
HOUSE BILL 2826

State of Washington

65th Legislature

2018 Regular Session

By Representatives Tharinger, Chapman, Appleton, and Santos

Read first time 01/17/18. Referred to Committee on Community Development, Housing & Tribal Affairs.

1 AN ACT Relating to Indian health care in Washington state;
2 amending RCW 38.52.040, 41.05.690, and 70.320.020; reenacting and
3 amending RCW 43.84.092; and adding a new chapter to Title 70 RCW.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 NEW SECTION. **Sec. 1.** The legislature declares it is the policy
6 of this state, in fulfillment of the state's unique relationships and
7 shared respect between sovereign governments to:

8 (1) Recognize the United States' trust responsibility to provide
9 health care to American Indians and Alaska Natives including those
10 individuals who are citizens of this state;

11 (2) Recognize that American Indians and Alaska Natives as
12 citizens of this state should have equitable access to any health
13 care benefits provided by the state;

14 (3) Improve upon and rectify unintended consequences of prior
15 state policies and actions that have limited American Indian and
16 Alaska Native access to health care that is part of the federal trust
17 responsibility and to health care benefits provided by the state to
18 its citizens;

19 (4) Assure that when the state delegates health care
20 responsibilities to nongovernmental entities, actions of those
21 entities that impact American Indian and Alaska Native access to

1 health care are consistent with maintaining the federal trust
2 responsibility to provide health care to American Indians and Alaska
3 Natives and consistent with the policies contained in this section;

4 (5) Assure that the state and tribes work in a government-to-
5 government relationship to provide quality health care for all tribal
6 members;

7 (6) Require that implementation of this chapter and all actions
8 under this chapter are carried out with active and meaningful
9 consultation with tribes and conference with urban Indian health
10 programs in accordance with the national policy of Indian self-
11 determination;

12 (7) Assure the highest possible health status for American
13 Indians and Alaska Natives by providing resources necessary to effect
14 that policy;

15 (8) Raise the health status of American Indians and Alaska
16 Natives to at least the levels set forth in the goals contained
17 within the federal healthy people 2020 initiative or successor
18 objectives;

19 (9) Assure maximum American Indian and Alaska Native
20 participation in the direction of health care services so as to
21 render the persons administering such services more responsive to the
22 needs and desires of American Indian and Alaskan Native individuals
23 and communities; and

24 (10) Assure that savings realized by the state for services
25 which are received through an Indian health service facility whether
26 operated by the Indian health service or by an Indian tribe or tribal
27 organization pursuant to 42 U.S.C. Sec. 1396d (b), are reinvested
28 back into the Indian health care delivery system within the state as
29 provided in section 11 of this act.

30 NEW SECTION. **Sec. 2.** The definitions in this section apply
31 throughout this chapter unless the context clearly requires
32 otherwise.

33 (1) "American Indian" or "Alaska Native" means any individual who
34 is: (a) A member of a federally recognized tribe; or (b) eligible for
35 the Indian health service.

36 (2) "American Indian health commission for Washington state"
37 means a Washington nonprofit corporation wholly controlled by the
38 tribes and urban Indian health programs in the state.

1 (3) "Authority" means the health care authority as the single
2 state medicaid agency.

3 (4) "Community health aide" means a health care worker certified
4 by a community health aide program of the Indian health service or an
5 Indian tribe or tribal organization consistent with the requirements
6 of 25 U.S.C. Sec. 1616 who can perform a wide range of duties within
7 the worker's scope of certified practice in health programs of an
8 Indian tribe or tribal organization to improve access to quality care
9 for American Indians and Alaska Natives and their families and
10 communities.

11 (5) "Fee-for-service" means the state's medicaid program for
12 which payments are made under the state plan in accordance with the
13 fee-for-service payment methodology.

14 (6) "Indian health care provider" means a health care program
15 operated by the Indian health service or by an Indian tribe, tribal
16 organization, or urban Indian organization as those terms are defined
17 in 25 U.S.C. Sec. 1603.

18 (7) "Indian health service" means a federal agency within the
19 United States department of health and human services.

20 (8) "Indian tribe" or "tribe" means any Indian tribe, band,
21 nation, or other organized group or community, including any Alaska
22 Native village or group or regional or village corporation as defined
23 in or established pursuant to the Alaska Native claims settlement act
24 (43 U.S.C. Sec. 1601 et seq.) which is recognized as eligible for the
25 special programs and services provided by the United States to
26 Indians because of their status as Indians.

