a licensed mental health professional, and up to twenty outpatient therapy hours per calendar year, including family therapy visits integral to a child's treatment. This section shall be administered in a manner consistent with federal early and periodic screening, diagnosis, and treatment requirements related to the receipt of medically necessary services when a child's need for such services is identified through developmental screening.

(2) The ((~~department~~)) authority and the children's mental health evidence-based practice institute established in RCW 71.24.061 shall collaborate to encourage and develop incentives for the use of prescribing practices and evidence-based and research-based treatment practices developed under RCW 74.09.490 by mental health professionals serving children under this section.

Sec. 29. RCW 74.09.522 and 1997 c 59 s 15 and 1997 c 34 s 1 are each reenacted and amended to read as follows:

(1) For the purposes of this section, "managed health care system" means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, health insuring organizations, or any combination thereof, that provides directly or by contract health care services covered under RCW 74.09.520 and rendered by licensed providers, on a prepaid capitated basis and that meets the requirements of section 1903(m)(1)(A) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act.

(2) The ((~~department of social and health services~~)) authority shall enter into agreements with managed health care systems to provide health care services to recipients of temporary assistance for needy families under the following conditions:

(a) Agreements shall be made for at least thirty thousand recipients statewide;

(b) Agreements in at least one county shall include enrollment of all recipients of temporary assistance for needy families;

(c) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act or federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act, recipients shall have a choice of systems in which to enroll and shall have the right to terminate their enrollment in a system: PROVIDED, That the ((~~department~~)) authority may limit recipient termination of enrollment without cause to the first month of a period of enrollment, which period shall not exceed twelve months: AND PROVIDED FURTHER, That the ((~~department~~)) authority shall not restrict a recipient's right to terminate enrollment in a system for good cause as established by the ((~~department~~)) authority by rule;

(d) To the extent that this provision is consistent with section 1903(m) of Title XIX of the federal social security act, participating managed health care systems shall not enroll a disproportionate number of medical assistance recipients within the total numbers of persons served by the managed health care systems, except as authorized by the ((~~department~~)) authority under federal demonstration waivers granted under section 1115(a) of Title XI of the federal social security act;

(e) In negotiating with managed health care systems the ((~~department~~)) authority shall adopt a uniform procedure to negotiate and enter into contractual arrangements, including standards regarding the quality of services to be provided; and financial integrity of the responding system;

(f) The ((~~department~~)) authority shall seek waivers from federal requirements as necessary to implement this chapter;

(g) The ((~~department~~)) authority shall, wherever possible, enter into prepaid capitation contracts that include inpatient care. However, if this is not possible or feasible, the ((~~department~~)) authority may enter into prepaid capitation contracts that do not include inpatient care;

(h) The ((~~department~~)) authority shall define those circumstances under which a managed health care system is

responsible for out-of-plan services and assure that recipients shall not be charged for such services; and

(i) Nothing in this section prevents the ((~~department~~)) authority from entering into similar agreements for other groups of people eligible to receive services under this chapter.

(3) The ((~~department~~)) authority shall ensure that publicly supported community health centers and providers in rural areas, who show serious intent and apparent capability to participate as managed health care systems are seriously considered as contractors. The ((~~department~~)) authority shall coordinate its managed care activities with activities under chapter 70.47 RCW.

(4) The ((~~department~~)) authority shall work jointly with the state of Oregon and other states in this geographical region in order to develop recommendations to be presented to the appropriate federal agencies and the United States congress for improving health care of the poor, while controlling related costs.

(5) The legislature finds that competition in the managed health care marketplace is enhanced, in the long term, by the existence of a large number of managed health care system options for medicaid clients. In a managed care delivery system, whose goal is to focus on prevention, primary care, and improved enrollee health status, continuity in care relationships is of substantial importance, and disruption to clients and health care providers should be minimized. To help ensure these goals are met, the following principles shall guide the ((~~department~~)) authority in its healthy options managed health care purchasing efforts:

(a) All managed health care systems should have an opportunity to contract with the ((~~department~~)) authority to the extent that minimum contracting requirements defined by the ((~~department~~)) authority are met, at payment rates that enable the ((~~department~~)) authority to operate as far below appropriated spending levels as possible, consistent with the principles established in this section.

(b) Managed health care systems should compete for the award of contracts and assignment of medicaid beneficiaries who do not voluntarily select a contracting system, based upon:

(i) Demonstrated commitment to or experience in serving low-income populations;

(ii) Quality of services provided to enrollees;

(iii) Accessibility, including appropriate utilization, of services offered to enrollees;

(iv) Demonstrated capability to perform contracted services, including ability to supply an adequate provider network;

(v) Payment rates; and

(vi) The ability to meet other specifically defined contract requirements established by the ((~~department~~)) authority, including consideration of past and current performance and participation in other state or federal health programs as a contractor.

(c) Consideration should be given to using multiple year contracting periods.

(d) Quality, accessibility, and demonstrated commitment to serving low-income populations shall be given significant weight in the contracting, evaluation, and assignment process.

(e) All contractors that are regulated health carriers must meet state minimum net worth requirements as defined in applicable state laws. The ((~~department~~)) authority shall adopt rules establishing the minimum net worth requirements for contractors that are not regulated health carriers. This subsection does not limit the authority of the ((~~department~~)) Washington state health care authority to take action under a contract upon finding that a contractor's financial status seriously jeopardizes the contractor's ability to meet its contract obligations.

(f) Procedures for resolution of disputes between the ((~~department~~)) authority and contract bidders or the ((~~department~~)) authority and contracting carriers related to the award of, or failure to award, a managed care contract must be clearly set out in the procurement document. ((~~In designing such procedures, the department shall give strong consideration to the negotiation and dispute resolution processes used by the Washington state health care authority in its managed health care contracting activities.~~))

(6) The ((~~department~~)) authority may apply the principles set forth in subsection (5) of this section to its managed health care purchasing efforts on behalf of clients receiving supplemental security income benefits to the extent appropriate.

Sec. 30. RCW 74.09.5222 and 2009 c 545 s 4 are each amended to read as follows:

(1) The ((~~department~~)) authority shall submit a section 1115 demonstration waiver request to the federal department of health and human services to expand and revise the medical assistance program as codified in Title XIX of the federal social security act. The waiver request should be designed to ensure the broadest federal financial participation under Title XIX and XXI of the federal social security act. To the extent permitted under federal law, the waiver request should include the following components:

(a) Establishment of a single eligibility standard for low-income persons, including expansion of categorical eligibility to include childless adults. The ((~~department~~)) authority shall request that the single eligibility standard be phased in such that incremental steps are taken to cover additional low-income parents and individuals over time, with the goal of offering coverage to persons with household income at or below two hundred percent of the federal poverty level;

(b) Establishment of a single seamless application and eligibility determination system for all state low-income medical programs included in the waiver. Applications may be electronic and may include an electronic signature for verification and authentication. Eligibility determinations should maximize federal financing where possible;

(c) The delivery of all low-income coverage programs as a single program, with a common core benefit package that may be similar to the basic health benefit package or an alternative benefit package approved by the secretary of the federal department of health and human services, including the option of supplemental coverage for select categorical groups, such as children, and individuals who are aged, blind, and disabled;

(d) A program design to include creative and innovative approaches such as: Coverage for preventive services with incentives to use appropriate preventive care; enhanced medical home reimbursement and bundled payment methodologies; cost-sharing options; use of care management and care coordination programs to improve coordination of medical and behavioral health services; application of an innovative predictive risk model to better target care management services; and mandatory enrollment in managed care, as may be necessary;

(e) The ability to impose enrollment limits or benefit design changes for eligibility groups that were not eligible under the Title XIX state plan in effect on the date of submission of the waiver application;

(f) A premium assistance program whereby employers can participate in coverage options for employees and dependents of employees otherwise eligible under the waiver. The waiver should make every effort to maximize enrollment in employer-sponsored health insurance when it is cost-effective for the state to do so, and the purchase is consistent with the requirements of Titles XIX and XXI of the federal social security act. To the extent allowable under federal law, the ((~~department~~)) authority shall require enrollment in available employer-sponsored coverage as a condition of eligibility for coverage under the waiver; and

(g) The ability to share savings that might accrue to the federal medicare program, Title XVIII of the federal social security act, from improved care management for persons who are eligible for both medicare and medicaid. Through the waiver application process, the ((~~department~~)) authority shall determine whether the

state could serve, directly or by contract, as a medicare special needs plan for persons eligible for both medicare and medicaid.

(2) The ((~~department~~)) authority shall hold ongoing stakeholder discussions as it is developing the waiver request, and provide opportunities for public review and comment as the request is being developed.

(3) The ((~~department and the health care~~)) authority shall identify statutory changes that may be necessary to ensure successful and timely implementation of the waiver request as submitted to the federal department of health and human services as the apple health program for adults.

(4) The legislature must authorize implementation of any waiver approved by the federal department of health and human services under this section.

Sec. 31. RCW 74.09.5225 and 2005 c 383 s 1 are each amended to read as follows:

(1) Payments for recipients eligible for medical assistance programs under this chapter for services provided by hospitals, regardless of the beneficiary's managed care enrollment status, shall be made based on allowable costs incurred during the year, when services are provided by a rural hospital certified by the centers for medicare and medicaid services as a critical access hospital. Any additional payments made by the ((~~medical assistance administration~~)) authority for the healthy options program shall be no more than the additional amounts per service paid under this section for other medical assistance programs.

(2) Beginning on July 24, 2005, a moratorium shall be placed on additional hospital participation in critical access hospital payments under this section. However, rural hospitals that applied for certification to the centers for medicare and medicaid services prior to January 1, 2005, but have not yet completed the process or have not yet been approved for certification, remain eligible for medical assistance payments under this section.

Sec. 32. RCW 74.09.530 and 2007 c 315 s 2 are each amended to read as follows:

(1)(a) The authority is designated as the single state agency for purposes of Title XIX of the federal social security act.

(b) The amount and nature of medical assistance and the determination of eligibility of recipients for medical assistance shall be the responsibility of the ((~~department of social and health services~~)) authority.

(c) The ((~~department~~)) authority shall establish reasonable standards of assistance and resource and income exemptions which shall be consistent with the provisions of the social security act and ((~~with the~~)) federal regulations ((~~of the secretary of health, education and welfare~~)) for determining eligibility of individuals for medical assistance and the extent of such assistance to the extent that funds are available from the state and federal government. The ((~~department~~)) authority shall not consider resources in determining continuing eligibility for recipients eligible under section 1931 of the social security act.

(d) The authority is authorized to collaborate with other state or local agencies and nonprofit organizations in carrying out its duties under this chapter and, to the extent appropriate, may enter into agreements with such other entities.

(2) Individuals eligible for medical assistance under RCW 74.09.510(3) shall be transitioned into coverage under that subsection immediately upon their termination from coverage under RCW 74.09.510(2)(a). The ((~~department~~)) authority shall use income eligibility standards and eligibility determinations applicable to children placed in foster care. The ((~~department, in consultation with the health care~~)) authority((~~,~~)) shall provide information regarding basic health plan enrollment and shall offer assistance with the application and enrollment process to individuals covered under RCW 74.09.510(3) who are approaching their twenty-first birthday.

Sec. 33. RCW 74.09.540 and 2001 2nd sp.s. c 15 s 2 are each amended to read as follows:

(1) It is the intent of the legislature to remove barriers to employment for individuals with disabilities by providing medical assistance to ((~~the~~)) working ((~~disabled~~)) individuals with disabilities through a buy-in program in accordance with section 1902(a)(10)(A)(ii) of the social security act and eligibility and cost-sharing requirements established by the ((~~department~~)) authority.

(2) The ((~~department~~)) authority shall establish income, resource, and cost-sharing requirements for the buy-in program in accordance with federal law and any conditions or limitations specified in the omnibus appropriations act. The ((~~department~~)) authority shall establish and modify eligibility and cost-sharing requirements in order to administer the program within available funds. The ((~~department~~)) authority shall make every effort to coordinate benefits with employer-sponsored coverage available to the working ((~~disabled~~)) individuals with disabilities receiving benefits under this chapter.

Sec. 34. RCW 74.09.555 and 2010 1st sp.s. c 8 s 30 are each amended to read as follows:

(1) The ((~~department~~)) authority shall adopt rules and policies providing that when persons with a mental disorder, who were enrolled in medical assistance immediately prior to confinement, are released from confinement, their medical assistance coverage will be fully reinstated on the day of their release, subject to any expedited review of their continued eligibility for medical assistance coverage that is required under federal or state law.

(2) The ((~~department~~)) authority, in collaboration with the Washington association of sheriffs and police chiefs, the department of corrections, and the regional support networks, shall establish procedures for coordination between the authority and department field offices, institutions for mental disease, and correctional institutions, as defined in RCW 9.94.049, that result in prompt reinstatement of eligibility and speedy eligibility determinations for persons who are likely to be eligible for medical assistance services upon release from confinement. Procedures developed under this subsection must address:

(a) Mechanisms for receiving medical assistance services applications on behalf of confined persons in anticipation of their release from confinement;

(b) Expeditious review of applications filed by or on behalf of confined persons and, to the extent practicable, completion of the review before the person is released;

(c) Mechanisms for providing medical assistance services identity cards to persons eligible for medical assistance services immediately upon their release from confinement; and

(d) Coordination with the federal social security administration, through interagency agreements or otherwise, to expedite processing of applications for federal supplemental security income or social security disability benefits, including federal acceptance of applications on behalf of confined persons.

(3) Where medical or psychiatric examinations during a person's confinement indicate that the person is disabled, the correctional institution or institution for mental diseases shall provide the ((~~department~~)) authority with that information for purposes of making medical assistance eligibility and enrollment determinations prior to the person's release from confinement. The ((~~department~~)) authority shall, to the maximum extent permitted by federal law, use the examination in making its determination whether the person is disabled and eligible for medical assistance.

(4) For purposes of this section, "confined" or "confinement" means incarcerated in a correctional institution, as defined in RCW

9.94.049, or admitted to an institute for mental disease, as defined in 42 C.F.R. part 435, Sec. 1009 on July 24, 2005.

(5) For purposes of this section, "likely to be eligible" means that a person:

(a) Was enrolled in medicaid or supplemental security income or the disability lifeline program immediately before he or she was confined and his or her enrollment was terminated during his or her confinement; or

(b) Was enrolled in medicaid or supplemental security income or the disability lifeline program at any time during the five years before his or her confinement, and medical or psychiatric examinations during the person's confinement indicate that the person continues to be disabled and the disability is likely to last at least twelve months following release.

(6) The economic services administration within the department shall adopt standardized statewide screening and application practices and forms designed to facilitate the application of a confined person who is likely to be eligible for medicaid.

Sec. 35. RCW 74.09.565 and 1989 c 87 s 4 are each amended to read as follows:

(1) An agreement between spouses transferring or assigning rights to future income from one spouse to the other shall be invalid for purposes of determining eligibility for medical assistance or the limited casualty program for the medically needy, but this subsection does not affect agreements between spouses transferring or assigning resources, and income produced by transferred or assigned resources shall continue to be recognized as the separate income of the transferee.

(2) In determining eligibility for medical assistance or the limited casualty program for the medically needy for a married person in need of institutional care, or care under home and community-based waivers as defined in Title XIX of the social security act, if the community income received in the name of the nonapplicant spouse exceeds the community income received in the name of the applicant spouse, the applicant's interest in that excess shall be considered unavailable to the applicant.

(3) The department or authority, as appropriate, shall adopt rules consistent with the provisions of section 1924 of the social security act entitled "Treatment of Income and Resources for Certain Institutionalized Spouses," in determining the allocation of income between an institutionalized and community spouse.

(4) The department or authority, as appropriate, shall establish the monthly maintenance needs allowance for the community spouse up to the maximum amount allowed by state appropriation or within available funds and permitted in section 1924 of the social security act. The total monthly needs allowance shall not exceed one thousand five hundred dollars, subject to adjustment provided in section 1924 of the social security act.

Sec. 36. RCW 74.09.575 and 2003 1st sp.s. c 28 s 1 are each amended to read as follows:

(1) The department or authority, as appropriate, shall promulgate rules consistent with the treatment of resources provisions of section 1924 of the social security act ((~~entitled "Treatment of Income and Resources for Certain Institutionalized Spouses,"~~)) in determining the allocation of resources between the institutionalized and community spouse.

(2) In the interest of supporting the community spouse the department or authority, as appropriate, shall allow the maximum resource allowance amount permissible under the social security act for the community spouse for persons institutionalized before August 1, 2003.

(3) For persons institutionalized on or after August 1, 2003, the department or authority, as appropriate, in the interest of supporting the community spouse, shall allow up to a maximum of forty thousand dollars in resources for the community spouse. For the fiscal biennium beginning July 1, 2005, and each fiscal biennium thereafter, the maximum resource allowance amount for the community spouse shall be adjusted for economic trends and conditions by increasing the amount allowable by the consumer price index as published by the federal bureau of labor statistics. However, in no case shall the amount allowable exceed the maximum resource allowance permissible under the social security act.

Sec. 37. RCW 74.09.585 and 1995 1st sp.s. c 18 s 81 are each amended to read as follows:

(1) The department or authority, as appropriate, shall establish standards consistent with section 1917 of the social security act in determining the period of ineligibility for medical assistance due to the transfer of resources.

(2) There shall be no penalty imposed for the transfer of assets that are excluded in a determination of the individual's eligibility for medicaid to the extent such assets are protected by the long-term care insurance policy or contract pursuant to chapter 48.85 RCW.

(3) The department or authority, as appropriate, may waive a period of ineligibility if the department or authority determines that denial of eligibility would work an undue hardship.

Sec. 38. RCW 74.09.595 and 1989 c 87 s 8 are each amended to read as follows:

The department or authority, as appropriate, shall in compliance with section 1924 of the social security act adopt procedures which provide due process for institutionalized or community spouses who request a fair hearing as to the valuation of resources, the amount of the community spouse resource allowance, or the monthly maintenance needs allowance.

Sec. 39. RCW 74.09.655 and 2008 c 245 s 1 are each amended to read as follows:

The ((~~department~~)) authority shall provide coverage under this chapter for smoking cessation counseling services, as well as prescription and nonprescription agents when used to promote smoking cessation, so long as such agents otherwise meet the definition of "covered outpatient drug" in 42 U.S.C. Sec. 1396r-8(k). However, the ((~~department~~)) authority may initiate an individualized inquiry and determine and implement by rule appropriate coverage limitations as may be required to encourage the use of effective, evidence-based services and prescription and nonprescription agents. The ((~~department~~)) authority shall track per-capita expenditures for a cohort of clients that receive smoking cessation benefits, and submit a cost-benefit analysis to the legislature on or before January 1, 2012.

Sec. 40. RCW 74.09.658 and 2009 c 326 s 1 are each amended to read as follows:

(1) The home health program shall require registered nurse oversight and intervention, as appropriate. In-person contact between a home health care registered nurse and a patient is not required under the state's medical assistance program for home health services that are: (a) Delivered with the assistance of telemedicine and (b) otherwise eligible for reimbursement as a medically necessary skilled home health nursing visit under the program.

(2) The department or authority, as appropriate, in consultation with home health care service providers shall develop reimbursement rules and, in rule, define the requirements that must be met for a reimbursable skilled nursing visit when services are rendered without a face-to-face visit and are assisted by telemedicine.

(3)(a) The department or authority, as appropriate, shall establish the reimbursement rate for skilled home health nursing services delivered with the assistance of telemedicine that meet the requirements of a reimbursable visit as defined by the department or authority, as appropriate.

(b) Reimbursement is not provided for purchase or lease of telemedicine equipment.

(4) Any home health agency licensed under chapter 70.127 RCW and eligible for reimbursement under the medical programs authorized under this chapter may be reimbursed for services under this section if the service meets the requirements for a reimbursable skilled nursing visit ((~~as defined by the department~~)).

(5) Nothing in this section shall be construed to alter the scope of practice of any home health care services provider or authorizes the delivery of home health care services in a setting or manner not otherwise authorized by law.

(6) The use of telemedicine is not intended to replace registered nurse health care ((~~visit[s]~~)) visits when necessary.

(7) For the purposes of this section, "telemedicine" means the use of telemonitoring to enhance the delivery of certain home health medical services through:

(a) The provision of certain education related to health care services using audio, video, or data communication instead of a face-to-face visit; or

(b) The collection of clinical data and the transmission of such data between a patient at a distant location and the home health provider through electronic processing technologies. Objective clinical data that may be transmitted includes, but is not limited to, weight, blood pressure, pulse, respirations, blood glucose, and pulse oximetry.

Sec. 41. RCW 74.09.659 and 2009 c 545 s 5 are each amended to read as follows:

(1) The ((~~department~~)) authority shall continue to submit applications for the family planning waiver program.

(2) The ((~~department~~)) authority shall submit a request to the federal department of health and human services to amend the current family planning waiver program as follows:

(a) Provide coverage for sexually transmitted disease testing and treatment;

(b) Return to the eligibility standards used in 2005 including, but not limited to, citizenship determination based on declaration or matching with federal social security databases, insurance eligibility standards comparable to 2005, and confidential service availability for minors and survivors of domestic and sexual violence; and

(c) Within available funds, increase income eligibility to two hundred fifty percent of the federal poverty level, to correspond with income eligibility for publicly funded maternity care services.

Sec. 42. RCW 74.09.700 and 2010 c 94 s 25 are each amended to read as follows:

(1) To the extent of available funds and subject to any conditions placed on appropriations made for this purpose, medical care may be provided under the limited casualty program to persons not ((~~otherwise~~)) eligible for medical assistance or medical care services who are medically needy as defined in the social security Title XIX state plan and medical indigents in accordance with eligibility requirements established by the ((~~department~~)) authority. The eligibility requirements may include minimum levels of incurred medical expenses. This includes residents of nursing facilities, residents of intermediate care facilities for persons with intellectual disabilities, and individuals who are otherwise eligible for section 1915(c) of the federal social security act home and community-based waiver services, administered by the department ((~~of social and health services aging and adult services administration,~~)) who are aged, blind, or disabled as defined in Title XVI of the federal social security act and whose income exceeds three hundred percent of the federal supplement security income benefit level.

(2) Determination of the amount, scope, and duration of medical coverage under the limited casualty program shall be the responsibility of the ((~~department~~)) authority, subject to the following:

(a) Only the following services may be covered:

(i) For persons who are medically needy as defined in the social security Title XIX state plan: Inpatient and outpatient hospital services, and home and community-based waiver services;

(ii) For persons who are medically needy as defined in the social security Title XIX state plan, and for persons who are medical indigents under the eligibility requirements established by the ((~~department~~)) authority: Rural health clinic services; physicians' and clinic services; prescribed drugs, dentures, prosthetic devices, and eyeglasses; nursing facility services; and intermediate care facility services for persons with intellectual disabilities; home health services; hospice services; other laboratory and X-ray services; rehabilitative services, including occupational therapy; medically necessary transportation; and other services for which funds are specifically provided in the omnibus appropriations act;

(b) Medical care services provided to the medically indigent and received no more than seven days prior to the date of application shall be retroactively certified and approved for payment on behalf of a person who was otherwise eligible at the time the medical services were furnished: PROVIDED, That eligible persons who fail to apply within the seven-day time period for medical reasons or other good cause may be retroactively certified and approved for payment.

(3) The ((~~department~~)) authority shall establish standards of assistance and resource and income exemptions. All nonexempt income and resources of limited casualty program recipients shall be applied against the cost of their medical care services.

Sec. 43. RCW 74.09.710 and 2007 c 259 s 4 are each amended to read as follows:

(1) The ((~~department of social and health services~~)) authority, in collaboration with the department of health and the department of social and health services, shall:

(a) Design and implement medical homes for its aged, blind, and disabled clients in conjunction with chronic care management programs to improve health outcomes, access, and cost-effectiveness. Programs must be evidence based, facilitating the use of information technology to improve quality of care, must acknowledge the role of primary care providers and include financial and other supports to enable these providers to effectively carry out their role in chronic care management, and must improve coordination of primary, acute, and long-term care for those clients with multiple chronic conditions. The ((~~department~~)) authority shall consider expansion of existing medical home and chronic care management programs and build on the Washington state collaborative initiative. The ((~~department~~)) authority shall use best practices in identifying those clients best served under a chronic care management model using predictive modeling through claims or other health risk information; and

(b) Evaluate the effectiveness of current chronic care management efforts in the ((~~health and recovery services administration and the aging and disability services administration~~)) authority and the department, comparison to best practices, and recommendations for future efforts and organizational structure to improve chronic care management.

(2) For purposes of this section:

(a) "Medical home" means a site of care that provides comprehensive preventive and coordinated care centered on the patient needs and assures high quality, accessible, and efficient care.

(b) "Chronic care management" means the ((~~department's~~)) authority's program that provides care management and coordination activities for medical assistance clients determined to be at risk for high medical costs. "Chronic care management" provides education and training and/or coordination that assist program participants in improving self-management skills to improve health outcomes and reduce medical costs by educating clients to better utilize services.

Sec. 44. RCW 74.09.715 and 2008 c 146 s 13 are each amended to read as follows:

Within funds appropriated for this purpose, the ((~~department~~)) authority shall establish two dental access projects to serve seniors and other adults who are categorically needy blind or disabled. The projects shall provide:

(1) Enhanced reimbursement rates for certified dentists for specific procedures, to begin no sooner than July 1, 2009;

(2) Reimbursement for trained medical providers for preventive oral health services, to begin no sooner than July 1, 2009;

(3) Training, development, and implementation through a partnership with the University of Washington school of dentistry;

(4) Local program coordination including outreach and case management; and

(5) An evaluation that measures the change in utilization rates and cost savings.

Sec. 45. RCW 74.09.720 and 1983 c 194 s 26 are each amended to read as follows:

(1) A prevention of blindness program is hereby established in the ((~~department of social and health services~~)) authority to provide prompt, specialized medical eye care, including assistance with costs when necessary, for conditions in which sight is endangered or sight can be restored or significantly improved. The ((~~department of social and health services~~)) authority shall adopt rules concerning program eligibility, levels of assistance, and the scope of services.

(2) The ((~~department of social and health services~~)) authority shall employ on a part-time basis an ophthalmological and/or an optometrical consultant to provide liaison with participating eye physicians and to review medical recommendations made by an applicant's eye physician to determine whether the proposed services meet program standards.

(3) The ((~~department of social and health services~~)) authority and the department of services for the blind shall formulate a cooperative agreement concerning referral of clients between the two agencies and the coordination of policies and services.

Sec. 46. RCW 74.09.725 and 2006 c 367 s 8 are each amended to read as follows:

((~~The department~~)) The authority shall provide coverage for prostate cancer screening under this chapter, provided that the screening is delivered upon the recommendation of the patient's physician, advanced registered nurse practitioner, or physician assistant.

Sec. 47. RCW 74.09.730 and 2009 c 538 s 1 are each amended to read as follows:

In establishing Title XIX payments for inpatient hospital services:

(1) To the extent funds are appropriated specifically for this purpose, and subject to any conditions placed on appropriations made for this purpose, the ((~~department of social and health services~~)) authority shall provide a disproportionate share hospital adjustment considering the following components:

(a) A low-income care component based on a hospital's medicaid utilization rate, its low-income utilization rate, its provision of obstetric services, and other factors authorized by federal law;

(b) A medical indigency care component based on a hospital's services to persons who are medically indigent; and

(c) A state-only component, to be paid from available state funds to hospitals that do not qualify for federal payments under (b) of this subsection, based on a hospital's services to persons who are medically indigent;

(2) The payment methodology for disproportionate share hospitals shall be specified by the ((~~department~~)) authority in regulation.

(3) Nothing in this section shall be construed as a right or an entitlement by any hospital to any payment from the authority.

Sec. 48. RCW 74.09.770 and 1989 1st ex.s. c 10 s 2 are each amended to read as follows:

(1) The legislature finds that Washington state and the nation as a whole have a high rate of infant illness and death compared with other industrialized nations. This is especially true for minority and low-income populations. Premature and low weight births have been directly linked to infant illness and death. The availability of adequate maternity care throughout the course of pregnancy has been identified as a major factor in reducing infant illness and death. Further, the investment in preventive health care programs, such as maternity care, contributes to the growth of a healthy and productive society and is a sound approach to health care cost containment. The legislature further finds that access to maternity care for low-income women in the state of Washington has declined significantly in recent years and has reached a crisis level.

(2) It is the purpose of this ((~~chapter [subchapter]~~)) subchapter to provide, consistent with appropriated funds, maternity care necessary to ensure healthy birth outcomes for low-income families. To this end, a maternity care access system is established based on the following principles:

(a) The family is the fundamental unit in our society and should be supported through public policy.

(b) Access to maternity care for eligible persons to ensure healthy birth outcomes should be made readily available in an expeditious manner through a single service entry point.

(c) Unnecessary barriers to maternity care for eligible persons should be removed.

(d) Access to preventive and other health care services should be available for low-income children.

(e) Each woman should be encouraged to and assisted in making her own informed decisions about her maternity care.

(f) Unnecessary barriers to the provision of maternity care by qualified health professionals should be removed.

(g) The system should be sensitive to cultural differences among eligible persons.

(h) To the extent possible, decisions about the scope, content, and delivery of services should be made at the local level involving a broad representation of community interests.

(i) The maternity care access system should be evaluated at appropriate intervals to determine effectiveness and need for modification.

(j) Maternity care services should be delivered in a cost-effective manner.

Sec. 49. RCW 74.09.790 and 1993 c 407 s 9 are each amended to read as follows:

Unless the context clearly requires otherwise, the definitions in this section apply throughout RCW 74.09.760 through 74.09.820 and 74.09.510:

(1) "At-risk eligible person" means an eligible person determined by the ((~~department~~)) authority to need special assistance in applying for and obtaining maternity care, including pregnant women who are substance abusers, pregnant and parenting adolescents, pregnant minority women, and other eligible persons who need special assistance in gaining access to the maternity care system.

(2) "County authority" means the board of county commissioners, county council, or county executive having the authority to participate in the maternity care access program or its designee. Two or more county authorities may enter into joint agreements to fulfill the requirements of this chapter.

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

(4) "Eligible person" means a woman in need of maternity care or a child, who is eligible for medical assistance pursuant to this chapter or the prenatal care program administered by the ((~~department~~)) authority.

(5) "Maternity care services" means inpatient and outpatient medical care, case management, and support services necessary during prenatal, delivery, and postpartum periods.

(6) "Support services" means, at least, public health nursing assessment and follow-up, health and childbirth education, psychological assessment and counseling, outreach services, nutritional assessment and counseling, needed vitamin and nonprescriptive drugs, transportation, family planning services, and child care. Support services may include alcohol and substance abuse treatment for pregnant women who are addicted or at risk of being addicted to alcohol or drugs to the extent funds are made available for that purpose.

(7) "Family planning services" means planning the number of one's children by use of contraceptive techniques.

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

Sec. 50. RCW 74.09.800 and 1993 c 407 s 10 are each amended to read as follows:

The ((~~department~~)) authority shall, consistent with the state budget act, develop a maternity care access program designed to ensure healthy birth outcomes as follows:

(1) Provide maternity care services to low-income pregnant women and health care services to children in poverty to the maximum extent allowable under the medical assistance program, Title XIX of the federal social security act;

(2) Provide maternity care services to low-income women who are not eligible to receive such services under the medical assistance program, Title XIX of the federal social security act;

(3) ((~~By January 1, 1990,~~)) Have the following procedures in place to improve access to maternity care services and eligibility determinations for pregnant women applying for maternity care services under the medical assistance program, Title XIX of the federal social security act:

(a) Use of a shortened and simplified application form;

(b) Outstationing ((~~department~~)) authority staff to make eligibility determinations;

(c) Establishing local plans at the county and regional level, coordinated by the ((~~department~~)) authority; and

(d) Conducting an interview for the purpose of determining medical assistance eligibility within five working days of the date of an application by a pregnant woman and making an eligibility determination within fifteen working days of the date of application by a pregnant woman;

(4) Establish a maternity care case management system that shall assist at-risk eligible persons with obtaining medical assistance benefits and receiving maternity care services, including transportation and child care services;

(5) Within available resources, establish appropriate reimbursement levels for maternity care providers;

(6) Implement a broad-based public education program that stresses the importance of obtaining maternity care early during pregnancy;

(7) Refer persons eligible for maternity care services under the program established by this section to persons, agencies, or organizations with maternity care service practices that primarily emphasize healthy birth outcomes;

(8) Provide family planning services including information about the synthetic progestin capsule implant form of contraception, for twelve months immediately following a pregnancy to women who were eligible for medical assistance under the maternity care access program during that pregnancy or who were eligible only for emergency labor and delivery services during that pregnancy; and

(9) Within available resources, provide family planning services to women who meet the financial eligibility requirements for services under subsections (1) and (2) of this section.

Sec. 51. RCW 74.09.810 and 1989 1st ex.s. c 10 s 6 are each amended to read as follows:

(1) The ((~~department~~)) authority shall establish an alternative maternity care service delivery system, if it determines that a county or a group of counties is a maternity care distressed area. A maternity care distressed area shall be defined by the ((~~department~~)) authority, in rule, as a county or a group of counties where eligible women are unable to obtain adequate maternity care. The ((~~department~~)) authority shall include the following factors in its determination:

(a) Higher than average percentage of eligible persons in the distressed area who receive late or no prenatal care;

(b) Higher than average percentage of eligible persons in the distressed area who go out of the area to receive maternity care;

(c) Lower than average percentage of obstetrical care providers in the distressed area who provide care to eligible persons;

(d) Higher than average percentage of infants born to eligible persons per obstetrical care provider in the distressed area; and

(e) Higher than average percentage of infants that are of low birth weight, five and one-half pounds or two thousand five hundred grams, born to eligible persons in the distressed area.

(2) If the ((~~department~~)) authority determines that a maternity care distressed area exists, it shall notify the relevant county authority. The county authority shall, within one hundred twenty days, submit a brief report to the ((~~department~~)) authority recommending remedial action. The report shall be prepared in consultation with the ((~~department and its~~)) authority and with the department's local community service offices, the local public health officer, community health clinics, health care providers, hospitals, the business community, labor representatives, and low-income advocates in the distressed area. A county authority may contract with a local nonprofit entity to develop the report. If the county authority is unwilling or unable to develop the report, it shall notify the ((~~department~~)) authority within thirty days, and the ((~~department~~)) authority shall develop the report for the distressed area.

(3) The ((~~department~~)) authority shall review the report and use it, to the extent possible, in developing strategies to improve maternity care access in the distressed area. The ((~~department~~)) authority may contract with or directly employ qualified maternity care health providers to provide maternity care services, if access to such providers in the distressed area is not possible by other means. In such cases, the ((~~department~~)) authority is authorized to pay that portion of the health care providers' malpractice liability insurance that represents the percentage of maternity care provided to eligible persons by that provider through increased medical assistance payments.

Sec. 52. RCW 74.09.820 and 1989 1st ex.s. c 10 s 7 are each amended to read as follows:

To the extent that federal matching funds are available, the ((~~department~~)) authority or the department of health ((~~if one is created~~)) shall establish, in consultation with the health science programs of the state's colleges and universities, and community health clinics, a loan repayment program that will encourage maternity care providers to practice in medically underserved areas in exchange for repayment of part or all of their health education loans.

NEW SECTION. **Sec. 53.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The following persons have the right to an adjudicative proceeding:

(a) Any applicant or recipient who is aggrieved by a decision of the authority or an authorized agency of the authority; or

(b) A current or former recipient who is aggrieved by the authority's claim that he or she owes a debt for overpayment of assistance.

(2) For purposes of this section:

(a) "Applicant" means any person who has made a request, or on behalf of whom a request has been made to the authority for any medical services program established under chapter 74.09 RCW.

(b) "Recipient" means a person who is receiving benefits from the authority for any medical services program established in this chapter.

(3) An applicant or recipient has no right to an adjudicative proceeding when the sole basis for the authority's decision is a federal or state law requiring an assistance adjustment for a class of applicants or recipients.

(4) An applicant or recipient may file an application for an adjudicative proceeding with either the authority or the department and must do so within ninety calendar days after receiving notice of the aggrieving decision. The authority shall determine which agency is responsible for representing the state of Washington in the hearing, in accordance with agreements entered pursuant to RCW 41.05.021.

(5)(a) The adjudicative proceeding is governed by the administrative procedure act, chapter 34.05 RCW, and this subsection. The following requirements shall apply to adjudicative proceedings in which an appellant seeks review of decisions made by more than one agency. When an appellant files a single application for an adjudicative proceeding seeking review of decisions by more than one agency, this review shall be conducted initially in one adjudicative proceeding. The presiding officer may sever the proceeding into multiple proceedings on the motion of any of the parties, when:

(i) All parties consent to the severance; or

(ii) Either party requests severance without another party's consent, and the presiding officer finds there is good cause for severing the matter and that the proposed severance is not likely to prejudice the rights of an appellant who is a party to any of the severed proceedings.

(b) If there are multiple adjudicative proceedings involving common issues or parties where there is one appellant and both the authority and the department are parties, upon motion of any party or upon his or her own motion, the presiding offer may consolidate the proceedings if he or she finds that the consolidation is not likely to prejudice the rights of the appellant who is a party to any of the consolidated proceedings.

(c) The adjudicative proceeding shall be conducted at the local community services office or other location in Washington convenient to the applicant or recipient and, upon agreement by the applicant or recipient, may be conducted telephonically.

(d) The applicant or recipient, or his or her representative, has the right to inspect his or her file from the authority and, upon request, to receive copies of authority documents relevant to the proceedings free of charge.

(e) The applicant or recipient has the right to a copy of the audio recording of the adjudicative proceeding free of charge.

(f) If a final adjudicative order is issued in favor of an applicant, medical services benefits must be provided from the date of earliest eligibility, the date of denial of the application for assistance, or forty-five days following the date of application, whichever is soonest. If a final adjudicative order is issued in favor of a recipient, medical services benefits must be provided from the effective date of the authority's decision.

(g) The authority is limited to recovering an overpayment arising from assistance being continued pending the adjudicative proceeding to the amount recoverable up to the sixtieth day after the director's receipt of the application for an adjudicative proceeding.

(6) If the director requires that a party seek administrative review of an initial order to an adjudicative proceeding governed by this section, in order for the party to exhaust administrative remedies pursuant to RCW 34.05.534, the director shall adopt and implement rules in accordance with this subsection.

(a) The director, in consultation with the secretary, shall adopt rules to create a process for parties to seek administrative review of initial orders issued pursuant to RCW 34.05.461 in adjudicative proceedings governed by this subsection when multiple agencies are parties.

(b) This process shall seek to minimize any procedural complexities imposed on appellants that result from multiple agencies being parties to the matter, without prejudicing the rights of parties who are public assistance applicants or recipients.

(c) Nothing in this subsection shall impose or modify any legal requirement that a party seek administrative review of initial orders in order to exhaust administrative remedies pursuant to RCW 34.05.534.

(7) This subsection only applies to an adjudicative proceeding in which the appellant is an applicant for or recipient of medical services programs established under this chapter and the issue is his or her eligibility or ineligibility due to the assignment or transfer of a resource. The burden is on the authority or its authorized agency to prove by a preponderance of the evidence that the person knowingly and willingly assigned or transferred the resource at less than market value for the purpose of qualifying or continuing to qualify for medical services programs established under this chapter. If the prevailing party in the adjudicative proceeding is the applicant or recipient, he or she is entitled to reasonable attorneys' fees.

(8) When an applicant or recipient files a petition for judicial review as provided in RCW 34.05.514 of an adjudicative order entered with respect to the medical services program, no filing fee may be collected from the person and no bond may be required on any appeal. In the event that the superior court, the court of appeals, or the supreme court renders a decision in favor of the applicant or recipient, the person is entitled to reasonable attorneys' fees and costs. If a decision of the court is made in favor of an applicant, assistance shall be paid from the date of earliest eligibility, the date of the denial of the application for assistance, or forty-five days following the date of application, whichever is soonest. If a decision of the court is made in favor of a recipient, assistance shall be paid from the effective date of the authority's decision.

(9) The provisions of RCW 74.08.080 do not apply to adjudicative proceedings requested or conducted with respect to the medical services program pursuant to this section.

(10) The authority shall adopt any rules it deems necessary to implement this section.

Sec. 54. RCW 41.05.011 and 2009 c 537 s 3 are each amended to read as follows:

The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) ((~~"Administrator"~~)) "Director" means the ((~~administrator~~)) director of the authority.

(2) "State purchased health care" or "health care" means medical and health care, pharmaceuticals, and medical equipment purchased with state and federal funds by the department of social and health services, the department of health, the basic health plan, the state health care authority, the department of labor and industries, the department of corrections, the department of veterans affairs, and local school districts.

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

(4) "Insuring entity" means an insurer as defined in chapter 48.01 RCW, a health care service contractor as defined in chapter

48.44 RCW, or a health maintenance organization as defined in chapter 48.46 RCW.

(5) "Flexible benefit plan" means a benefit plan that allows employees to choose the level of health care coverage provided and the amount of employee contributions from among a range of choices offered by the authority.

(6) "Employee" includes all employees of the state, whether or not covered by civil service; elected and appointed officials of the executive branch of government, including full-time members of boards, commissions, or committees; justices of the supreme court and judges of the court of appeals and the superior courts; and members of the state legislature. Pursuant to contractual agreement with the authority, "employee" may also include: (a) Employees of a county, municipality, or other political subdivision of the state and members of the legislative authority of any county, city, or town who are elected to office after February 20, 1970, if the legislative authority of the county, municipality, or other political subdivision of the state seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.04.205 and 41.05.021(1)(g); (b) employees of employee organizations representing state civil service employees, at the option of each such employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of each such employee organization; (c) employees of a school district if the authority agrees to provide any of the school districts' insurance programs by contract with the authority as provided in RCW 28A.400.350; and (d) employees of a tribal government, if the governing body of the tribal government seeks and receives the approval of the authority to provide any of its insurance programs by contract with the authority, as provided in RCW 41.05.021(1) (f) and (g). "Employee" does not include: Adult family homeowners; unpaid volunteers; patients of state hospitals; inmates; employees of the Washington state convention and trade center as provided in RCW 41.05.110; students of institutions of higher education as determined by their institution; and any others not expressly defined as employees under this chapter or by the authority under this chapter.