27 (9) "Medicaid managed care entity" means a managed care entity as
28 defined in 42 U.S.C. Sec. 1396u-2 (a)(1)(B).

29 (10) "Traditional healing services" means culturally appropriate
30 healing methods developed and practiced by generations of tribal
31 healers who apply methods for physical, mental, and emotional
32 healing. The array of practices provided by traditional healers must
33 be in accordance with an individual tribe's established and accepted
34 traditional healing practices.

35 (11) "Tribal organization" has the meaning set forth in 25 U.S.C.
36 Sec. 5304.

37 (12) "Urban Indian" means any individual who resides in an urban
38 center and is: (a) A member of a tribe terminated since 1940 and
39 those tribes recognized now or in the future by the state in which
40 they reside, or who is a descendant, in the first or second degree,

1 of any such member; (b) an Eskimo or Aleut or other Alaska Native;
2 (c) considered by the secretary of the interior to be an Indian for
3 any purpose; or (d) considered by the United States secretary of
4 health and human services to be an Indian for purposes of eligibility
5 for Indian health services, including as a California Indian, Eskimo,
6 Aleut, or other Alaska Native.

7 (13) "Urban Indian health program" means an urban Indian
8 organization, as defined by 25 U.S.C. Sec. 1603(29), that is
9 operating a facility delivering health care.

10 NEW SECTION. **Sec. 3.** (1) The governor's Indian health council
11 is established. It is the intent of the legislature to implement the
12 national policy of Indian self-determination and to assure the
13 highest possible health status for American Indians and Alaska
14 Natives by providing resources necessary to effect this policy
15 through the creation of the governor's Indian health council. This
16 council shall create an action plan to raise the health status of
17 American Indians and Alaska Natives to at least the levels set forth
18 in the goals contained within the federal healthy people 2020
19 initiative or successor objectives.

20 (2) In collaboration with staff whom the authority may assign,
21 the authority must assist the governor by convening and providing
22 assistance to the council. The council must consist of the following
23 representatives:

24 (a) The tribal liaisons from each of the following state
25 agencies: The authority; the department of children, youth, and
26 families; the department of commerce; the department of corrections;
27 the department of health; the department of social and health
28 services; the office of the insurance commissioner; the office of the
29 superintendent of public instruction; and the Washington health
30 benefit exchange;

31 (b) One individual from each tribe, designated by the tribal
32 council, who is either the tribe's American Indian health commission
33 for Washington state delegate or an individual specifically
34 designated for this role, or his or her designee;

35 (c) The chief operating officer of each Indian health service
36 area office and service unit, or his or her designee;

37 (d) The chief operating officer of each urban Indian health
38 program, or the urban Indian health program's American Indian health
39 commission for Washington state delegate, or his or her designee;

1 (e) The executive director of the American Indian health
2 commission for Washington state, or his or her designee;

3 (f) The executive director of the northwest Portland area Indian
4 health board, or his or her designee;

5 (g) One member from each of the two largest caucuses of the house
6 of representatives, appointed by the speaker of the house of
7 representatives;

8 (h) One member from each of the two largest caucuses of the
9 senate, appointed by the president of the senate; and

10 (i) Two designees representing the governor's office.

11 (3) With assistance from the authority, the council must convene
12 to:

13 (a) Address current or proposed policies or actions that have
14 tribal implications and are not able to be resolved or addressed at
15 the agency level;

16 (b) Facilitate training for agency leadership, staff, and
17 legislators on the Indian health system and tribal sovereignty; and

18 (c) Provide oversight of contracting and performance of service
19 coordination organizations or service contracting entities as defined
20 in RCW 70.320.010 in order to address their impacts on services to
21 American Indians and Alaska Natives and relationships with Indian
22 health care providers.

23 (4) The governor's Indian health council meetings,
24 recommendations, and other forms of collaboration support the
25 consultation process established in section 4 of this act but are not
26 a substitute for the requirement for state agencies to conduct
27 consultation under federal and state law.