(7) "Seasonal employee" means an employee hired to work during a recurring, annual season with a duration of three months or more, and anticipated to return each season to perform similar work.

(8) "Faculty" means an academic employee of an institution of higher education whose workload is not defined by work hours but whose appointment, workload, and duties directly serve the institution's academic mission, as determined under the authority of its enabling statutes, its governing body, and any applicable collective bargaining agreement.

(9) "Board" means the public employees' benefits board established under RCW 41.05.055.

(10) "Retired or disabled school employee" means:

(a) Persons who separated from employment with a school district or educational service district and are receiving a retirement allowance under chapter 41.32 or 41.40 RCW as of September 30, 1993;

(b) Persons who separate from employment with a school district or educational service district on or after October 1, 1993, and immediately upon separation receive a retirement allowance under chapter 41.32, 41.35, or 41.40 RCW;

(c) Persons who separate from employment with a school district or educational service district due to a total and permanent disability, and are eligible to receive a deferred retirement allowance under chapter 41.32, 41.35, or 41.40 RCW.

(11) "Premium payment plan" means a benefit plan whereby state and public employees may pay their share of group health plan premiums with pretax dollars as provided in the salary reduction plan under this chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the internal revenue code.

(12) "Salary" means a state employee's monthly salary or wages.

(13) "Participant" means an individual who fulfills the eligibility and enrollment requirements under the salary reduction plan.

(14) "Plan year" means the time period established by the authority.

(15) "Separated employees" means persons who separate from employment with an employer as defined in:

(a) RCW 41.32.010((~~(11)~~)) (17) on or after July 1, 1996; or

(b) RCW 41.35.010 on or after September 1, 2000; or

(c) RCW 41.40.010 on or after March 1, 2002;

and who are at least age fifty-five and have at least ten years of service under the teachers' retirement system plan 3 as defined in RCW 41.32.010((~~(40)~~)) (33), the Washington school employees' retirement system plan 3 as defined in RCW 41.35.010, or the public employees' retirement system plan 3 as defined in RCW 41.40.010.

(16) "Emergency service personnel killed in the line of duty" means law enforcement officers and firefighters as defined in RCW 41.26.030, members of the Washington state patrol retirement fund as defined in RCW 43.43.120, and reserve officers and firefighters as defined in RCW 41.24.010 who die as a result of injuries sustained in the course of employment as determined consistent with Title 51 RCW by the department of labor and industries.

(17) "Employer" means the state of Washington.

(18) "Employing agency" means a division, department, or separate agency of state government, including an institution of higher education; a county, municipality, school district, educational service district, or other political subdivision; and a tribal government covered by this chapter.

(19) "Tribal government" means an Indian tribal government as defined in section 3(32) of the employee retirement income security act of 1974, as amended, or an agency or instrumentality of the tribal government, that has government offices principally located in this state.

(20) "Dependent care assistance program" means a benefit plan whereby state and public employees may pay for certain employment related dependent care with pretax dollars as provided in the salary reduction plan under this chapter pursuant to 26 U.S.C. Sec. 129 or other sections of the internal revenue code.

(21) "Salary reduction plan" means a benefit plan whereby state and public employees may agree to a reduction of salary on a pretax basis to participate in the dependent care assistance program, medical flexible spending arrangement, or premium payment plan offered pursuant to 26 U.S.C. Sec. 125 or other sections of the internal revenue code.

(22) "Medical flexible spending arrangement" means a benefit plan whereby state and public employees may reduce their salary before taxes to pay for medical expenses not reimbursed by insurance as provided in the salary reduction plan under this chapter pursuant to 26 U.S.C. Sec. 125 or other sections of the internal revenue code.

Sec. 55. RCW 41.05.015 and 2000 c 5 s 16 are each amended to read as follows:

The ((~~administrator~~)) director shall designate a medical director who is licensed under chapter 18.57 or 18.71 RCW. The director shall also appoint such professional personnel and other assistants and employees, including professional medical screeners, as may be reasonably necessary to carry out the provisions of this chapter and chapter 74.09 RCW. The medical screeners must be supervised by one or more physicians whom the director or the director's designee shall appoint.

Sec. 56. RCW 41.05.021 and 2009 c 537 s 4 are each amended to read as follows:

(1) The Washington state health care authority is created within the executive branch. The authority shall have ((~~an administrator~~)) a director appointed by the governor, with the consent of the senate. The ((~~administrator~~)) director shall serve at the pleasure of the governor. The ((~~administrator~~)) director may employ ((~~up to seven staff members~~)) a deputy director, and such assistant directors and special assistants as may be needed to administer the authority, who shall be exempt from chapter 41.06 RCW, and any additional staff members as are necessary to administer this chapter. The ((~~administrator~~)) director may delegate any power or duty vested in him or her by ((~~this chapter~~)) law, including authority to make final decisions and enter final orders in hearings conducted under chapter 34.05 RCW. The primary duties of the authority shall be to: Administer state employees' insurance benefits and retired or disabled school employees' insurance benefits; administer the basic health plan pursuant to chapter 70.47 RCW; administer the children's health program pursuant to chapter 74.09 RCW; study state-purchased health care programs in order to maximize cost containment in these programs while ensuring access to quality health care; implement state initiatives, joint purchasing strategies, and techniques for efficient administration that have potential application to all state-purchased health services; and administer grants that further the mission and goals of the authority. The authority's duties include, but are not limited to, the following:

(a) To administer health care benefit programs for employees and retired or disabled school employees as specifically authorized in RCW 41.05.065 and in accordance with the methods described in RCW 41.05.075, 41.05.140, and other provisions of this chapter;

(b) To analyze state-purchased health care programs and to explore options for cost containment and delivery alternatives for those programs that are consistent with the purposes of those programs, including, but not limited to:

(i) Creation of economic incentives for the persons for whom the state purchases health care to appropriately utilize and purchase health care services, including the development of flexible benefit plans to offset increases in individual financial responsibility;

(ii) Utilization of provider arrangements that encourage cost containment, including but not limited to prepaid delivery systems, utilization review, and prospective payment methods, and that ensure access to quality care, including assuring reasonable access to local providers, especially for employees residing in rural areas;

(iii) Coordination of state agency efforts to purchase drugs effectively as provided in RCW 70.14.050;

(iv) Development of recommendations and methods for purchasing medical equipment and supporting services on a volume discount basis;

(v) Development of data systems to obtain utilization data from state-purchased health care programs in order to identify cost centers, utilization patterns, provider and hospital practice patterns, and procedure costs, utilizing the information obtained pursuant to RCW 41.05.031; and

(vi) In collaboration with other state agencies that administer state purchased health care programs, private health care purchasers, health care facilities, providers, and carriers:

(A) Use evidence-based medicine principles to develop common performance measures and implement financial incentives in contracts with insuring entities, health care facilities, and providers that:

(I) Reward improvements in health outcomes for individuals with chronic diseases, increased utilization of appropriate preventive health services, and reductions in medical errors; and

(II) Increase, through appropriate incentives to insuring entities, health care facilities, and providers, the adoption and use of information technology that contributes to improved health outcomes, better coordination of care, and decreased medical errors;

(B) Through state health purchasing, reimbursement, or pilot strategies, promote and increase the adoption of health information technology systems, including electronic medical records, by hospitals as defined in RCW 70.41.020(4), integrated delivery systems, and providers that:

(I) Facilitate diagnosis or treatment;

(II) Reduce unnecessary duplication of medical tests;

(III) Promote efficient electronic physician order entry;

(IV) Increase access to health information for consumers and their providers; and

(V) Improve health outcomes;

(C) Coordinate a strategy for the adoption of health information technology systems using the final health information technology report and recommendations developed under chapter 261, Laws of 2005;

(c) To analyze areas of public and private health care interaction;

(d) To provide information and technical and administrative assistance to the board;

(e) To review and approve or deny applications from counties, municipalities, and other political subdivisions of the state to provide state-sponsored insurance or self-insurance programs to their employees in accordance with the provisions of RCW 41.04.205 and (g) of this subsection, setting the premium contribution for approved groups as outlined in RCW 41.05.050;

(f) To review and approve or deny the application when the governing body of a tribal government applies to transfer their employees to an insurance or self-insurance program administered under this chapter. In the event of an employee transfer pursuant to this subsection (1)(f), members of the governing body are eligible to be included in such a transfer if the members are authorized by the tribal government to participate in the insurance program being transferred from and subject to payment by the members of all costs of insurance for the members. The authority shall: (i) Establish the conditions for participation; (ii) have the sole right to reject the application; and (iii) set the premium contribution for approved groups as outlined in RCW 41.05.050. Approval of the application by the authority transfers the employees and dependents involved to the insurance, self-insurance, or health care program approved by the authority;

(g) To ensure the continued status of the employee insurance or self-insurance programs administered under this chapter as a governmental plan under section 3(32) of the employee retirement income security act of 1974, as amended, the authority shall limit the participation of employees of a county, municipal, school district, educational service district, or other political subdivision, or a tribal government, including providing for the participation of those employees whose services are substantially all in the performance of essential governmental functions, but not in the performance of commercial activities;

(h) To establish billing procedures and collect funds from school districts in a way that minimizes the administrative burden on districts;

(i) To publish and distribute to nonparticipating school districts and educational service districts by October 1st of each year a description of health care benefit plans available through the authority and the estimated cost if school districts and educational service district employees were enrolled;

(j) To apply for, receive, and accept grants, gifts, and other payments, including property and service, from any governmental or other public or private entity or person, and make arrangements as to the use of these receipts to implement initiatives and strategies developed under this section;

(k) To issue, distribute, and administer grants that further the mission and goals of the authority;

(l) To adopt rules consistent with this chapter as described in RCW 41.05.160 including, but not limited to:

(i) Setting forth the criteria established by the board under RCW 41.05.065 for determining whether an employee is eligible for benefits;

(ii) Establishing an appeal process in accordance with chapter 34.05 RCW by which an employee may appeal an eligibility determination;

(iii) Establishing a process to assure that the eligibility determinations of an employing agency comply with the criteria under this chapter, including the imposition of penalties as may be authorized by the board;

(m)(i) To administer the medical services programs established under chapter 74.09 RCW as the designated single state agency for purposes of Title XIX of the federal social security act;

(ii) To administer the state children's health insurance program under chapter 74.09 RCW for purposes of Title XXI of the federal social security act;

(iii) To enter into agreements with the department of social and health services for administration of medical care services programs under Titles XIX and XXI of the social security act. The agreements shall establish the division of responsibilities between the authority and the department with respect to mental health, chemical dependency, and long-term care services, including services for persons with developmental disabilities. The agreements shall be revised as necessary, to comply with the final implementation plan adopted under section 117 of this act;

(iv) To adopt rules to carry out the purposes of chapter 74.09 RCW;

(v) To appoint such advisory committees or councils as may be required by any federal statute or regulation as a condition to the receipt of federal funds by the authority. The director may appoint statewide committees or councils in the following subject areas: (A) Health facilities; (B) children and youth services; (C) blind services; (D) medical and health care; (E) drug abuse and alcoholism; (F) rehabilitative services; and (G) such other subject matters as are or come within the authority's responsibilities. The statewide councils shall have representation from both major political parties and shall have substantial consumer representation. Such committees or councils shall be constituted as required by federal law or as the director in his or her discretion may determine. The members of the committees or councils shall hold office for three years except in the case of a vacancy, in which event appointment shall be only for the remainder of the unexpired term for which the vacancy occurs. No member shall serve more than two consecutive terms. Members of such state advisory committees or councils may be paid their travel expenses in accordance with RCW 43.03.050 and 43.03.060 as now existing or hereafter amended.

(2) On and after January 1, 1996, the public employees' benefits board may implement strategies to promote managed competition among employee health benefit plans. Strategies may include but are not limited to:

(a) Standardizing the benefit package;

(b) Soliciting competitive bids for the benefit package;

(c) Limiting the state's contribution to a percent of the lowest priced qualified plan within a geographical area;

(d) Monitoring the impact of the approach under this subsection with regards to: Efficiencies in health service delivery, cost shifts to subscribers, access to and choice of managed care plans statewide, and quality of health services. The health care authority shall also advise on the value of administering a benchmark employer-managed plan to promote competition among managed care plans.

Sec. 57. RCW 41.05.036 and 2009 c 300 s 2 are each amended to read as follows:

The definitions in this section apply throughout RCW 41.05.039 through 41.05.046 unless the context clearly requires otherwise.

(1) ((~~"Administrator"~~)) "Director" means the ((~~administrator~~)) director of the state health care authority under this chapter.

(2) "Exchange" means the methods or medium by which health care information may be electronically and securely exchanged among authorized providers, payors, and patients within Washington state.

(3) "Health care provider" or "provider" has the same meaning as in RCW 48.43.005.

(4) "Health data provider" means an organization that is a primary source for health-related data for Washington residents, including but not limited to:

(a) The children's health immunizations linkages and development profile immunization registry provided by the department of health pursuant to chapter 43.70 RCW;

(b) Commercial laboratories providing medical laboratory testing results;

(c) Prescription drugs clearinghouses, such as the national patient health information network; and

(d) Diagnostic imaging centers.

(5) "Lead organization" means a private sector organization or organizations designated by the ((~~administrator~~)) director to lead development of processes, guidelines, and standards under chapter 300, Laws of 2009.

(6) "Payor" means public purchasers, as defined in this section, carriers licensed under chapters 48.20, 48.21, 48.44, 48.46, and 48.62 RCW, and the Washington state health insurance pool established in chapter 48.41 RCW.

(7) "Public purchaser" means the department of social and health services, the department of labor and industries, and the health care authority.

(8) "Secretary" means the secretary of the department of health.

Sec. 58. RCW 41.05.037 and 2007 c 259 s 15 are each amended to read as follows:

To the extent that ((~~sufficient~~)) funding is provided specifically for this purpose, the ((~~administrator, in collaboration with the department of social and health services,~~)) director shall provide all persons enrolled in health plans under this chapter and chapters 70.47 and 74.09 RCW with access to a twenty-four hour, seven day a week nurse hotline.

Sec. 59. RCW 41.05.140 and 2000 c 80 s 5 are each amended to read as follows:

(1) Except for property and casualty insurance, the authority may self-fund, self-insure, or enter into other methods of providing insurance coverage for insurance programs under its jurisdiction, including the basic health plan as provided in chapter 70.47 RCW. The authority shall contract for payment of claims or other administrative services for programs under its jurisdiction. If a program does not require the prepayment of reserves, the authority shall establish such reserves within a reasonable period of time for the payment of claims as are normally required for that type of insurance under an insured program. The authority shall endeavor to reimburse basic health plan health care providers under this section at rates similar to the average reimbursement rates offered by the statewide benchmark plan determined through the request for proposal process.

(2) Reserves established by the authority for employee and retiree benefit programs shall be held in a separate trust fund by the state treasurer and shall be known as the public employees' and

retirees' insurance reserve fund. The state investment board shall act as the investor for the funds and, except as provided in RCW 43.33A.160 and 43.84.160, one hundred percent of all earnings from these investments shall accrue directly to the public employees' and retirees' insurance reserve fund.

(3) Any savings realized as a result of a program created for employees and retirees under this section shall not be used to increase benefits unless such use is authorized by statute.

(4) Reserves established by the authority to provide insurance coverage for the basic health plan under chapter 70.47 RCW shall be held in a separate trust account in the custody of the state treasurer and shall be known as the basic health plan self-insurance reserve account. The state investment board shall act as the investor for the funds as set forth in RCW 43.33A.230 and, except as provided in RCW 43.33A.160 and 43.84.160, one hundred percent of all earnings from these investments shall accrue directly to the basic health plan self-insurance reserve account.

(5) Any program created under this section shall be subject to the examination requirements of chapter 48.03 RCW as if the program were a domestic insurer. In conducting an examination, the commissioner shall determine the adequacy of the reserves established for the program.

(6) The authority shall keep full and adequate accounts and records of the assets, obligations, transactions, and affairs of any program created under this section.

(7) The authority shall file a quarterly statement of the financial condition, transactions, and affairs of any program created under this section in a form and manner prescribed by the insurance commissioner. The statement shall contain information as required by the commissioner for the type of insurance being offered under the program. A copy of the annual statement shall be filed with the speaker of the house of representatives and the president of the senate.

(8) The provisions of this section do not apply to the administration of chapter 74.09 RCW.

Sec. 60. RCW 41.05.185 and 1997 c 276 s 1 are each amended to read as follows:

The legislature finds that diabetes imposes a significant health risk and tremendous financial burden on the citizens and government of the state of Washington, and that access to the medically accepted standards of care for diabetes, its treatment and supplies, and self-management training and education is crucial to prevent or delay the short and long-term complications of diabetes and its attendant costs.

(1) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Person with diabetes" means a person diagnosed by a health care provider as having insulin using diabetes, noninsulin using diabetes, or elevated blood glucose levels induced by pregnancy; and

(b) "Health care provider" means a health care provider as defined in RCW 48.43.005.

(2) All state-purchased health care purchased or renewed after January 1, 1998, except the basic health plan described in chapter 70.47 RCW and services provided under chapter 74.09 RCW, shall provide benefits for at least the following services and supplies for persons with diabetes:

(a) For state-purchased health care that includes coverage for pharmacy services, appropriate and medically necessary equipment and supplies, as prescribed by a health care provider, that includes but is not limited to insulin, syringes, injection aids, blood glucose monitors, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescriptive oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes, and glucagon emergency kits; and

(b) For all state-purchased health care, outpatient self-management training and education, including medical nutrition therapy, as ordered by the health care provider. Diabetes outpatient self-management training and education may be provided only by health care providers with expertise in diabetes. Nothing in this section prevents any state agency purchasing health care according to this section from restricting patients to seeing only health care providers who have signed participating provider agreements with that state agency or an insuring entity under contract with that state agency.

(3) Coverage required under this section may be subject to customary cost-sharing provisions established for all other similar services or supplies within a policy.

(4) Health care coverage may not be reduced or eliminated due to this section.

(5) Services required under this section shall be covered when deemed medically necessary by the medical director, or his or her designee, subject to any referral and formulary requirements.

Sec. 61. RCW 43.20A.365 and 1997 c 430 s 2 are each amended to read as follows:

A committee or council required by federal law, within the ((~~department of social and health services~~)) health care authority, that makes policy recommendations regarding reimbursement for drugs under the requirements of federal law or regulations is subject to chapters 42.30 and 42.32 RCW.

Sec. 62. RCW 74.04.005 and 2010 1st sp.s. c 8 s 4 are each amended to read as follows:

For the purposes of this title, unless the context indicates otherwise, the following definitions shall apply:

(1) "Public assistance" or "assistance"--Public aid to persons in need thereof for any cause, including services, medical care, assistance grants, disbursing orders, work relief, disability lifeline benefits and federal aid assistance.

(2) "Department"--The department of social and health services.

(3) "County or local office"--The administrative office for one or more counties or designated service areas.

(4) ((~~"Director" or~~)) "Secretary" means the secretary of social and health services.

(5) "Disability lifeline program" means a program that provides aid and support in accordance with the conditions set out in this subsection.

(a) Aid and assistance shall be provided to persons who are not eligible to receive federal aid assistance, other than basic food benefits transferred electronically and medical assistance and meet one of the following conditions:

(i) Are pregnant and in need, based upon the current income and resource requirements of the federal temporary assistance for needy families program; or

(ii) Are incapacitated from gainful employment by reason of bodily or mental infirmity that will likely continue for a minimum of ninety days as determined by the department. The standard for incapacity in this subsection, as evidenced by the ninety-day duration standard, is not intended to be as stringent as federal supplemental security income disability standards; and

(A) Are citizens or aliens lawfully admitted for permanent residence or otherwise residing in the United States under color of law;

(B) Have furnished the department their social security number. If the social security number cannot be furnished because it has not been issued or is not known, an application for a number shall be made prior to authorization of benefits, and the social security number shall be provided to the department upon receipt;

(C) Have not refused or failed without good cause to participate in drug or alcohol treatment if an assessment by a certified chemical dependency counselor indicates a need for such treatment. Good cause must be found to exist when a person's physical or mental

condition, as determined by the department, prevents the person from participating in drug or alcohol dependency treatment, when needed outpatient drug or alcohol treatment is not available to the person in the county of his or her residence or when needed inpatient treatment is not available in a location that is reasonably accessible for the person; and

(D) Have not refused or failed without good cause to participate in vocational rehabilitation services, if an assessment conducted under RCW 74.04.655 indicates that the person might benefit from such services. Good cause must be found to exist when a person's physical or mental condition, as determined by the department, prevents the person from participating in vocational rehabilitation services, or when vocational rehabilitation services are not available to the person in the county of his or her residence.

(b)(i) Persons who initially apply and are found eligible for disability lifeline benefits based upon incapacity from gainful employment under (a) of this subsection on or after September 2, 2010, who are homeless and have been assessed as needing chemical dependency or mental health treatment or both, must agree, as a condition of eligibility for the disability lifeline program, to accept a housing voucher in lieu of a cash grant if a voucher is available. The department shall establish the dollar value of the housing voucher. The dollar value of the housing voucher may differ from the value of the cash grant. Persons receiving a housing voucher under this subsection also shall receive a cash stipend of fifty dollars per month.

(ii) If the department of commerce has determined under RCW 43.330.175 that sufficient housing is not available, persons described in this subsection who apply for disability lifeline benefits during the time period that housing is not available shall receive a cash grant in lieu of a cash stipend and housing voucher.

(iii) Persons who refuse to accept a housing voucher under this subsection but otherwise meet the eligibility requirements of (a) of this subsection are eligible for medical care services benefits under RCW 74.09.035, subject to the time limits in (h) of this subsection.

(c) The following persons are not eligible for the disability lifeline program:

(i) Persons who are unemployable due primarily to alcohol or drug addiction. These persons shall be referred to appropriate assessment, treatment, shelter, or supplemental security income referral services as authorized under chapter 74.50 RCW. Referrals shall be made at the time of application or at the time of eligibility review. This subsection shall not be construed to prohibit the department from granting disability lifeline benefits to alcoholics and drug addicts who are incapacitated due to other physical or mental conditions that meet the eligibility criteria for the disability lifeline program;

(ii) Persons who refuse or fail to cooperate in obtaining federal aid assistance, without good cause.

(d) Disability lifeline benefits shall be provided only to persons who are not members of assistance units receiving federal aid assistance, except as provided in (a) of this subsection, and who will accept available services that can reasonably be expected to enable the person to work or reduce the need for assistance unless there is good cause to refuse. Failure to accept such services shall result in termination until the person agrees to cooperate in accepting such services and subject to the following maximum periods of ineligibility after reapplication:

(i) First failure: One week;

(ii) Second failure within six months: One month;

(iii) Third and subsequent failure within one year: Two months.

(e) Persons who are likely eligible for federal supplemental security income benefits shall be moved into the disability lifeline expedited component of the disability lifeline program. Persons placed in the expedited component of the program may, if otherwise eligible, receive disability lifeline benefits pending application for federal supplemental security income benefits. The monetary value of any disability lifeline benefit that is subsequently duplicated by the person's receipt of supplemental security income for the same period shall be considered a debt due the state and shall by operation of law be subject to recovery through all available legal remedies.

(f) For purposes of determining whether a person is incapacitated from gainful employment under (a) of this subsection:

(i) The department shall adopt by rule medical criteria for disability lifeline incapacity determinations to ensure that eligibility decisions are consistent with statutory requirements and are based on clear, objective medical information; and

(ii) The process implementing the medical criteria shall involve consideration of opinions of the treating or consulting physicians or health care professionals regarding incapacity, and any eligibility decision which rejects uncontroverted medical opinion must set forth clear and convincing reasons for doing so.

(g) Persons receiving disability lifeline benefits based upon a finding of incapacity from gainful employment who remain otherwise eligible shall have their benefits discontinued unless the recipient demonstrates no material improvement in their medical or mental health condition. The department may discontinue benefits when there was specific error in the prior determination that found the person eligible by reason of incapacitation.

(h)(i) Beginning September 1, 2010, no person who is currently receiving or becomes eligible for disability lifeline program benefits shall be eligible to receive benefits under the program for more than twenty-four months in a sixty-month period. For purposes of this subsection, months of receipt of general assistance-unemployable benefits count toward the twenty-four month limit. Months during which a person received benefits under the expedited component of the disability lifeline or general assistance program or under the aged, blind, or disabled component of the disability lifeline or general assistance program shall not be included when determining whether a person has been receiving benefits for more than twenty-four months. On or before July 1, 2010, the department must review the cases of all persons who have received disability lifeline benefits or general assistance unemployable benefits for at least twenty months as of that date. On or before September 1, 2010, the department must review the cases of all remaining persons who have received disability lifeline benefits for at least twelve months as of that date. The review should determine whether the person meets the federal supplemental security income disability standard and, if the person does not meet that standard, whether the receipt of additional services could lead to employability. If a need for additional services is identified, the department shall provide case management services, such as assistance with arranging transportation or locating stable housing, that will facilitate the person's access to needed services. A person may not be determined ineligible due to exceeding the time limit unless he or she has received a case review under this subsection finding that the person does not meet the federal supplemental security income disability standard.

(ii) The time limits established under this subsection expire June 30, 2013.

(i) No person may be considered an eligible individual for disability lifeline benefits with respect to any month if during that month the person:

(i) Is fleeing to avoid prosecution of, or to avoid custody or confinement for conviction of, a felony, or an attempt to commit a felony, under the laws of the state of Washington or the place from which the person flees; or

(ii) Is violating a condition of probation, community supervision, or parole imposed under federal or state law for a felony or gross misdemeanor conviction.

(6) "Disability lifeline expedited" means a component of the disability lifeline program under which persons receiving disability lifeline benefits have been determined, after examination by an appropriate health care provider, to be likely to be eligible for federal supplemental security income benefits based on medical and behavioral health evidence that meets the disability standards used for the federal supplemental security income program.

(7) "Federal aid assistance"--The specific categories of assistance for which provision is made in any federal law existing or hereafter passed by which payments are made from the federal government to the state in aid or in respect to payment by the state for public assistance rendered to any category of needy persons for which provision for federal funds or aid may from time to time be made, or a federally administered needs-based program.

(8) "Applicant"--Any person who has made a request, or on behalf of whom a request has been made, to any county or local office for assistance.

(9) "Recipient"--Any person receiving assistance and in addition those dependents whose needs are included in the recipient's assistance.

(10) "Standards of assistance"--The level of income required by an applicant or recipient to maintain a level of living specified by the department.

(11) "Resource"--Any asset, tangible or intangible, owned by or available to the applicant at the time of application, which can be applied toward meeting the applicant's need, either directly or by conversion into money or its equivalent. The department may by rule designate resources that an applicant may retain and not be ineligible for public assistance because of such resources. Exempt resources shall include, but are not limited to:

(a) A home that an applicant, recipient, or their dependents is living in, including the surrounding property;

(b) Household furnishings and personal effects;

(c) A motor vehicle, other than a motor home, used and useful having an equity value not to exceed five thousand dollars;

(d) A motor vehicle necessary to transport a household member with a physical disability. This exclusion is limited to one vehicle per person with a physical disability;

(e) All other resources, including any excess of values exempted, not to exceed one thousand dollars or other limit as set by the department, to be consistent with limitations on resources and exemptions necessary for federal aid assistance. The department shall also allow recipients of temporary assistance for needy families to exempt savings accounts with combined balances of up to an additional three thousand dollars;

(f) Applicants for or recipients of disability lifeline benefits shall have their eligibility based on resource limitations consistent with the temporary assistance for needy families program rules adopted by the department; and

(g) If an applicant for or recipient of public assistance possesses property and belongings in excess of the ceiling value, such value shall be used in determining the need of the applicant or recipient, except that: (i) The department may exempt resources or income when the income and resources are determined necessary to the applicant's or recipient's restoration to independence, to decrease the need for public assistance, or to aid in rehabilitating the applicant or recipient or a dependent of the applicant or recipient; and (ii) the department may provide grant assistance for a period not to exceed nine months from the date the agreement is signed pursuant to this section to persons who are otherwise ineligible because of excess real property owned by such persons when they are making a good faith effort to dispose of that property: PROVIDED, That:

(A) The applicant or recipient signs an agreement to repay the lesser of the amount of aid received or the net proceeds of such sale;

(B) If the owner of the excess property ceases to make good faith efforts to sell the property, the entire amount of assistance may become an overpayment and a debt due the state and may be recovered pursuant to RCW 43.20B.630;

(C) Applicants and recipients are advised of their right to a fair hearing and afforded the opportunity to challenge a decision that good faith efforts to sell have ceased, prior to assessment of an overpayment under this section; and

(D) At the time assistance is authorized, the department files a lien without a sum certain on the specific property.

(12) "Income"--(a) All appreciable gains in real or personal property (cash or kind) or other assets, which are received by or become available for use and enjoyment by an applicant or recipient during the month of application or after applying for or receiving public assistance. The department may by rule and regulation exempt income received by an applicant for or recipient of public assistance which can be used by him or her to decrease his or her need for public assistance or to aid in rehabilitating him or her or his or her dependents, but such exemption shall not, unless otherwise provided in this title, exceed the exemptions of resources granted under this chapter to an applicant for public assistance. In addition, for cash assistance the department may disregard income pursuant to RCW 74.08A.230 and 74.12.350.

(b) If, under applicable federal requirements, the state has the option of considering property in the form of lump sum compensatory awards or related settlements received by an applicant or recipient as income or as a resource, the department shall consider such property to be a resource.

(13) "Need"--The difference between the applicant's or recipient's standards of assistance for himself or herself and the dependent members of his or her family, as measured by the standards of the department, and value of all nonexempt resources and nonexempt income received by or available to the applicant or recipient and the dependent members of his or her family.

(14) "Authority" means the health care authority.

(15) "Director" means the director of the health care authority.

(16) For purposes of determining eligibility for public assistance and participation levels in the cost of medical care, the department shall exempt restitution payments made to people of Japanese and Aleut ancestry pursuant to the Civil Liberties Act of 1988 and the Aleutian and Pribilof Island Restitution Act passed by congress, P.L. 100-383, including all income and resources derived therefrom.

((~~(15)~~)) (17) In the construction of words and phrases used in this title, the singular number shall include the plural, the masculine gender shall include both the feminine and neuter genders and the present tense shall include the past and future tenses, unless the context thereof shall clearly indicate to the contrary.

Sec. 63. RCW 74.04.015 and 1981 1st ex.s. c 6 s 2 are each amended to read as follows:

(1) The secretary of social and health services shall be the responsible state officer for the administration ((~~of,~~)) and ((~~the~~)) disbursement of all funds, goods, commodities, and services, which may be received by the state in connection with programs of public assistance or services related directly or indirectly to assistance programs, and all other matters included in the federal social security act ((~~approved August 14, 1935~~)) as amended, or any other federal act or as the same may be amended ((~~excepting those specifically required to be administered by other entities~~)) except as otherwise provided by law.

(2) The director shall be the responsible state officer for the administration and disbursement of funds that the state receives in connection with the medical services programs established under chapter 74.09 RCW, including the state children's health insurance

program, Titles XIX and XXI of the social security act of 1935, as amended.

((He)) (3) The department and the authority, as appropriate, shall make such reports and render such accounting as may be required by ((the)) federal ((agency having authority in the premises)) law.

Sec. 64. RCW 74.04.025 and 2010 c 296 s 7 are each amended to read as follows:

(1) The department, the authority, and the office of administrative hearings shall ensure that bilingual services are provided to non-English speaking applicants and recipients. The services shall be provided to the extent necessary to assure that non-English speaking persons are not denied, or unable to obtain or maintain, services or benefits because of their inability to speak English.

(2) If the number of non-English speaking applicants or recipients sharing the same language served by any community service office client contact job classification equals or exceeds fifty percent of the average caseload of a full-time position in such classification, the department shall, through attrition, employ bilingual personnel to serve such applicants or recipients.

(3) Regardless of the applicant or recipient caseload of any community service office, each community service office shall ensure that bilingual services required to supplement the community service office staff are provided through contracts with language access providers, local agencies, or other community resources.

(4) The department shall certify, authorize, and qualify language access providers as needed to maintain an adequate pool of providers.

(5) The department shall require compliance with RCW 41.56.113(2) through its contracts with third parties.

(6) Initial client contact materials shall inform clients in all primary languages of the availability of interpretation services for non-English speaking persons. Basic informational pamphlets shall be translated into all primary languages.

(7) To the extent all written communications directed to applicants or recipients are not in the primary language of the applicant or recipient, the department and the office of administrative hearings shall include with the written communication a notice in all primary languages of applicants or recipients describing the significance of the communication and specifically how the applicants or recipients may receive assistance in understanding, and responding to if necessary, the written communication. The department shall assure that sufficient resources are available to assist applicants and recipients in a timely fashion with understanding, responding to, and complying with the requirements of all such written communications.

(8) As used in this section:

(a) "Language access provider" means any independent contractor who provides spoken language interpreter services for department appointments or medicaid enrollee appointments, or provided these services on or after January 1, 2009, and before June 10, 2010, whether paid by a broker, language access agency, or the department. "Language access provider" does not mean an owner, manager, or employee of a broker or a language access agency.

(b) "Primary languages" includes but is not limited to Spanish, Vietnamese, Cambodian, Laotian, and Chinese.

Sec. 65. RCW 74.04.050 and 1981 1st ex.s. c 6 s 3 are each amended to read as follows:

(1) The department ((shall serve)) is designated as the single state agency to administer the following public assistance((. The department is hereby empowered and authorized to cooperate in the administration of such federal laws, consistent with the public assistance laws of this state, as may be necessary to qualify for federal funds for:

(1) Medical assistance;

(2) Aid to dependent children;

(3))) programs:

(a) Temporary assistance to needy families;

(b) Child welfare services; and

(((4))) (c) Any other programs of public assistance for which provision for federal grants or funds may from time to time be made, except as otherwise provided by law.

(2) The authority is hereby designated as the single state agency to administer the medical services programs established under chapter 74.09 RCW, including the state children's health insurance program, Titles XIX and XXI of the federal social security act of 1935, as amended.

(3) The department and the authority are hereby empowered and authorized to cooperate in the administration of such federal laws, consistent with the public assistance laws of this state, as may be necessary to qualify for federal funds.

(4) The state hereby accepts and assents to all the present provisions of the federal law under which federal grants or funds, goods, commodities, and services are extended to the state for the support of programs ((administered by the department)) referenced in this section, and to such additional legislation as may subsequently be enacted as is not inconsistent with the purposes of this title, authorizing public welfare and assistance activities. The provisions of this title shall be so administered as to conform with federal requirements with respect to eligibility for the receipt of federal grants or funds.

(5) The department and the authority shall periodically make application for federal grants or funds and submit such plans, reports and data, as are required by any act of congress as a condition precedent to the receipt of federal funds for such assistance. The department and the authority shall make and enforce such rules and regulations as shall be necessary to insure compliance with the terms and conditions of such federal grants or funds.

Sec. 66. RCW 74.04.055 and 1991 c 126 s 2 are each amended to read as follows:

In furtherance of the policy of this state to cooperate with the federal government in the programs included in this title the secretary or director, as appropriate, shall issue such rules and regulations as may become necessary to entitle this state to participate in federal grants-in-aid, goods, commodities and services unless the same be expressly prohibited by this title. Any section or provision of this title which may be susceptible to more than one construction shall be interpreted in favor of the construction most likely to satisfy federal laws entitling this state to receive federal matching or other funds for the various programs of public assistance. If any part of this chapter is found to be in conflict with federal requirements which are a prescribed condition to the receipts of federal funds to the state, the conflicting part of this chapter is hereby inoperative solely to the extent of the conflict with respect to the agencies directly affected, and such finding or determination shall not affect the operation of the remainder of this chapter.

Sec. 67. RCW 74.04.060 and 2006 c 259 s 5 are each amended to read as follows:

(1)(a) For the protection of applicants and recipients, the department, the authority, and the county offices and their respective officers and employees are prohibited, except as hereinafter provided, from disclosing the contents of any records, files, papers and communications, except for purposes directly connected with the administration of the programs of this title. In any judicial proceeding, except such proceeding as is directly concerned with the administration of these programs, such records, files, papers and communications, and their contents, shall be deemed privileged communications and except for the right of any individual to inquire of the office whether a named individual is a recipient of welfare

assistance and such person shall be entitled to an affirmative or negative answer.

(b) Upon written request of a parent who has been awarded visitation rights in an action for divorce or separation or any parent with legal custody of the child, the department shall disclose to him or her the last known address and location of his or her natural or adopted children. The secretary shall adopt rules which establish procedures for disclosing the address of the children and providing, when appropriate, for prior notice to the custodian of the children. The notice shall state that a request for disclosure has been received and will be complied with by the department unless the department receives a copy of a court order which enjoins the disclosure of the information or restricts or limits the requesting party's right to contact or visit the other party or the child. Information supplied to a parent by the department shall be used only for purposes directly related to the enforcement of the visitation and custody provisions of the court order of separation or decree of divorce. No parent shall disclose such information to any other person except for the purpose of enforcing visitation provisions of the said order or decree.

(c) The department shall review methods to improve the protection and confidentiality of information for recipients of welfare assistance who have disclosed to the department that they are past or current victims of domestic violence or stalking.

(2) The county offices shall maintain monthly at their offices a report showing the names and addresses of all recipients in the county receiving public assistance under this title, together with the amount paid to each during the preceding month.

(3) The provisions of this section shall not apply to duly designated representatives of approved private welfare agencies, public officials, members of legislative interim committees and advisory committees when performing duties directly connected with the administration of this title, such as regulation and investigation directly connected therewith: PROVIDED, HOWEVER, That any information so obtained by such persons or groups shall be treated with such degree of confidentiality as is required by the federal social security law.

(4) It shall be unlawful, except as provided in this section, for any person, body, association, firm, corporation or other agency to solicit, publish, disclose, receive, make use of, or to authorize, knowingly permit, participate in or acquiesce in the use of any lists or names for commercial or political purposes of any nature. The violation of this section shall be a gross misdemeanor.

Sec. 68. RCW 74.04.062 and 1997 c 58 s 1006 are each amended to read as follows:

Upon written request of a person who has been properly identified as an officer of the law or a properly identified United States immigration official the department or authority shall disclose to such officer the current address and location of a recipient of public welfare if the officer furnishes the department or authority with such person's name and social security account number and satisfactorily demonstrates that such recipient is a fugitive, that the location or apprehension of such fugitive is within the officer's official duties, and that the request is made in the proper exercise of those duties.

When the department or authority becomes aware that a public assistance recipient is the subject of an outstanding warrant, the department or authority may contact the appropriate law enforcement agency and, if the warrant is valid, provide the law enforcement agency with the location of the recipient.

Sec. 69. RCW 74.04.290 and 1983 1st ex.s. c 41 s 22 are each amended to read as follows:

In carrying out any of the provisions of this title, the secretary, the director, county administrators, hearing examiners, or other duly authorized officers of the department or authority shall have power to subpoena witnesses, administer oaths, take testimony and compel the production of such papers, books, records and documents as they may deem relevant to the performance of their duties. Subpoenas issued under this power shall be under RCW 43.20A.605.

Sec. 70. RCW 7.68.080 and 1990 c 3 s 503 are each amended to read as follows:

The provisions of chapter 51.36 RCW as now or hereafter amended govern the provision of medical aid under this chapter to victims injured as a result of a criminal act, including criminal acts committed between July 1, 1981, and January 1, 1983, except that:

(1) The provisions contained in RCW 51.36.030, 51.36.040, and 51.36.080 as now or hereafter amended do not apply to this chapter;

(2) The specific provisions of RCW 51.36.020 as now or hereafter amended relating to supplying emergency transportation do not apply: PROVIDED, That:

(a) When the injury to any victim is so serious as to require the victim's being taken from the place of injury to a place of treatment, reasonable transportation costs to the nearest place of proper treatment shall be reimbursed from the fund established pursuant to RCW 7.68.090; and

(b) In the case of alleged rape or molestation of a child the reasonable costs of a colposcope examination shall be reimbursed from the fund pursuant to RCW 7.68.090. Hospital, clinic, and medical charges along with all related fees under this chapter shall conform to regulations promulgated by the director. The director shall set these service levels and fees at a level no lower than those established by the ((~~department of social and health services~~)) health care authority under Title 74 RCW. In establishing fees for medical and other health care services, the director shall consider the director's duty to purchase health care in a prudent, cost-effective manner. The director shall establish rules adopted in accordance with chapter 34.05 RCW. Nothing in this chapter may be construed to require the payment of interest on any billing, fee, or charge.

Sec. 71. RCW 43.41.160 and 1986 c 303 s 11 are each amended to read as follows:

(1) It is the purpose of this section to ensure implementation and coordination of chapter 70.14 RCW as well as other legislative and executive policies designed to contain the cost of health care that is purchased or provided by the state. In order to achieve that purpose, the director may:

(a) Establish within the ((~~office of financial management~~)) health care authority a health care cost containment program in cooperation with all state agencies;

(b) Implement lawful health care cost containment policies that have been adopted by the legislature or the governor, including appropriation provisos;

(c) Coordinate the activities of all state agencies with respect to health care cost containment policies;

(d) Study and make recommendations on health care cost containment policies;

(e) Monitor and report on the implementation of health care cost containment policies;

(f) Appoint a health care cost containment technical advisory committee that represents state agencies that are involved in the direct purchase, funding, or provision of health care; and

(g) Engage in other activities necessary to achieve the purposes of this section.

(2) All state agencies shall cooperate with the director in carrying out the purpose of this section.

Sec. 72. RCW 43.41.260 and 2009 c 479 s 28 are each amended to read as follows:

The health care authority((~~,~~)) and the office of financial management((~~, and the department of social and health services~~)) shall together monitor the enrollee level in the basic health plan and the medicaid caseload of children. The office of financial management shall adjust the funding levels by interagency

reimbursement of funds between the basic health plan and medicaid and adjust the funding levels ((~~between~~)) for the health care authority ((~~and the medical assistance administration of the department of social and health services~~)) to maximize combined enrollment.

Sec. 73. RCW 43.70.670 and 2007 c 259 s 38 are each amended to read as follows:

(1) "Human immunodeficiency virus insurance program," as used in this section, means a program that provides health insurance coverage for individuals with human immunodeficiency virus, as defined in RCW 70.24.017(7), who are not eligible for medical assistance programs from the ((~~department of social and health services~~)) health care authority as defined in RCW 74.09.010((~~(8)~~)) (10) and meet eligibility requirements established by the department of health.

(2) The department of health may pay for health insurance coverage on behalf of persons with human immunodeficiency virus, who meet department eligibility requirements, and who are eligible for "continuation coverage" as provided by the federal consolidated omnibus budget reconciliation act of 1985, group health insurance policies, or individual policies.

Sec. 74. RCW 47.06B.020 and 2011 c 60 s 45 are each amended to read as follows:

(1) The agency council on coordinated transportation is created. The purpose of the council is to advance and improve accessibility to and coordination of special needs transportation services statewide. The council is composed of fourteen voting members and four nonvoting, legislative members.

(2) The fourteen voting members are the superintendent of public instruction or a designee, the secretary of transportation or a designee, the ((~~secretary of the department of social and health services~~)) director of the health care authority or a designee, and eleven members appointed by the governor as follows:

(a) One representative from the office of the governor;

(b) Three persons who are consumers of special needs transportation services, which must include:

(i) One person designated by the executive director of the governor's committee on disability issues and employment; and

(ii) One person who is designated by the executive director of the developmental disabilities council;

(c) One representative from the Washington association of pupil transportation;

(d) One representative from the Washington state transit association;

(e) One of the following:

(i) A representative from the community transportation association of the Northwest; or

(ii) A representative from the community action council association;

(f) One person who represents regional transportation planning organizations and metropolitan planning organizations;

(g) One representative of brokers who provide nonemergency, medically necessary trips to persons with special transportation needs under the medicaid program administered by the ((~~department of social and health services~~)) health care authority;

(h) One representative from the Washington state department of veterans affairs; and

(i) One representative of the state association of counties.

(3) The four nonvoting members are legislators as follows:

(a) Two members from the house of representatives, one from each of the two largest caucuses, appointed by the speaker of the house of representatives, including at least one member from the house transportation policy and budget committee or the house appropriations committee; and

(b) Two members from the senate, one from each of the two largest caucuses, appointed by the president of the senate, including at least one member from the senate transportation committee or the senate ways and means committee.

(4) Gubernatorial appointees of the council will serve two-year terms. Members may not receive compensation for their service on the council, but will be reimbursed for actual and necessary expenses incurred in performing their duties as members as set forth in RCW 43.03.220.

(5) The council shall vote on an annual basis to elect one of its voting members to serve as chair. The position of chair must rotate among the represented agencies, associations, and interest groups at least every two years. If the position of chair is vacated for any reason, the secretary of transportation or the secretary's designee shall serve as acting chair until the next regular meeting of the council, at which time the members will elect a chair.

(6) The council shall periodically assess its membership to ensure that there exists a balanced representation of persons with special transportation needs and providers of special transportation needs services. Recommendations for modifying the membership of the council must be included in the council's biennial report to the legislature as provided in RCW 47.06B.050.

(7) The department of transportation shall provide necessary staff support for the council.

(8) The council may receive gifts, grants, or endowments from public or private sources that are made from time to time, in trust or otherwise, for the use and benefit of the purposes of the council and spend gifts, grants, or endowments or income from the public or private sources according to their terms, unless the receipt of the gifts, grants, or endowments violates RCW 42.17A.560.

(9) The meetings of the council must be open to the public, with the agenda published in advance, and minutes kept and made available to the public. The public notice of the meetings must indicate that accommodations for persons with disabilities will be made available upon request.

(10) All meetings of the council must be held in locations that are readily accessible to public transportation, and must be scheduled for times when public transportation is available.

(11) The council shall make an effort to include presentations by and work sessions including persons with special transportation needs.

Sec. 75. RCW 47.06B.060 and 2009 c 515 s 1 are each amended to read as follows:

(1) In 2007, the legislature directed the joint transportation committee to conduct a study of special needs transportation to examine and evaluate the effectiveness of special needs transportation in the state. A particular goal of the study was to explore opportunities to enhance coordination of special needs transportation programs to ensure that they are delivered efficiently and result in improved access and increased mobility options for their clients. It is the intent of the legislature to further consider some of the recommendations, and to implement many of these recommendations in the form of two pilot projects that will test the potential for applying these recommendations statewide in the future.

(2) The legislature is aware that the department of social and health services submitted an application in December of 2008 to the federal centers for medicare and medicaid services, seeking approval to use the medical match system, a federal funding system that has different requirements from the federal administrative match system currently used by the department. It is the intent of the legislature to advance the goals of chapter 515, Laws of 2009 and the recommendations of the study identified in subsection (1) of this section without jeopardizing the application made by the department.

(3) By August 15, 2009, the agency council on coordinated transportation shall appoint a work group for the purpose of identifying relevant federal requirements related to special needs transportation, and identifying solutions to streamline the requirements and increase efficiencies in transportation services provided for persons with special transportation needs. To advance its purpose, the work group shall work with relevant federal representatives and agencies to identify and address various challenges and barriers.

(4) Membership of the work group must include, but not be limited to, one or more representatives from:

(a) The departments of transportation, veterans affairs, health, and ((~~social and health services~~)) the health care authority;

(b) Medicaid nonemergency medical transportation brokers;

(c) Public transit agencies;

(d) Regional and metropolitan transportation planning organizations, including a representative of the regional transportation planning organization or organizations that provide staff support to the local coordinating coalition established under RCW 47.06B.070;

(e) Indian tribes;

(f) The agency council on coordinated transportation;

(g) The local coordinating coalitions established under RCW 47.06B.070; and

(h) The office of the superintendent of public instruction.

(5) The work group shall elect one or more of its members to service as chair or cochairs.

(6) The work group shall immediately contact representatives of the federal congressional delegation for Washington state and the relevant federal agencies and coordinating authorities including, but not limited to, the federal transit administration, the United States department of health and human services, and the interagency transportation coordinating council on access and mobility, and invite the federal representatives to work collaboratively to:

(a) Identify transportation definitions and terminology used in the various relevant state and federal programs, and establish consistent transportation definitions and terminology. For purposes of this subsection, relevant state definitions exclude terminology that requires a medical determination, including whether a trip or service is medically necessary;

(b) Identify restrictions or barriers that preclude federal, state, and local agencies from sharing client lists or other client information, and make progress towards removing any restrictions or barriers;

(c) Identify relevant state and federal performance and cost reporting systems and requirements, and work towards establishing consistent and uniform performance and cost reporting systems and requirements; and

(d) Explore, subject to federal approval, opportunities to test cost allocation models, including the pilot projects established in RCW 47.06B.080, that:

(i) Allow for cost sharing among public paratransit and medicaid nonemergency medical trips; and

(ii) Capture the value of medicaid trips provided by public transit agencies for which they are not currently reimbursed with a funding match by federal medicaid dollars.

(7) By December 1, 2009, the work group shall submit a report to the joint transportation committee that explains the progress made towards the goals of this section and identifies any necessary legislative action that must be taken to implement all the provisions of this section. A second progress report must be submitted to the joint transportation committee by June 1, 2010, and a final report must be submitted to the joint transportation committee by December 1, 2010.

Sec. 76. RCW 47.06B.070 and 2009 c 515 s 9 are each amended to read as follows:

(1) A local coordinating coalition is created in each nonemergency medical transportation brokerage region, as designated by the ((~~department of social and health services~~)) health care authority, that encompasses:

(a) A single county that has a population of more than seven hundred fifty thousand but less than one million; and

(b) Five counties, and is comprised of at least one county that has a population of more than four hundred thousand.

(2) The purpose of a local coordinating coalition is to advance local efforts to coordinate and maximize efficiencies in special needs transportation programs and services, contributing to the overall objectives and goals of the agency council on coordinated transportation. The local coordinating coalition shall serve in an advisory capacity to the agency council on coordinated transportation by providing the council with a focused and ongoing assessment of the special transportation needs and services provided within its region.

(3) The composition and size of each local coordinating coalition may vary by region. Local coordinating coalition members, appointed by the chair of the agency council on coordinated transportation to two-year terms, must reflect a balanced representation of the region's providers of special needs transportation services and must include:

(a) Members of existing local coordinating coalitions, with approval by those members;

(b) One or more representatives of the public transit agency or agencies serving the region;

(c) One or more representatives of private service providers;

(d) A representative of civic or community-based service providers;

(e) A consumer of special needs transportation services;

(f) A representative of nonemergency medical transportation medicaid brokers;

(g) A representative of social and human service programs;

(h) A representative of local high school districts; and

(i) A representative from the Washington state department of veterans affairs.

(4) Each coalition shall vote on an annual basis to elect one of its members to serve as chair. The position of chair must rotate among the represented members at least every two years. If the position of chair is vacated for any reason, the member representing the regional transportation planning organization described in subsection (6) of this section shall serve as acting chair until the next regular meeting of the coalition, at which time the members will elect a chair.

(5) Regular meetings of the local coordinating coalition may be convened at the call of the chair or by a majority of the members. Meetings must be open to the public, and held in locations that are readily accessible to public transportation.

(6) The regional transportation planning organization, as described in chapter 47.80 RCW, serving the region in which the local coordinating coalition is created shall provide necessary staff support for the local coordinating coalition. In regions served by more than one regional transportation planning organization, unless otherwise agreed to by the relevant planning organizations, the regional transportation planning organization serving the largest population within the region shall provide the necessary staff support.

Sec. 77. RCW 48.01.235 and 2003 c 248 s 2 are each amended to read as follows:

(1) An issuer and an employee welfare benefit plan, whether insured or self funded, as defined in the employee retirement income security act of 1974, 29 U.S.C. Sec. 1101 et seq. may not deny enrollment of a child under the health plan of the child's parent on the grounds that:

(a) The child was born out of wedlock;

(b) The child is not claimed as a dependent on the parent's federal tax return; or

(c) The child does not reside with the parent or in the issuer's, or insured or self funded employee welfare benefit plan's service area.

(2) Where a child has health coverage through an issuer, or an insured or self funded employee welfare benefit plan of a noncustodial parent, the issuer, or insured or self funded employee welfare benefit plan, shall:

(a) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(b) Permit the provider or the custodial parent to submit claims for covered services without the approval of the noncustodial parent. If the provider submits the claim, the provider will obtain the custodial parent's assignment of insurance benefits or otherwise secure the custodial parent's approval.

For purposes of this subsection the ((~~department of social and health services~~)) health care authority as the state medicaid agency under RCW 74.09.500 may reassign medical insurance rights to the provider for custodial parents whose children are eligible for services under RCW 74.09.500; and

(c) Make payments on claims submitted in accordance with (b) of this subsection directly to the custodial parent, to the provider, or to the ((~~department of social and health services~~)) health care authority as the state medicaid agency under RCW 74.09.500.

(3) Where a child does not reside in the issuer's service area, an issuer shall cover no less than urgent and emergent care. Where the issuer offers broader coverage, whether by policy or reciprocal agreement, the issuer shall provide such coverage to any child otherwise covered that does not reside in the issuer's service area.

(4) Where a parent is required by a court order to provide health coverage for a child, and the parent is eligible for family health coverage, the issuer, or insured or self funded employee welfare benefit plan, shall:

(a) Permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(b) Enroll the child under family coverage upon application of the child's other parent, ((~~department of social and health services~~)) health care authority as the state medicaid agency under RCW 74.09.500, or child support enforcement program, if the parent is enrolled but fails to make application to obtain coverage for such child; and

(c) Not disenroll, or eliminate coverage of, such child who is otherwise eligible for the coverage unless the issuer or insured or self funded employee welfare benefit plan is provided satisfactory written evidence that:

(i) The court order is no longer in effect; or

(ii) The child is or will be enrolled in comparable health coverage through another issuer, or insured or self funded employee welfare benefit plan, which will take effect not later than the effective date of disenrollment.

(5) An issuer, or insured or self funded employee welfare benefit plan, that has been assigned the rights of an individual eligible for medical assistance under medicaid and coverage for health benefits from the issuer, or insured or self funded employee welfare benefit plan, may not impose requirements on the ((~~department of social and health services~~)) health care authority that are different from requirements applicable to an agent or assignee of any other individual so covered.

Sec. 78. RCW 48.43.008 and 2007 c 259 s 24 are each amended to read as follows:

When the ((~~department of social and health services~~)) health care authority determines that it is cost-effective to enroll a person eligible for medical assistance under chapter 74.09 RCW in an employer-sponsored health plan, a carrier shall permit the enrollment of the person in the health plan for which he or she is otherwise eligible without regard to any open enrollment period restrictions.

Sec. 79. RCW 48.43.517 and 2007 c 5 s 7 are each amended to read as follows:

When the ((~~department of social and health services~~)) health care authority has determined that it is cost-effective to enroll a child participating in a medical assistance program under chapter 74.09 RCW in an employer-sponsored health plan, the carrier shall permit the enrollment of the participant who is otherwise eligible for coverage in the health plan without regard to any open enrollment restrictions. The request for special enrollment shall be made by the ((~~department~~)) authority or participant within sixty days of the ((~~department's~~)) authority's determination that the enrollment would be cost-effective.

Sec. 80. RCW 69.41.030 and 2010 c 83 s 1 are each amended to read as follows:

(1) It shall be unlawful for any person to sell, deliver, or possess any legend drug except upon the order or prescription of a physician under chapter 18.71 RCW, an osteopathic physician and surgeon under chapter 18.57 RCW, an optometrist licensed under chapter 18.53 RCW who is certified by the optometry board under RCW 18.53.010, a dentist under chapter 18.32 RCW, a podiatric physician and surgeon under chapter 18.22 RCW, a veterinarian under chapter 18.92 RCW, a commissioned medical or dental officer in the United States armed forces or public health service in the discharge of his or her official duties, a duly licensed physician or dentist employed by the veterans administration in the discharge of his or her official duties, a registered nurse or advanced registered nurse practitioner under chapter 18.79 RCW when authorized by the nursing care quality assurance commission, an osteopathic physician assistant under chapter 18.57A RCW when authorized by the board of osteopathic medicine and surgery, a physician assistant under chapter 18.71A RCW when authorized by the medical quality assurance commission, or any of the following professionals in any province of Canada that shares a common border with the state of Washington or in any state of the United States: A physician licensed to practice medicine and surgery or a physician licensed to practice osteopathic medicine and surgery, a dentist licensed to practice dentistry, a podiatric physician and surgeon licensed to practice podiatric medicine and surgery, a licensed advanced registered nurse practitioner, or a veterinarian licensed to practice veterinary medicine: PROVIDED, HOWEVER, That the above provisions shall not apply to sale, delivery, or possession by drug wholesalers or drug manufacturers, or their agents or employees, or to any practitioner acting within the scope of his or her license, or to a common or contract carrier or warehouseman, or any employee thereof, whose possession of any legend drug is in the usual course of business or employment: PROVIDED FURTHER, That nothing in this chapter or chapter 18.64 RCW shall prevent a family planning clinic that is under contract with the ((~~department of social and health services~~)) health care authority from selling, delivering, possessing, and dispensing commercially prepackaged oral contraceptives prescribed by authorized, licensed health care practitioners.

(2)(a) A violation of this section involving the sale, delivery, or possession with intent to sell or deliver is a class B felony punishable according to chapter 9A.20 RCW.

(b) A violation of this section involving possession is a misdemeanor.

Sec. 81. RCW 69.41.190 and 2009 c 575 s 1 are each amended to read as follows:

(1)(a) Except as provided in subsection (2) of this section, any pharmacist filling a prescription under a state purchased health care program as defined in RCW 41.05.011(2) shall substitute, where

identified, a preferred drug for any nonpreferred drug in a given therapeutic class, unless the endorsing practitioner has indicated on the prescription that the nonpreferred drug must be dispensed as written, or the prescription is for a refill of an antipsychotic, antidepressant, antiepileptic, chemotherapy, antiretroviral, or immunosuppressive drug, or for the refill of a immunomodulator/antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks but no more than forty-eight weeks, in which case the pharmacist shall dispense the prescribed nonpreferred drug.

(b) When a substitution is made under (a) of this subsection, the dispensing pharmacist shall notify the prescribing practitioner of the specific drug and dose dispensed.

(2)(a) A state purchased health care program may impose limited restrictions on an endorsing practitioner's authority to write a prescription to dispense as written only under the following circumstances:

(i) There is statistical or clear data demonstrating the endorsing practitioner's frequency of prescribing dispensed as written for nonpreferred drugs varies significantly from the prescribing patterns of his or her peers;

(ii) The medical director of a state purchased health program has: (A) Presented the endorsing practitioner with data that indicates the endorsing practitioner's prescribing patterns vary significantly from his or her peers, (B) provided the endorsing practitioner an opportunity to explain the variation in his or her prescribing patterns to those of his or her peers, and (C) if the variation in prescribing patterns cannot be explained, provided the endorsing practitioner sufficient time to change his or her prescribing patterns to align with those of his or her peers; and

(iii) The restrictions imposed under (a) of this subsection (2) must be limited to the extent possible to reduce variation in prescribing patterns and shall remain in effect only until such time as the endorsing practitioner can demonstrate a reduction in variation in line with his or her peers.

(b) A state purchased health care program may immediately designate an available, less expensive, equally effective generic product in a previously reviewed drug class as a preferred drug, without first submitting the product to review by the pharmacy and therapeutics committee established pursuant to RCW 70.14.050.

(c) For a patient's first course of treatment within a therapeutic class of drugs, a state purchased health care program may impose limited restrictions on endorsing practitioners' authority to write a prescription to dispense as written, only under the following circumstances:

(i) There is a less expensive, equally effective therapeutic alternative generic product available to treat the condition;

(ii) The drug use review board established under WAC 388-530-4000 reviews and provides recommendations as to the appropriateness of the limitation;

(iii) Notwithstanding the limitation set forth in (c)(ii) of this subsection (2), the endorsing practitioner shall have an opportunity to request as medically necessary, that the brand name drug be prescribed as the first course of treatment;

(iv) The state purchased health care program may provide, where available, prescription, emergency room, diagnosis, and hospitalization history with the endorsing practitioner; and

(v) Specifically for antipsychotic restrictions, the state purchased health care program shall effectively guide good practice without interfering with the timeliness of clinical decision making. ((~~Department of social and health services~~)) Health care authority prior authorization programs must provide for responses within twenty-four hours and at least a seventy-two hour emergency supply of the requested drug.

(d) If, within a therapeutic class, there is an equally effective therapeutic alternative over-the-counter drug available, a state purchased health care program may designate the over-the-counter drug as the preferred drug.

(e) A state purchased health care program may impose limited restrictions on endorsing practitioners' authority to prescribe pharmaceuticals to be dispensed as written for a purpose outside the scope of their approved labels only under the following circumstances:

(i) There is a less expensive, equally effective on-label product available to treat the condition;

(ii) The drug use review board established under WAC 388-530-4000 reviews and provides recommendations as to the appropriateness of the limitation; and

(iii) Notwithstanding the limitation set forth in (e)(ii) of this subsection (2), the endorsing practitioner shall have an opportunity to request as medically necessary, that the drug be prescribed for a covered off-label purpose.

(f) The provisions of this subsection related to the definition of medically necessary, prior authorization procedures and patient appeal rights shall be implemented in a manner consistent with applicable federal and state law.

(3) Notwithstanding the limitations in subsection (2) of this section, for refills for an antipsychotic, antidepressant, antiepileptic, chemotherapy, antiretroviral, or immunosuppressive drug, or for the refill of an immunomodulator antiviral treatment for hepatitis C for which an established, fixed duration of therapy is prescribed for at least twenty-four weeks by no more than forty-eight weeks, the pharmacist shall dispense the prescribed nonpreferred drug.

Sec. 82. RCW 70.01.010 and 2011 c 27 s 3 are each amended to read as follows:

In furtherance of the policy of this state to cooperate with the federal government in the public health programs, the department of health ((~~and~~)), the state board of health, and the health care authority shall adopt such rules as may become necessary to entitle this state to participate in federal funds unless expressly prohibited by law. Any section or provision of the public health laws of this state which may be susceptible to more than one construction shall be interpreted in favor of the construction most likely to satisfy federal laws entitling this state to receive federal funds for the various programs of public health.

Sec. 83. RCW 70.47.010 and 2009 c 568 s 1 are each amended to read as follows:

(1)(a) The legislature finds that limitations on access to health care services for enrollees in the state, such as in rural and underserved areas, are particularly challenging for the basic health plan. Statutory restrictions have reduced the options available to the ((~~administrator~~)) director to address the access needs of basic health plan enrollees. It is the intent of the legislature to authorize the ((~~administrator~~)) director to develop alternative purchasing strategies to ensure access to basic health plan enrollees in all areas of the state, including: (i) The use of differential rating for managed health care systems based on geographic differences in costs; and (ii) limited use of self-insurance in areas where adequate access cannot be assured through other options.

(b) In developing alternative purchasing strategies to address health care access needs, the ((~~administrator~~)) director shall consult with interested persons including health carriers, health care providers, and health facilities, and with other appropriate state agencies including the office of the insurance commissioner and the office of community and rural health. In pursuing such alternatives, the ((~~administrator~~)) director shall continue to give priority to prepaid managed care as the preferred method of assuring access to basic health plan enrollees followed, in priority order, by preferred providers, fee for service, and self-funding.

(2) The legislature further finds that:

(a) A significant percentage of the population of this state does not have reasonably available insurance or other coverage of the costs of necessary basic health care services;

(b) This lack of basic health care coverage is detrimental to the health of the individuals lacking coverage and to the public welfare, and results in substantial expenditures for emergency and remedial health care, often at the expense of health care providers, health care facilities, and all purchasers of health care, including the state; and

(c) The use of managed health care systems has significant potential to reduce the growth of health care costs incurred by the people of this state generally, and by low-income pregnant women, and at-risk children and adolescents who need greater access to managed health care.

(3) The purpose of this chapter is to provide or make more readily available necessary basic health care services in an appropriate setting to working persons and others who lack coverage, at a cost to these persons that does not create barriers to the utilization of necessary health care services. To that end, this chapter establishes a program to be made available to those residents not eligible for medicare who share in a portion of the cost or who pay the full cost of receiving basic health care services from a managed health care system.

(4) It is not the intent of this chapter to provide health care services for those persons who are presently covered through private employer-based health plans, nor to replace employer-based health plans. However, the legislature recognizes that cost-effective and affordable health plans may not always be available to small business employers. Further, it is the intent of the legislature to expand, wherever possible, the availability of private health care coverage and to discourage the decline of employer-based coverage.

(5)(a) It is the purpose of this chapter to acknowledge the initial success of this program that has (i) assisted thousands of families in their search for affordable health care; (ii) demonstrated that low-income, uninsured families are willing to pay for their own health care coverage to the extent of their ability to pay; and (iii) proved that local health care providers are willing to enter into a public-private partnership as a managed care system.

(b) As a consequence, the legislature intends to extend an option to enroll to certain citizens above two hundred percent of the federal poverty guidelines within the state who reside in communities where the plan is operational and who collectively or individually wish to exercise the opportunity to purchase health care coverage through the basic health plan if the purchase is done at no cost to the state. It is also the intent of the legislature to allow employers and other financial sponsors to financially assist such individuals to purchase health care through the program so long as such purchase does not result in a lower standard of coverage for employees.

(c) The legislature intends that, to the extent of available funds, the program be available throughout Washington state to subsidized and nonsubsidized enrollees. It is also the intent of the legislature to enroll subsidized enrollees first, to the maximum extent feasible.

(d) The legislature directs that the basic health plan ((~~administrator~~)) director identify enrollees who are likely to be eligible for medical assistance and assist these individuals in applying for and receiving medical assistance. ((~~The administrator and the department of social and health services shall implement a seamless system to coordinate eligibility determinations and benefit coverage for enrollees of the basic health plan and medical assistance recipients.~~)) Enrollees receiving medical assistance are not eligible for the Washington basic health plan.

Sec. 84. RCW 70.47.020 and 2011 c 205 s 1 are each amended to read as follows:

As used in this chapter:

(1) ((~~"Administrator" means the Washington basic health plan administrator, who also holds the position of administrator~~)) "Director" means the director of the Washington state health care authority.

(2) "Health coverage tax credit eligible enrollee" means individual workers and their qualified family members who lose their jobs due to the effects of international trade and are eligible for certain trade adjustment assistance benefits; or are eligible for benefits under the alternative trade adjustment assistance program; or are people who receive benefits from the pension benefit guaranty corporation and are at least fifty-five years old.

(3) "Health coverage tax credit program" means the program created by the Trade Act of 2002 (P.L. 107-210) that provides a federal tax credit that subsidizes private health insurance coverage for displaced workers certified to receive certain trade adjustment assistance benefits and for individuals receiving benefits from the pension benefit guaranty corporation.

(4) "Managed health care system" means: (a) Any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the ((~~administrator~~)) director and rendered by duly licensed providers, to a defined patient population enrolled in the plan and in the managed health care system; or (b) a self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(7).

(5) "Nonsubsidized enrollee" means an individual, or an individual plus the individual's spouse or dependent children: (a) Who is not eligible for medicare; (b) who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the ((~~administrator~~)) director; (c) who is accepted for enrollment by the ((~~administrator~~)) director as provided in RCW 48.43.018, either because the potential enrollee cannot be required to complete the standard health questionnaire under RCW 48.43.018, or, based upon the results of the standard health questionnaire, the potential enrollee would not qualify for coverage under the Washington state health insurance pool; (d) who resides in an area of the state served by a managed health care system participating in the plan; (e) who chooses to obtain basic health care coverage from a particular managed health care system; and (f) who pays or on whose behalf is paid the full costs for participation in the plan, without any subsidy from the plan.

(6) "Premium" means a periodic payment, which an individual, their employer or another financial sponsor makes to the plan as consideration for enrollment in the plan as a subsidized enrollee, a nonsubsidized enrollee, or a health coverage tax credit eligible enrollee.

(7) "Rate" means the amount, negotiated by the ((~~administrator~~)) director with and paid to a participating managed health care system, that is based upon the enrollment of subsidized, nonsubsidized, and health coverage tax credit eligible enrollees in the plan and in that system.

(8) "Subsidy" means the difference between the amount of periodic payment the ((~~administrator~~)) director makes to a managed health care system on behalf of a subsidized enrollee plus the administrative cost to the plan of providing the plan to that subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

(9) "Subsidized enrollee" means:

(a) An individual, or an individual plus the individual's spouse or dependent children:

(i) Who is not eligible for medicare;

(ii) Who is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the ((~~administrator~~)) director;

(iii) Who is not a full-time student who has received a temporary visa to study in the United States;

(iv) Who resides in an area of the state served by a managed health care system participating in the plan;

(v) Until March 1, 2011, whose gross family income at the time of enrollment does not exceed two hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services;

(vi) Who chooses to obtain basic health care coverage from a particular managed health care system in return for periodic payments to the plan;

(vii) Who is not receiving medical assistance administered by the ((~~department of social and health services~~)) authority; and

(viii) After February 28, 2011, who is in the basic health transition eligibles population under 1115 medicaid demonstration project number 11-W-00254/10;

(b) An individual who meets the requirements in (a)(i) through (iv), (vi), and (vii) of this subsection and who is a foster parent licensed under chapter 74.15 RCW and whose gross family income at the time of enrollment does not exceed three hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services; and

(c) To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, an individual, or an individual's spouse or dependent children, who meets the requirements in (a)(i) through (iv), (vi), and (vii) of this subsection and whose gross family income at the time of enrollment is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services.

(10) "Washington basic health plan" or "plan" means the system of enrollment and payment for basic health care services, administered by the plan ((~~administrator~~)) director through participating managed health care systems, created by this chapter.

Sec. 85. RCW 70.47.110 and 1991 sp.s. c 4 s 3 are each amended to read as follows:

The ((~~department of social and health services~~)) health care authority may make payments to ((~~the administrator or to~~)) participating managed health care systems on behalf of any enrollee who is a recipient of medical care under chapter 74.09 RCW, at the maximum rate allowable for federal matching purposes under Title XIX of the social security act. Any enrollee on whose behalf the ((~~department of social and health services~~)) health care authority makes such payments may continue as an enrollee, making premium payments based on the enrollee's own income as determined under the sliding scale, after eligibility for coverage under chapter 74.09 RCW has ended, as long as the enrollee remains eligible under this chapter. Nothing in this section affects the right of any person eligible for coverage under chapter 74.09 RCW to receive the services offered to other persons under that chapter but not included in the schedule of basic health care services covered by the plan. The ((~~administrator~~)) director shall seek to determine which enrollees or prospective enrollees may be eligible for medical care under chapter 74.09 RCW and may require these individuals to complete the eligibility determination process under chapter 74.09 RCW prior to enrollment or continued participation in the plan. The ((~~administrator and the department of social and health services~~)) director shall ((~~cooperatively~~)) adopt procedures to facilitate the transition of plan enrollees and payments on their behalf between the plan and the programs established under chapter 74.09 RCW.

Sec. 86. RCW 70.48.130 and 1993 c 409 s 1 are each amended to read as follows:

(1) It is the intent of the legislature that all jail inmates receive appropriate and cost-effective emergency and necessary medical care. Governing units, the ((~~department of social and health services~~)) health care authority, and medical care providers shall cooperate to achieve the best rates consistent with adequate care.

(2) Payment for emergency or necessary health care shall be by the governing unit, except that the ((~~department of social and health services~~)) health care authority shall directly reimburse the provider pursuant to chapter 74.09 RCW, in accordance with the rates and benefits established by the ((~~department~~)) authority, if the confined person is eligible under the ((~~department's~~)) authority's medical care programs as authorized under chapter 74.09 RCW. After payment by the ((~~department~~)) authority, the financial responsibility for any remaining balance, including unpaid client liabilities that are a condition of eligibility or participation under chapter 74.09 RCW, shall be borne by the medical care provider and the governing unit as may be mutually agreed upon between the medical care provider and the governing unit. In the absence of mutual agreement between the medical care provider and the governing unit, the financial responsibility for any remaining balance shall be borne equally between the medical care provider and the governing unit. Total payments from all sources to providers for care rendered to confined persons eligible under chapter 74.09 RCW shall not exceed the amounts that would be paid by the ((~~department~~)) authority for similar services provided under Title XIX medicaid, unless additional resources are obtained from the confined person.

(3) As part of the screening process upon booking or preparation of an inmate into jail, general information concerning the inmate's ability to pay for medical care shall be identified, including insurance or other medical benefits or resources to which an inmate is entitled. This information shall be made available to the ((~~department~~)) authority, the governing unit, and any provider of health care services.

(4) The governing unit or provider may obtain reimbursement from the confined person for the cost of health care services not provided under chapter 74.09 RCW, including reimbursement from any insurance program or from other medical benefit programs available to the confined person. Nothing in this chapter precludes civil or criminal remedies to recover the costs of medical care provided jail inmates or paid for on behalf of inmates by the governing unit. As part of a judgment and sentence, the courts are authorized to order defendants to repay all or part of the medical costs incurred by the governing unit or provider during confinement.

(5) To the extent that a confined person is unable to be financially responsible for medical care and is ineligible for the ((~~department's~~)) authority's medical care programs under chapter 74.09 RCW, or for coverage from private sources, and in the absence of an interlocal agreement or other contracts to the contrary, the governing unit may obtain reimbursement for the cost of such medical services from the unit of government whose law enforcement officers initiated the charges on which the person is being held in the jail: PROVIDED, That reimbursement for the cost of such services shall be by the state for state prisoners being held in a jail who are accused of either escaping from a state facility or of committing an offense in a state facility.

(6) There shall be no right of reimbursement to the governing unit from units of government whose law enforcement officers initiated the charges for which a person is being held in the jail for care provided after the charges are disposed of by sentencing or otherwise, unless by intergovernmental agreement pursuant to chapter 39.34 RCW.

(7) Under no circumstance shall necessary medical services be denied or delayed because of disputes over the cost of medical care or a determination of financial responsibility for payment of the costs of medical care provided to confined persons.

(8) Nothing in this section shall limit any existing right of any party, governing unit, or unit of government against the person receiving the care for the cost of the care provided.

Sec. 87. RCW 70.168.040 and 2010 c 161 s 1158 are each amended to read as follows:

The emergency medical services and trauma care system trust account is hereby created in the state treasury. Moneys shall be transferred to the emergency medical services and trauma care system trust account from the public safety education account or other sources as appropriated, and as collected under RCW 46.63.110(7) and 46.68.440. Disbursements shall be made by the department subject to legislative appropriation. Expenditures may be made only for the purposes of the state trauma care system under this chapter, including emergency medical services, trauma care services, rehabilitative services, and the planning and development of related services under this chapter and for reimbursement by the ((~~department of social and health services~~)) health care authority for trauma care services provided by designated trauma centers.

Sec. 88. RCW 70.225.040 and 2007 c 259 s 45 are each amended to read as follows:

(1) Prescription information submitted to the department shall be confidential, in compliance with chapter 70.02 RCW and federal health care information privacy requirements and not subject to disclosure, except as provided in subsections (3) and (4) of this section.

(2) The department shall maintain procedures to ensure that the privacy and confidentiality of patients and patient information collected, recorded, transmitted, and maintained is not disclosed to persons except as in subsections (3) and (4) of this section.

(3) The department may provide data in the prescription monitoring program to the following persons:

(a) Persons authorized to prescribe or dispense controlled substances, for the purpose of providing medical or pharmaceutical care for their patients;

(b) An individual who requests the individual's own prescription monitoring information;

(c) Health professional licensing, certification, or regulatory agency or entity;

(d) Appropriate local, state, and federal law enforcement or prosecutorial officials who are engaged in a bona fide specific investigation involving a designated person;

(e) Authorized practitioners of the department of social and health services and the health care authority regarding medicaid program recipients;

(f) The director or director's designee within the department of labor and industries regarding workers' compensation claimants;

(g) The director or the director's designee within the department of corrections regarding offenders committed to the department of corrections;

(h) Other entities under grand jury subpoena or court order; and

(i) Personnel of the department for purposes of administration and enforcement of this chapter or chapter 69.50 RCW.

(4) The department may provide data to public or private entities for statistical, research, or educational purposes after removing information that could be used to identify individual patients, dispensers, prescribers, and persons who received prescriptions from dispensers.

(5) A dispenser or practitioner acting in good faith is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for requesting, receiving, or using information from the program.

NEW SECTION. **Sec. 89.** The purpose of this chapter is to provide the health care authority with the powers, duties, and authority with respect to the collection of overpayments and the coordination of benefits that are currently provided to the department of social and health services in chapter 43.20B RCW. Providing the health care authority with these powers is necessary for the authority to administer medical services programs established under chapter 74.09 RCW currently administered by the department of social and health services programs but transferred to the authority under this act. The authority is authorized to collaborate with other state agencies in carrying out its duties under this chapter and, to the extent appropriate, may enter into agreements with such other agencies. Nothing in this chapter may be construed as diminishing the powers, duties, and authority granted to the department of social and health services in chapter 43.20B RCW with respect to the programs that will remain under its jurisdiction following enactment of this act.

NEW SECTION. **Sec. 90.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise:

(1) "Assistance" means all programs administered by the authority. (2) "Authority" means the Washington state health care authority.

(3) "Director" means the director of the Washington state health care authority.

(4) "Overpayment" means any payment or benefit to a recipient or to a vendor in excess of that to which is entitled by law, rule, or contract, including amounts in dispute.

(5) "Vendor" means a person or entity that provides goods or services to or for clientele of the authority and that controls operational decisions.

NEW SECTION. **Sec. 91.** The authority is authorized to charge fees for services provided unless otherwise prohibited by law. The fees may be sufficient to cover the full cost of the service provided if practical or may be charged on an ability-to-pay basis if practical. This section does not supersede other statutory authority enabling the assessment of fees by the authority. Whenever the authority is authorized by law to collect total or partial reimbursement for the cost of its providing care of or exercising custody over any person, the authority shall collect the reimbursement to the extent practical.

NEW SECTION. **Sec. 92.** (1) Except as otherwise provided by law, including subsection (2) of this section, there may be no collection of overpayments and other debts due the authority after the expiration of six years from the date of notice of such overpayment or other debt unless the authority has commenced recovery action in a court of law or unless an administrative remedy authorized by statute is in place. However, any amount due in a case thus extended ceases to be a debt due the authority at the expiration of ten years from the date of the notice of the overpayment or other debt unless a court-ordered remedy would be in effect for a longer period.

(2) There may be no collection of debts due the authority after the expiration of twenty years from the date a lien is recorded pursuant to section 97 of this act.

(3) The authority, at any time, may accept offers of compromise of disputed claims or may grant partial or total write-off of any debt due the authority if it is no longer cost-effective to pursue. The authority shall adopt rules establishing the considerations to be made in the granting or denial of a partial or total write-off of debts.

NEW SECTION. **Sec. 93.** The form of the lien in section 95 of this act must be substantially as follows:

STATEMENT OF LIEN

Notice is hereby given that the State of Washington, Health Care Authority, has rendered assistance to . . . . . ., a person who was injured on or about the . . . . day of . . . . . in the county of . . . . . state of . . . . . ., and the said authority hereby asserts a lien, to the extent provided in section 95 of this act, for the amount of such

assistance, upon any sum due and owing . . . . . (name of injured person) from . . . . ., alleged to have caused the injury, and/or his or her insurer and from any other person or insurer liable for the injury or obligated to compensate the injured person on account of such injuries by contract or otherwise.

STATE OF WASHINGTON, HEALTH

CARE AUTHORITY

By: ..... (Title)

STATE OF WASHINGTON }
} ss.
COUNTY OF }

I, ..., being first duly sworn, on oath state: That I am . . . . . (title); that I have read the foregoing Statement of Lien, know the contents thereof, and believe the same to be true.

.....

Signed and sworn to or affirmed before me this . . . . day of . . . . . ., ...

by .....

(name of person making statement).

(Seal or stamp)

.....

Notary Public in and for the State

of Washington

My appointment expires: .....

NEW SECTION. **Sec. 94.** (1) No settlement made by and between a recipient and either the tort feasor or insurer, or both, discharges or otherwise compromises the lien created in section 95 of this act without the express written consent of the director or the director's designee. Discretion to compromise such liens rests solely with the director or the director's designee.

(2) No settlement or judgment may be entered purporting to compromise the lien created by section 95 of this act without the express written consent of the director or the director's designee.

NEW SECTION. **Sec. 95.** (1) To secure reimbursement of any assistance paid as a result of injuries to or illness of a recipient caused by the negligence or wrong of another, the authority is subrogated to the recipient's rights against a tort feasor or the tort feasor's insurer, or both.

(2) The authority has the right to file a lien upon any recovery by or on behalf of the recipient from such tort feasor or the tort feasor's insurer, or both, to the extent of the value of the assistance paid by the authority: PROVIDED, That such lien is not effective against recoveries subject to wrongful death when there are surviving dependents of the deceased. The lien becomes effective upon filing with the county auditor in the county where the assistance was authorized or where any action is brought against the tort feasor or insurer. The lien may also be filed in any other county or served upon the recipient in the same manner as a civil summons if, in the authority's discretion, such alternate filing or service is necessary to secure the authority's interest. The additional lien is effective upon filing or service.

(3) The lien of the authority may be against any claim, right of action, settlement proceeds, money, or benefits arising from an insurance program to which the recipient might be entitled (a) against the tort feasor or insurer of the tort feasor, or both, and (b) under any contract of insurance purchased by the recipient or by any other person providing coverage for the illness or injuries for which the assistance is paid or provided by the authority.

(4) If recovery is made by the authority under this section and the subrogation is fully or partially satisfied through an action brought by or on behalf of the recipient, the amount paid to the authority must bear its proportionate share of attorneys' fees and costs.

(a) The determination of the proportionate share to be borne by the authority must be based upon:

(i) The fees and costs approved by the court in which the action was initiated; or

(ii) The written agreement between the attorney and client which establishes fees and costs when fees and costs are not addressed by the court.

(b) When fees and costs have been approved by a court, after notice to the authority, the authority has the right to be heard on the matter of attorneys' fees and costs or its proportionate share.

(c) When fees and costs have not been addressed by the court, the authority shall receive at the time of settlement a copy of the written agreement between the attorney and client which establishes fees and costs and may request and examine documentation of fees and costs associated with the case. The authority may bring an action in superior court to void a settlement if it believes the attorneys' calculation of its proportionate share of fees and costs is inconsistent with the written agreement between the attorney and client which establishes fees and costs or if the fees and costs associated with the case are exorbitant in relation to cases of a similar nature.

(5) The rights and remedies provided to the authority in this section to secure reimbursement for assistance, including the authority's lien and subrogation rights, may be delegated to a managed health care system by contract entered into pursuant to RCW 74.09.522. A managed health care system may enforce all rights and remedies delegated to it by the authority to secure and recover assistance provided under a managed health care system consistent with its agreement with the authority.

NEW SECTION. **Sec. 96.** (1) An attorney representing a person who, as a result of injuries or illness sustained through the negligence or wrong of another, has received, is receiving, or has applied to receive shall:

(a) Notify the authority at the time of filing any claim against a third party, commencing an action at law, negotiating a settlement, or accepting a settlement offer from the tort feasor or the tort feasor's insurer, or both; and

(b) Give the authority thirty days' notice before any judgment, award, or settlement may be satisfied in any action or any claim by the applicant or recipient to recover damages for such injuries or illness.

(2) The proceeds from any recovery made pursuant to any action or claim described in section 95 of this act that is necessary to fully satisfy the authority's lien against recovery must be placed in a trust account or in the registry of the court until the authority's lien is satisfied.

NEW SECTION. **Sec. 97.** (1) The authority shall file liens, seek adjustment, or otherwise effect recovery for assistance correctly paid on behalf of an individual consistent with 42 U.S.C. Sec. 1396p. The authority shall adopt a rule providing for prior notice and hearing rights to the record title holder or purchaser under a land sale contract.

(2) Liens may be adjusted by foreclosure in accordance with chapter 61.12 RCW.

(3) In the case of an individual who was fifty-five years of age or older when the individual received assistance, the authority shall seek adjustment or recovery from the individual's estate, and from nonprobate assets of the individual as defined by RCW 11.02.005, but only for assistance consisting of services that the authority determines to be appropriate, and related hospital and prescription drug services. Recovery from the individual's estate, including foreclosure of liens imposed under this section, must be undertaken as soon as practicable, consistent with 42 U.S.C. Sec. 1396p.

(4) The authority shall apply the assistance estate recovery law as it existed on the date that benefits were received when calculating an estate's liability to reimburse the authority for those benefits.

(5)(a) The authority shall establish procedures consistent with standards established by the federal department of health and human services and pursuant to 42 U.S.C. Sec. 1396p to waive recovery when such recovery would work an undue hardship. The authority shall recognize an undue hardship for a surviving domestic partner whenever recovery would not have been permitted if he or she had been a surviving spouse. The authority is not authorized to pursue recovery under such circumstances.

(b) Recovery of assistance from a recipient's estate may not include property made exempt from claims by federal law or treaty, including exemption for tribal artifacts that may be held by individual Native Americans.

(6) A lien authorized under this section relates back to attach to any real property that the decedent had an ownership interest in immediately before death and is effective as of that date or date of recording, whichever is earlier.

(7) The authority may enforce a lien authorized under this section against a decedent's life estate or joint tenancy interest in real property held by the decedent immediately prior to his or her death. Such a lien enforced under this subsection may not end and must continue as provided in this subsection until the authority's lien has been satisfied.

(a) The value of the life estate subject to the lien is the value of the decedent's interest in the property subject to the life estate immediately prior to the decedent's death.

(b) The value of the joint tenancy interest subject to the lien is the value of the decedent's fractional interest the recipient would have owned in the jointly held interest in the property had the recipient and the surviving joint tenants held title to the property as tenants in common on the date of the recipient's death.

(c) The authority may not enforce the lien provided by this subsection against a bona fide purchaser or encumbrancer that obtains an interest in the property after the death of the recipient and before the authority records either its lien or the request for notice of transfer or encumbrance as provided by section 116 of this act.

(d) The authority may not enforce a lien provided by this subsection against any property right that vested prior to July 1, 2005.

(8)(a) Subject to the requirements of 42 U.S.C. Sec. 1396p(a) and the conditions of this subsection (8), the authority is authorized to file a lien against the property of an individual prior to his or her death, and to seek adjustment and recovery from the individual's estate or sale of the property subject to the lien, if:

(i) The individual is an inpatient in a nursing facility, intermediate care facility for persons with intellectual disabilities, or other medical institution; and

(ii) The authority has determined after notice and opportunity for a hearing that the individual cannot reasonably be expected to be discharged from the medical institution and to return home.

(b) If the individual is discharged from the medical facility and returns home, the authority shall dissolve the lien.

(9) The authority is authorized to adopt rules to effect recovery under this section. The authority may adopt by rule later enactments of the federal laws referenced in this section.

(10) It is the responsibility of the authority to fully disclose in advance verbally and in writing, in easy to understand language, the terms and conditions of estate recovery to all persons offered care subject to recovery of payments.

(11) In disclosing estate recovery costs to potential clients, and to family members at the consent of the client, the authority shall provide a written description of the community service options.

NEW SECTION. **Sec. 98.** (1) Overpayments of assistance become a lien against the real and personal property of the recipient from the time of filing by the authority with the county auditor of the county in which the recipient resides or owns property, and the lien claim has preference over the claims of all unsecured creditors.

(2) Debts due the state for overpayments of assistance may be recovered by the state by deduction from the subsequent assistance payments to such persons, lien and foreclosure, or order to withhold and deliver, or may be recovered by civil action.

NEW SECTION. **Sec. 99.** (1) Any person who owes a debt to the state for an overpayment of assistance must be notified of that debt by either personal service or certified mail, return receipt requested. Personal service, return of the requested receipt, or refusal by the debtor of such notice is proof of notice to the debtor of the debt owed. Service of the notice must be in the manner prescribed for the service of a summons in a civil action. The notice must include a statement of the debt owed; a statement that the property of the debtor will be subject to collection action after the debtor terminates from assistance; a statement that the property will be subject to lien and foreclosure, distraint, seizure and sale, or order to withhold and deliver; and a statement that the net proceeds will be applied to the satisfaction of the overpayment debt. Action to collect the debt by lien and foreclosure, distraint, seizure and sale, or order to withhold and deliver, is lawful after ninety days from the debtor's termination from assistance or the receipt of the notice of debt, whichever is later. This does not preclude the authority from recovering overpayments by deduction from subsequent assistance payments, not exceeding deductions as authorized under federal law with regard to financial assistance programs: PROVIDED, That subject to federal legal requirement, deductions may not exceed five percent of the grant payment standard if the overpayment resulted from error on the part of the authority or error on the part of the recipient without willful or knowing intent of the recipient in obtaining or retaining the overpayment.

(2) A current or former recipient who is aggrieved by a claim that he or she owes a debt for an overpayment of assistance has the right to an adjudicative proceeding pursuant to section 53 of this act. If no application is filed, the debt is subject to collection action as authorized under this chapter. If a timely application is filed, the execution of collection action on the debt is stayed pending the final adjudicative order or termination of the debtor from assistance, whichever occurs later.

NEW SECTION. **Sec. 100.** (1) After service of a notice of debt for an overpayment as provided for in section 99 of this act, stating the debt accrued, the director may issue to any person, firm, corporation, association, political subdivision, or department of the state an order to withhold and deliver property of any kind including, but not restricted to, earnings which are due, owing, or belonging to the debtor, when the director has reason to believe that there is in the possession of such person, firm, corporation, association, political subdivision, or department of the state property which is due, owing, or belonging to the debtor. The order to withhold and deliver must state the amount of the debt, and must state in summary the terms of this section, RCW 6.27.150 and 6.27.160, chapters 6.13 and 6.15 RCW, 15 U.S.C. Sec. 1673, and

other state or federal exemption laws applicable generally to debtors. The order to withhold and deliver must be served in the manner prescribed for the service of a summons in a civil action or by certified mail, return receipt requested. Any person, firm, corporation, association, political subdivision, or department of the state upon whom service has been made shall answer the order to withhold and deliver within twenty days, exclusive of the day of service, under oath and in writing, and shall make true answers to the matters inquired of therein. The director may require further and additional answers to be completed by the person, firm, corporation, association, political subdivision, or department of the state. If any such person, firm, corporation, association, political subdivision, or department of the state possesses any property which may be subject to the claim of the authority, such property must be withheld immediately upon receipt of the order to withhold and deliver and must, after the twenty-day period, upon demand, be delivered forthwith to the director. The director shall hold the property in trust for application on the indebtedness involved or for return, without interest, in accordance with final determination of liability or nonliability. In the alternative, there may be furnished to the director a good and sufficient bond, satisfactory to the director, conditioned upon final determination of liability. Where money is due and owing under any contract of employment, express or implied, or is held by any person, firm, corporation, association, political subdivision, or department of the state subject to withdrawal by the debtor, such money must be delivered by remittance payable to the order of the director. Delivery to the director, subject to the exemptions under RCW 6.27.150 and 6.27.160, chapters 6.13 and 6.15 RCW, 15 U.S.C. Sec. 1673, and other state or federal law applicable generally to debtors, of the money or other property held or claimed satisfies the requirement of the order to withhold and deliver. Delivery to the director serves as full acquittance, and the state warrants and represents that it shall defend and hold harmless for such actions persons delivering money or property to the director pursuant to this chapter. The state also warrants and represents that it shall defend and hold harmless for such actions persons withholding money or property pursuant to this chapter.

(2) The director shall also, on or before the date of service of the order to withhold and deliver, mail or cause to be mailed by certified mail a copy of the order to withhold and deliver to the debtor at the debtor's last known post office address or, in the alternative, a copy of the order to withhold and deliver must be served on the debtor in the same manner as a summons in a civil action on or before the date of service of the order or within two days thereafter. The copy of the order must be mailed or served together with a concise explanation of the right to petition for a hearing on any issue related to the collection. This requirement is not jurisdictional, but, if the copy is not mailed or served as provided in this section, or if any irregularity appears with respect to the mailing or service, the superior court, on its discretion on motion of the debtor promptly made and supported by affidavit showing that the debtor has suffered substantial injury due to the failure to mail the copy, may set aside the order to withhold and deliver and award to the debtor an amount equal to the damages resulting from the director's failure to serve on or mail to the debtor the copy.

NEW SECTION. **Sec. 101.** If any person, firm, corporation, association, political subdivision, or department of the state fails to answer an order to withhold and deliver within the time prescribed in section 100 of this act, or fails or refuses to deliver property pursuant to the order, or after actual notice of filing of a lien as provided for in this chapter, pays over, releases, sells, transfers, or conveys real or personal property subject to such lien to or for the benefit of the debtor or any other person, or fails or refuses to surrender upon demand property distrained under section 100 of this act, or fails or refuses to honor an assignment of wages presented by the director, such person, firm, corporation, association, political subdivision, or department of the state is liable to the authority in an amount equal to one hundred percent of the value of the debt which is the basis of the lien, order to withhold and deliver, distraint, or assignment of wages, together with costs, interest, and reasonable attorneys' fees.

NEW SECTION. **Sec. 102.** Any person, firm, corporation, association, political subdivision, or department employing a person owing a debt for overpayment of assistance received shall honor, according to its terms, a duly executed assignment of earnings presented to the employer by the director as a plan to satisfy or retire an overpayment debt. This requirement to honor the assignment of earnings is applicable whether the earnings are to be paid presently or in the future and continues in force and effect until released in writing by the director. Payment of moneys pursuant to an assignment of earnings presented to the employer by the director serves as full acquittance under any contract of employment, and the state warrants and represents it shall defend and hold harmless such action taken pursuant to the assignment of earnings. The director is released from liability for improper receipt of moneys under assignment of earnings upon return of any moneys so received.

NEW SECTION. **Sec. 103.** If an improper real property transfer is made as defined in RCW 74.08.331 through 74.08.338, the authority may request the attorney general to file suit to rescind the transaction except as to subsequent bona fide purchasers for value. If it is established by judicial proceedings that a fraudulent conveyance occurred, the value of any assistance which has been furnished may be recovered in any proceedings from the recipient or the recipient's estate.

NEW SECTION. **Sec. 104.** When the authority provides assistance to persons who possess excess real property under RCW 74.04.005(11)(g), the authority may file a lien against or otherwise perfect its interest in such real property as a condition of granting such assistance, and the authority has the status of a secured creditor.

NEW SECTION. **Sec. 105.** (1) When the authority determines that a vendor was overpaid by the authority for either goods or services, or both, provided to authority clients, except nursing homes under chapter 74.46 RCW, the authority shall give written notice to the vendor. The notice must include the amount of the overpayment, the basis for the claim, and the rights of the vendor under this section.

(2) The notice may be served upon the vendor in the manner prescribed for the service of a summons in civil action or be mailed to the vendor at the last known address by certified mail, return receipt requested, demanding payment within twenty days of the date of receipt.

(3) The vendor has the right to an adjudicative proceeding governed by the administrative procedure act, chapter 34.05 RCW, and the rules of the authority. The vendor's application for an adjudicative proceeding must be in writing, state the basis for contesting the overpayment notice, and include a copy of the authority's notice. The application must be served on and received by the authority within twenty-eight days of the vendor's receipt of the notice of overpayment. The vendor must serve the authority in a manner providing proof of receipt.

(4) Where an adjudicative proceeding has been requested, the presiding or reviewing office shall determine the amount, if any, of the overpayment received by the vendor.

(5) If the vendor fails to attend or participate in the adjudicative proceeding, upon a showing of valid service, the presiding or reviewing officer may enter an administrative order declaring the amount claimed in the notice to be assessed against the vendor and subject to collection action by the authority.

(6) Failure to make an application for an adjudicative proceeding within twenty-eight days of the date of notice results in the establishment of a final debt against the vendor in the amount

asserted by the authority and that amount is subject to collection action. The authority may also charge the vendor with any costs associated with the collection of any final overpayment or debt established against the vendor.

(7) The authority may enforce a final overpayment or debt through lien and foreclosure, distraint, seizure and sale, order to withhold and deliver, or other collection action available to the authority to satisfy the debt due.

(8) Debts determined under this chapter are subject to collection action without further necessity of action by a presiding or reviewing officer. The authority may collect the debt in accordance with sections 100, 101, and 106 of this act. In addition, a vendor lien may be subject to distraint and seizure and sale in the same manner as prescribed for support liens in RCW 74.20A.130.

(9) Chapter 66, Laws of 1998 applies to overpayments for goods or services provided on or after July 1, 1998.

(10) The authority may adopt rules consistent with this section.

NEW SECTION. **Sec. 106.** (1) The authority may, at the director's discretion, secure the repayment of any outstanding overpayment, plus interest, if any, through the filing of a lien against the vendor's real property, or by requiring the posting of a bond, assignment of deposit, or some other form of security acceptable to the authority, or by doing both.

(a) Any lien is effective from the date of filing for record with the county auditor of the county in which the property is located and the lien claim has preference over the claims of all unsecured creditors.

(b) The authority shall review and determine the acceptability of all other forms of security.

(c) Any bond must be issued by a company licensed as a surety in the state of Washington.

(d) This subsection does not apply to nursing homes licensed under chapter 18.51 RCW or portions of hospitals licensed under chapter 70.41 RCW and operating as a nursing home, if those facilities are subject to chapter 74.46 RCW.

(2) The authority may recover any overpayment, plus interest, if any, by setoff or recoupment against subsequent payments to the vendor.

NEW SECTION. **Sec. 107.** Liens created under section 106 of this act bind the affected property for a period of ten years after the lien has been recorded or ten years after the resolution of all good faith disputes as to the overpayment, whichever is later. Any civil action by the authority to enforce such lien must be timely commenced before the ten-year period expires or the lien is released. A civil action to enforce such lien is not timely commenced unless the summons and complaint are filed within the ten-year period in a court having jurisdiction and service of the summons and complaint is made upon all parties in the manner prescribed by appropriate civil court rules.

NEW SECTION. **Sec. 108.** Any action to enforce a vendor overpayment debt must be commenced within six years from the date of the authority's notice to the vendor.

NEW SECTION. **Sec. 109.** The remedies under sections 106 and 107 of this act are nonexclusive and nothing contained in this chapter may be construed to impair or affect the right of the authority to maintain a civil action or to pursue any other remedies available to it under the laws of this state to recover such debt.

NEW SECTION. **Sec. 110.** (1) Except as provided in subsection (4) of this section, vendors shall pay interest on overpayments at the rate of one percent per month or portion thereof. Where partial repayment of an overpayment is made, interest accrues on the remaining balance. Interest must not accrue when the overpayment occurred due to authority error.

(2) If the overpayment is discovered by the vendor prior to discovery and notice by the authority, the interest begins accruing ninety days after the vendor notifies the authority of such overpayment.

(3) If the overpayment is discovered by the authority prior to discovery and notice by the vendor, the interest begins accruing thirty days after the date of notice by the authority to the vendor.

(4) This section does not apply to:

(a) Interagency or intergovernmental transactions; and

(b) Contracts for public works, goods and services procured for the exclusive use of the authority, equipment, or travel.

NEW SECTION. **Sec. 111.** (1) To avoid a duplicate payment of benefits, a recipient of assistance from the authority is deemed to have subrogated the authority to the recipient's right to recover temporary total disability compensation due to the recipient and the recipient's dependents under Title 51 RCW, to the extent of such assistance or compensation, whichever is less. However, the amount to be repaid to the authority must bear its proportionate share of attorneys' fees and costs, if any, incurred under Title 51 RCW by the recipient or the recipient's dependents.

(2) The authority may assert and enforce a lien and notice to withhold and deliver to secure reimbursement. The authority shall identify in the lien and notice to withhold and deliver the recipient of assistance and temporary total disability compensation and the amount claimed by the authority.

NEW SECTION. **Sec. 112.** The effective date of the lien and notice to withhold and deliver provided in section 111 of this act is the day that it is received by the department of labor and industries or a self-insurer as defined in chapter 51.08 RCW. Service of the lien and notice to withhold and deliver may be made personally, by regular mail with postage prepaid, or by electronic means. A statement of lien and notice to withhold and deliver must be mailed to the recipient at the recipient's last known address by certified mail, return receipt requested, no later than two business days after the authority mails, delivers, or transmits the lien and notice to withhold and deliver to the department of labor and industries or a self-insurer.

NEW SECTION. **Sec. 113.** The director of labor and industries or the director's designee, or a self-insurer as defined in chapter 51.08 RCW, following receipt of the lien and notice to withhold and deliver, shall deliver to the director of the authority or the director's designee any temporary total disability compensation payable to the recipient named in the lien and notice to withhold and deliver up to the amount claimed. The director of labor and industries or self-insurer shall withhold and deliver from funds currently in the director's or self-insurer's possession or from any funds that may at any time come into the director's or self-insurer's possession on account of temporary total disability compensation payable to the recipient named in the lien and notice to withhold and deliver.

NEW SECTION. **Sec. 114.** (1) A recipient feeling aggrieved by the action of the authority in recovering his or her temporary total disability compensation as provided in sections 111 through 115 of this act has the right to an adjudicative proceeding.

(2) A recipient seeking an adjudicative proceeding shall file an application with the director within twenty-eight days after the statement of lien and notice to withhold and deliver was mailed to the recipient. If the recipient files an application more than twenty-eight days after, but within one year of, the date the statement of lien and notice to withhold and deliver was mailed, the recipient is entitled to a hearing if the recipient shows good cause for the recipient's failure to file a timely application. The filing of a late application does not affect prior collection action pending the final adjudicative order. Until good cause for failure to file a timely application is decided, the authority may continue to collect under the lien and notice to withhold and deliver.

(3) The proceeding shall be governed by chapter 34.05 RCW, the administrative procedure act.

NEW SECTION. **Sec. 115.** Sections 111 through 114 of this act and this section do not apply to persons whose eligibility for benefits under Title 51 RCW is based upon an injury or illness occurring prior to July 1, 1972.

NEW SECTION. **Sec. 116.** (1) When an individual receives assistance subject to recovery under this chapter and the individual is the holder of record title to real property or the purchaser under a land sale contract, the authority may present to the county auditor for recording in the deed and mortgage records of a county a request for notice of transfer or encumbrance of the real property. The authority shall adopt a rule providing prior notice and hearing rights to the record title holder or purchaser under a land sale contract.

(2) The authority shall present to the county auditor for recording a termination of request for notice of transfer or encumbrance when, in the judgment of the authority, it is no longer necessary or appropriate for the authority to monitor transfers or encumbrances related to the real property.

(3) The authority shall adopt by rule a form for the request for notice of transfer or encumbrance and the termination of request for notice of transfer or encumbrance that, at a minimum:

(a) Contains the name of the assistance recipient and a case identifier or other appropriate information that links the individual who is the holder of record title to real property or the purchaser under a land sale contract to the individual's assistance records;

(b) Contains the legal description of the real property;

(c) Contains a mailing address for the authority to receive the notice of transfer or encumbrance; and

(d) Complies with the requirements for recording in RCW 36.18.010 for those forms intended to be recorded.

(4) The authority shall pay the recording fee required by the county clerk under RCW 36.18.010.

(5) The request for notice of transfer or encumbrance described in this section does not affect title to real property and is not a lien on, encumbrance of, or other interest in the real property.

NEW SECTION. **Sec. 117.** (1) By December 10, 2011, the department of social and health services and the health care authority shall provide a preliminary report, and by December 1, 2012, provide a final implementation plan, to the governor and the legislature with recommendations regarding the role of the health care authority in the state's purchasing of mental health treatment, substance abuse treatment, and long-term care services, including services for those with developmental disabilities.

(2) The reports shall:

(a) Consider options for effectively coordinating the purchase and delivery of care for people who need long-term care, developmental disabilities, mental health, or chemical dependency services. Options considered may include, but are not limited to, transitioning purchase of these services from the department of social and health services to the health care authority, and strategies for the agencies to collaborate seamlessly while purchasing services separately; and

(b) Address the following components:

(i) Incentives to improve prevention efforts;

(ii) Service delivery approaches, including models for care management and care coordination and benefit design;

(iii) Rules to assure that those requiring long-term care services and supports receive that care in the least restrictive setting appropriate to their needs;

(iv) Systems to measure cost savings;

(v) Mechanisms to measure health outcomes and consumer satisfaction;

(vi) The designation of a single point of entry for financial and functional eligibility determinations for long-term care services; and

(vii) Process for collaboration with local governments.

(3) In developing these recommendations, the agencies shall:

(a) Consult with tribal governments and with interested stakeholders, including consumers, health care and other service providers, health insurance carriers, and local governments; and

(b) Cooperate with the joint select committee on health reform implementation established in House Concurrent Resolution No. 4404 and any of its advisory committees. The agencies shall strongly consider the guidance and input received from these forums in the development of its recommendations.

(4) The agencies shall submit a progress report to the governor and the legislature by November 15, 2013, that provides details on the agencies' progress on purchasing coordination to date.

Sec. 118. RCW 74.09A.005 and 2007 c 179 s 1 are each amended to read as follows:

The legislature finds that:

(1) Simplification in the administration of payment of health benefits is important for the state, providers, and health insurers;

(2) The state, providers, and health insurers should take advantage of all opportunities to streamline operations through automation and the use of common computer standards;

(3) It is in the best interests of the state, providers, and health insurers to identify all third parties that are obligated to cover the cost of health care coverage of joint beneficiaries; and

(4) Health insurers, as a condition of doing business in Washington, must increase their effort to share information with the ((~~department~~)) authority and accept the ((~~department's~~)) authority's timely claims consistent with 42 U.S.C. 1396a(a)(25).

Therefore, the legislature declares that to improve the coordination of benefits between the ((~~department of social and health services~~)) health care authority and health insurers to ensure that medical insurance benefits are properly utilized, a transfer of information between the ((~~department~~)) authority and health insurers should be instituted, and the process for submitting requests for information and claims should be simplified.

Sec. 119. RCW 74.09A.010 and 2007 c 179 s 2 are each amended to read as follows:

For the purposes of this chapter:

(1) ((~~"Department"~~)) "Authority" means the ((~~department of social and health services~~)) Washington state health care authority.

(2) "Health insurance coverage" includes any policy, contract, or agreement under which health care items or services are provided, arranged, reimbursed, or paid for by a health insurer.

(3) "Health insurer" means any party that is, by statute, policy, contract, or agreement, legally responsible for payment of a claim for a health care item or service, including, but not limited to, a commercial insurance company providing disability insurance under chapter 48.20 or 48.21 RCW, a health care service contractor providing health care coverage under chapter 48.44 RCW, a health maintenance organization providing comprehensive health care services under chapter 48.46 RCW, an employer or union self-insured plan, any private insurer, a group health plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, and a third party administrator.

(4) "Computerized" means online or batch processing with standardized format via magnetic tape output.

(5) "Joint beneficiary" is an individual who has health insurance coverage and is a recipient of public assistance benefits under chapter 74.09 RCW.

Sec. 120. RCW 74.09A.020 and 2007 c 179 s 3 are each amended to read as follows:

(1) The ((~~department~~)) authority shall provide routine and periodic computerized information to health insurers regarding client eligibility and coverage information. Health insurers shall use this information to identify joint beneficiaries. Identification of joint beneficiaries shall be transmitted to the ((~~department~~)) authority. The ((~~department~~)) authority shall use this information

to improve accuracy and currency of health insurance coverage and promote improved coordination of benefits.

(2) To the maximum extent possible, necessary data elements and a compatible database shall be developed by affected health insurers and the ((~~department~~)) authority. The ((~~department~~)) authority shall establish a representative group of health insurers and state agency representatives to develop necessary technical and file specifications to promote a standardized database. The database shall include elements essential to the ((~~department~~)) authority and its population's health insurance coverage information.

(3) If the state and health insurers enter into other agreements regarding the use of common computer standards, the database identified in this section shall be replaced by the new common computer standards.

(4) The information provided will be of sufficient detail to promote reliable and accurate benefit coordination and identification of individuals who are also eligible for ((~~department~~)) authority programs.

(5) The frequency of updates will be mutually agreed to by each health insurer and the ((~~department~~)) authority based on frequency of change and operational limitations. In no event shall the computerized data be provided less than semiannually.

(6) The health insurers and the ((~~department~~)) authority shall safeguard and properly use the information to protect records as provided by law, including but not limited to chapters 42.48, 74.09, 74.04, 70.02, and 42.56 RCW, and 42 U.S.C. Sec. 1396a and 42 C.F.R. Sec. 43 et seq. The purpose of this exchange of information is to improve coordination and administration of benefits and ensure that medical insurance benefits are properly utilized.

(7) The ((~~department~~)) authority shall target implementation of this section to those health insurers with the highest probability of joint beneficiaries.

Sec. 121. RCW 74.09A.030 and 2007 c 179 s 4 are each amended to read as follows:

Health insurers, as a condition of doing business in Washington, must:

(1) Provide, with respect to individuals who are eligible for, or are provided, medical assistance under chapter 74.09 RCW, upon the request of the ((~~department~~)) authority, information to determine during what period the individual or their spouses or their dependants may be, or may have been, covered by a health insurer and the nature of coverage that is or was provided by the health insurer, including the name, address, and identifying number of the plan, in a manner prescribed by the ((~~department~~)) authority;

(2) Accept the ((~~department's~~)) authority's right to recovery and the assignment to the ((~~department~~)) authority of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under chapter 74.09 RCW;

(3) Respond to any inquiry by the ((~~department~~)) authority regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of such health care item or service;

(4) Agree not to deny a claim submitted by the ((~~department~~)) authority solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if:

(a) The claim is submitted by the ((~~department~~)) authority within the three-year period beginning on the date the item or service was furnished; and

(b) Any action by the ((~~department~~)) authority to enforce its rights with respect to such claim is commenced within six years of the ((~~department's~~)) authority's submission of such claim; and

(5) Agree that the prevailing party in any legal action to enforce this section receives reasonable attorneys' fees as well as related collection fees and costs incurred in the enforcement of this section.

NEW SECTION. **Sec. 122.** The following acts or parts of acts are each repealed:

(1) RCW 74.09.085 (Contracts--Performance measures--Financial incentives) and 2005 c 446 s 3;

(2) RCW 74.09.110 (Administrative personnel--Professional consultants and screeners) and 1979 c 141 s 339 & 1959 c 26 s 74.09.110;

(3) RCW 74.09.5221 (Medical assistance--Federal standards--Waivers--Application) and 1997 c 231 s 112;

(4) RCW 74.09.5227 (Implementation date--Payments for services provided by rural hospitals) and 2001 2nd sp.s. c 2 s 3;

(5) RCW 74.09.755 (AIDS--Community-based care--Federal social security act waiver) and 1989 c 427 s 12;

(6) RCW 43.20A.860 (Requirement to seek federal waivers and state law changes to medical assistance program) and 1995 c 265 s 26; and

(7) RCW 74.04.270 (Audit of accounts--Uniform accounting system) and 1979 c 141 s 304 & 1959 c 26 s 74.04.270.

Sec. 123. RCW 74.09.015 and 2007 c 259 s 16 are each amended to read as follows:

To the extent that sufficient funding is provided specifically for this purpose, the ((~~department, in collaboration with the health care~~)) authority((~~,~~)) shall provide all persons receiving services under this chapter with access to a twenty-four hour, seven day a week nurse hotline. The ((~~health care~~)) authority ((~~and the department of social and health services~~)) shall determine the most appropriate way to provide the nurse hotline under RCW 41.05.037 and this section, which may include use of the 211 system established in chapter 43.211 RCW.

NEW SECTION. **Sec. 124.** A new section is added to chapter 43.20A RCW to read as follows:

The secretary shall enter into agreements with the director of the health care authority, in his or her capacity as the director of the designated single state agency to administer medical services programs under Titles XIX and XXI of the social security act, to establish the division of responsibilities between the agencies with respect to mental health, chemical dependency, and long-term care services, including services for people with developmental disabilities. Except to the extent expressly authorized in the omnibus operating budget or other legislative act and where necessary to improve coordination of care for individual clients, nothing in this section or in section 117 of this act shall be construed as authorizing the secretary or the director to transfer funds appropriated to one agency or program in the omnibus operating budget to another agency or program.

NEW SECTION. **Sec. 125.** (1) All powers, duties, and functions of the department of social and health services pertaining to the medical assistance program and the medicaid purchasing administration are transferred to the health care authority to the extent necessary to carry out the purposes of this act. All references to the secretary or the department of social and health services in the Revised Code of Washington shall be construed to mean the director or the health care authority when referring to the functions transferred in this section.

(2)(a) All reports, documents, surveys, books, records, files, papers, or written material in the possession of the department of social and health services pertaining to the powers, functions, and duties transferred shall be delivered to the custody of the health care authority. All cabinets, furniture, office equipment, motor vehicles, and other tangible property employed by the department of social and health services in carrying out the powers, functions, and duties transferred shall be made available to the health care authority. All

funds, credits, or other assets held in connection with the powers, functions, and duties transferred shall be assigned to the health care authority.

(b) Any appropriations made to the department of social and health services for carrying out the powers, functions, and duties transferred shall, on the effective date of this section, be transferred and credited to the health care authority.

(c) Whenever any question arises as to the transfer of any personnel, funds, books, documents, records, papers, files, equipment, or other tangible property used or held in the exercise of the powers and the performance of the duties and functions transferred, the director of financial management shall make a determination as to the proper allocation and certify the same to the state agencies concerned.

(3) All employees of the medicaid purchasing administration at the department of social and health services are transferred to the jurisdiction of the health care authority. All employees classified under chapter 41.06 RCW, the state civil service law, are assigned to the health care authority to perform their usual duties upon the same terms as formerly, without any loss of rights, subject to any action that may be appropriate thereafter in accordance with the laws and rules governing state civil service.

(4) All rules and all pending business before the department of social and health services pertaining to the powers, functions, and duties transferred shall be continued and acted upon by the health care authority. All existing contracts and obligations shall remain in full force and shall be performed by the health care authority.

(5) The transfer of the powers, duties, functions, and personnel of the department of social and health services shall not affect the validity of any act performed before the effective date of this section.

(6) If apportionments of budgeted funds are required because of the transfers directed by this section, the director of financial management shall certify the apportionments to the agencies affected, the state auditor, and the state treasurer. Each of these shall make the appropriate transfer and adjustments in funds and appropriation accounts and equipment records in accordance with the certification.

(7) A nonsupervisory medicaid purchasing unit bargaining unit is created at the health care authority. All nonsupervisory civil service employees of the medicaid purchasing administration at the department of social and health services assigned to the health care authority under this section whose positions are within the existing bargaining unit description at the department of social and health services shall become a part of the nonsupervisory medicaid purchasing unit bargaining unit at the health care authority under the provisions of chapter 41.80 RCW. The exclusive bargaining representative of the existing bargaining unit at the department of social and health services is certified as the exclusive bargaining representative of the nonsupervisory medicaid purchasing unit bargaining unit at the health care authority without the necessity of an election.

(8) A supervisory medicaid purchasing unit bargaining unit is created at the health care authority. All supervisory civil service employees of the medicaid purchasing administration at the department of social and health services assigned to the health care authority under this section whose positions are within the existing bargaining unit description at the department of social and health services shall become a part of the supervisory medicaid purchasing unit bargaining unit at the health care authority under the provisions of chapter 41.80 RCW. The exclusive bargaining representative of the existing bargaining unit at the department of social and health services is certified as the exclusive bargaining representative of the supervisory medicaid purchasing unit bargaining unit at the health care authority without the necessity of an election.

(9) The bargaining units of employees created under this section are appropriate units under the provisions of chapter 41.80 RCW. However, nothing contained in this section shall be construed to alter the authority of the public employment relations commission under the provisions of chapter 41.80 RCW to amend or modify the bargaining units.

(10) Positions from the department of social and health services central administration are transferred to the jurisdiction of the health care authority. Employees classified under chapter 41.06 RCW, the state civil service law, are assigned to the health care authority to perform their usual duties upon the same terms as formerly, without any loss of rights, subject to any action that may be appropriate thereafter in accordance with the laws and rules governing state civil service.

(11) All classified employees of the department of social and health services central administration assigned to the health care authority under subsection (10) of this section whose positions are within an existing bargaining unit description at the health care authority shall become a part of the existing bargaining unit at the health care authority and shall be considered an appropriate inclusion or modification of the existing bargaining unit under the provisions of chapter 41.80 RCW.

NEW SECTION. **Sec. 126.** The code reviser shall note wherever "administrator" is used or referred to in the Revised Code of Washington as the head of the health care authority that the title of the agency head has been changed to "director." The code reviser shall prepare legislation for the 2012 regular session that changes all statutory references to "administrator" of the health care authority to "director" of the health care authority.

NEW SECTION. **Sec. 127.** RCW 43.20A.365 is recodified as a section in chapter 74.09 RCW.

NEW SECTION. **Sec. 128.** Sections 89 through 116 of this act constitute a new chapter in Title 41 RCW, to be codified as chapter 41.05A RCW.

NEW SECTION. **Sec. 129.** Sections 74 through 76 of this act expire June 30, 2012.

NEW SECTION. **Sec. 130.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 131.** This act is necessary for the immediate preservation of the public peace, health, or safety, or support of the state government and its existing public institutions, and takes effect July 1, 2011."

Senator Keiser spoke in favor of adoption of the committee striking amendment.

MOTION

Senator Delvin moved that the following amendment by Senators Delvin and Regala to the committee striking amendment be adopted:

On page 64, line 3 after "Sec. 60." Strike all language down through and including line 11 on page 65.

Renumber sections accordingly and correct all internal references.

Senators Delvin and Regala spoke in favor of adoption of the amendment to the committee striking amendment.

The President Pro Tempore declared the question before the Senate to be the adoption of the amendment by Senators Delvin and Regala on page 64, line 3 to the committee striking amendment to Second Engrossed Second Substitute House Bill No. 1738.

The motion by Senator Delvin carried and the amendment to the committee striking amendment was adopted by voice vote.

The President Pro Tempore declared the question before the Senate to be the adoption of the committee striking amendment by the Committee on Ways & Means as amended to Second Engrossed Second Substitute House Bill No. 1738.

The motion by Senator Keiser carried and the committee striking amendment as amended was adopted by voice vote.

MOTION

There being no objection, the following title amendment was adopted:

On page 1, line 4 of the title amendment, after "authority;" strike the remainder of the title and insert "amending RCW 74.09.037, 74.09.050, 74.09.055, 74.09.075, 74.09.080, 74.09.120, 74.09.160, 74.09.180, 74.09.185, 74.09.190, 74.09.200, 74.09.210, 74.09.240, 74.09.260, 74.09.280, 74.09.290, 74.09.300, 74.09.470, 74.09.480, 74.09.490, 74.09.500, 74.09.510, 74.09.515, 74.09.520, 74.09.521, 74.09.5222, 74.09.5225, 74.09.530, 74.09.540, 74.09.555, 74.09.565, 74.09.575, 74.09.585, 74.09.595, 74.09.655, 74.09.658, 74.09.659, 74.09.700, 74.09.710, 74.09.715, 74.09.720, 74.09.725, 74.09.730, 74.09.770, 74.09.790, 74.09.800, 74.09.810, 74.09.820, 41.05.011, 41.05.015, 41.05.021, 41.05.036, 41.05.037, 41.05.140, 41.05.185, 43.20A.365, 74.04.005, 74.04.015, 74.04.025, 74.04.050, 74.04.055, 74.04.060, 74.04.062, 74.04.290, 7.68.080, 43.41.160, 43.41.260, 43.70.670, 47.06B.020, 47.06B.060, 47.06B.070, 48.01.235, 48.43.008, 48.43.517, 69.41.030, 69.41.190, 70.01.010, 70.47.010, 70.47.020, 70.47.110, 70.48.130, 70.168.040, 70.225.040, 74.09A.005, 74.09A.010, 74.09A.020, 74.09A.030, and 74.09.015; reenacting and amending RCW 74.09.010, 74.09.035, and 74.09.522; adding new sections to chapter 74.09 RCW; adding a new section to chapter 43.20A RCW; adding a new chapter to Title 41 RCW; creating new sections; recodifying RCW 43.20A.365; repealing RCW 74.09.085, 74.09.110, 74.09.5221, 74.09.5227, 74.09.755, 43.20A.860, and 74.04.270; providing an effective date; providing an expiration date; and declaring an emergency."

MOTION

On motion of Senator Keiser, the rules were suspended, Second Engrossed Second Substitute House Bill No. 1738 as amended by the Senate was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator Keiser spoke in favor of passage of the bill.

The President Pro Tempore declared the question before the Senate to be the final passage of Second Engrossed Second Substitute House Bill No. 1738 as amended by the Senate.

ROLL CALL

The Secretary called the roll on the final passage of Second Engrossed Second Substitute House Bill No. 1738 as amended by the Senate and the bill passed the Senate by the following vote: Yeas, 44; Nays, 0; Absent, 1; Excused, 4.

Voting yea: Senators Baumgartner, Baxter, Benton, Brown, Carrell, Chase, Conway, Delvin, Ericksen, Fain, Fraser, Hargrove, Harper, Hatfield, Haugen, Hewitt, Hill, Hobbs, Holmquist Newbry, Honeyford, Kastama, Keiser, Kilmer, King, Kline, Kohl-Welles, Litzow, Morton, Murray, Nelson, Parlette, Pflug, Prentice, Pridemore, Ranker, Regala, Roach, Rockefeller, Schoesler, Sheldon, Stevens, Swecker, Tom and White

Absent: Senator Zarelli

Excused: Senators Becker, Eide, McAuliffe and Shin

SECOND ENGROSSED SECOND SUBSTITUTE HOUSE BILL NO. 1738 as amended by the Senate, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

MOTION

On motion of Senator Ericksen, Senator Zarelli was excused.

SECOND READING

HOUSE BILL NO. 2070, by Representative Seaquist

Determining average salary for the pension purposes of state and local government employees as certified by their employer.

The measure was read the second time.

MOTION

On motion of Senator Kilmer, the rules were suspended, House Bill No. 2070 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senators Kilmer and Schoesler spoke in favor of passage of the bill.

The President Pro Tempore declared the question before the Senate to be the final passage of House Bill No. 2070.

ROLL CALL

The Secretary called the roll on the final passage of House Bill No. 2070 and the bill passed the Senate by the following vote: Yeas, 40; Nays, 4; Absent, 0; Excused, 5.

Voting yea: Senators Baumgartner, Baxter, Benton, Brown, Carrell, Chase, Conway, Delvin, Fain, Fraser, Hargrove, Harper, Hatfield, Haugen, Hewitt, Hobbs, Holmquist Newbry, Honeyford, Kastama, Keiser, Kilmer, King, Kline, Kohl-Welles, Litzow, Morton, Murray, Nelson, Parlette, Prentice, Pridemore, Ranker, Regala, Roach, Rockefeller, Schoesler, Sheldon, Swecker, Tom and White

Voting nay: Senators Ericksen, Hill, Pflug and Stevens

Excused: Senators Becker, Eide, McAuliffe, Shin and Zarelli

HOUSE BILL NO. 2070, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

SECOND READING

SENATE BILL NO. 5935, by Senator Hargrove

Addressing adoption support payments for hard to place children.

MOTIONS

On motion of Senator Hargrove, Substitute Senate Bill No. 5935 was substituted for Senate Bill No. 5935 and the substitute bill was placed on the second reading and read the second time.

On motion of Senator Hargrove, the rules were suspended, Substitute Senate Bill No. 5935 was advanced to third reading, the second reading considered the third and the bill was placed on final passage.

Senator Hargrove spoke in favor of passage of the bill.

The President Pro Tempore declared the question before the Senate to be the final passage of Substitute Senate Bill No. 5935.

ROLL CALL

The Secretary called the roll on the final passage of Substitute Senate Bill No. 5935 and the bill passed the Senate by the following vote: Yeas, 42; Nays, 2; Absent, 0; Excused, 5.

Voting yea: Senators Baumgartner, Baxter, Benton, Brown, Carrell, Chase, Conway, Delvin, Ericksen, Fain, Fraser, Hargrove, Harper, Hatfield, Hewitt, Hill, Hobbs, Holmquist Newbry, Honeyford, Kastama, Keiser, Kilmer, King, Kline, Kohl-Welles, Litzow, Morton, Murray, Parlette, Pflug, Prentice, Pridemore, Ranker, Regala, Roach, Rockefeller, Schoesler, Sheldon, Stevens, Swecker, Tom and White

Voting nay: Senators Haugen and Nelson

Excused: Senators Becker, Eide, McAuliffe, Shin and Zarelli

SUBSTITUTE SENATE BILL NO. 5935, having received the constitutional majority, was declared passed. There being no objection, the title of the bill was ordered to stand as the title of the act.

MOTION

On motion of Senator White, Senator Kastama was excused.

SECOND READING

SENATE JOINT MEMORIAL NO. 8009, by Senators Regala and Nelson

Requesting respectfully for adoption of the federal main street fairness act.

The measure was read the second time.

MOTION

On motion of Senator Regala, the rules were suspended, Senate Joint Memorial No. 8009 was advanced to third reading, the second reading considered the third and the memorial was placed on final passage.

Senator Regala spoke in favor of passage of the memorial.

The President Pro Tempore declared the question before the Senate to be the final passage of Senate Joint Memorial No. 8009.

ROLL CALL

The Secretary called the roll on the final passage of Senate Joint Memorial No. 8009 and the memorial passed the Senate by the following vote: Yeas, 32; Nays, 12; Absent, 0; Excused, 5.

Voting yea: Senators Baumgartner, Brown, Chase, Conway, Fain, Fraser, Hargrove, Harper, Hatfield, Haugen, Hewitt, Hobbs, Keiser, Kilmer, Kline, Kohl-Welles, Litzow, Morton, Murray, Nelson, Parlette, Pflug, Prentice, Pridemore, Ranker, Regala, Rockefeller, Schoesler, Swecker, Tom, White and Zarelli

Voting nay: Senators Baxter, Benton, Carrell, Delvin, Ericksen, Hill, Holmquist Newbry, Honeyford, King, Roach, Sheldon and Stevens

Excused: Senators Becker, Eide, Kastama, McAuliffe and Shin

SENATE JOINT MEMORIAL NO. 8009, having received the constitutional majority, was declared passed.

MOTION

At 3:07 p.m., on motion of Senator Rockefeller, the Senate adjourned until 10:00 a.m. Tuesday, May 10, 2011.

BRAD OWEN, President of the Senate

THOMAS HOEMANN, Secretary of the Senate