28 (5) The governor's Indian health council must establish an Indian
29 health improvement reinvestment account committee to provide
30 oversight over the Indian health improvement reinvestment account
31 established in section 8 of this act. The tribal and Indian health
32 care provider representatives of the committee must determine which
33 projects should receive funding from the Indian health improvement
34 reinvestment account, in what amounts, and under what reporting
35 requirements. This committee must consist of the following
36 representatives:

37 (a) Each federally recognized tribe in the state of Washington
38 must be represented in a voting capacity by an individual designated
39 by tribal council, either the tribe's delegate to the American Indian

1 health commission for Washington state or an individual specifically
2 designated for this role by the tribal council;

3 (b) Each urban Indian health program must be represented in a
4 voting capacity by an individual designated by the governing board of
5 the program, either the program's delegate to the American Indian
6 health commission for Washington state or an individual specifically
7 designated for this role by the board of the program;

8 (c) Each Indian health service unit must be represented in a
9 nonvoting capacity by the chief executive officer or his or her
10 designee who is also an officer of the Indian health service unit;

11 (d) One or more representatives from the office of financial
12 management;

13 (e) The American Indian health commission for Washington state
14 must be represented in a nonvoting capacity by the executive director
15 or an individual specifically designated for this role by the
16 American Indian health commission for Washington state; and

17 (f) The northwest Portland area Indian health board must be
18 represented in a nonvoting capacity by the executive director or an
19 individual specifically designated for this role by the governing
20 board of the northwest Portland Indian area health board.

21 NEW SECTION. **Sec. 4.** (1) The tribal consultation policy of the
22 authority applies to all medicaid matters, including medicaid state
23 plan amendments, waivers, and program-related contracts. Under this
24 consultation policy, the authority must provide tribes and Indian
25 health care providers the opportunity and resources to be fully
26 informed of all medicaid waivers and state plan amendments and their
27 impacts on tribes, Indian health care providers, and American Indians
28 and Alaska Natives. The authority must give tribes and Indian health
29 care providers sufficient information to determine the impacts of
30 these medicaid waivers and state plan amendments on their individual
31 health care delivery systems. The authority must consult with the
32 tribes and Indian health care providers and seek advice regarding any
33 medicaid managed care contracts between the state and a medicaid
34 managed care entity.

35 (2) State agencies must consult with tribes and confer with urban
36 Indian health programs in the design and implementation of health
37 transformation initiatives to assure coordination between Indian and
38 non-Indian health systems and include approaches focused on

1 effectiveness in addressing the needs of American Indian and Alaska
2 Native people.

3 NEW SECTION. **Sec. 5.** As a condition of state funding, including
4 federal funding received through the state, the authority must
5 require the accountable communities of health to: (1) Provide one
6 seat on the governing board of each accountable community of health
7 for each of the tribes and urban Indian health programs within their
8 region; (2) appoint a tribal liaison within each accountable
9 community of health; and (3) establish mutually agreed upon written
10 engagement and communication protocols with the tribes and urban
11 Indian health programs within their regions or jurisdictions. The
12 tribal representatives, tribes, urban Indian health program
13 representatives, and urban Indian health programs are exempt from
14 liability for the actions of the accountable communities of health
15 and their governing boards.

16 NEW SECTION. **Sec. 6.** As a condition of state funding, service
17 coordination organizations or service contracting entities as defined
18 in RCW 70.320.010 must: (1) Appoint a tribal liaison within the
19 organization; (2) establish mutually agreed upon written engagement
20 and communication protocols with the tribes and urban Indian health
21 programs within their regions or jurisdictions; and (3) follow
22 recommendations from the governor's Indian health council regarding
23 services to American Indians and Alaska Natives and relationships
24 with Indian health care providers.

25 NEW SECTION. **Sec. 7.** (1) The legislature finds that costs of
26 medicaid services are shared between the federal and state
27 government. The federal government pays the state a percentage of its
28 total medicaid expenditures referred to as the federal medical
29 assistance percentage. However, services which are received by an
30 eligible American Indian or Alaska Native through an Indian health
31 service facility, whether operated by the Indian health service or by
32 an Indian tribe or tribal organization pursuant to 42 U.S.C. Sec.
33 1396d (b), can be reimbursed at one hundred percent of the federal
34 medical assistance percentage resulting in the state receiving
35 increased federal funds.

36 (2) Beginning July 1, 2018, one hundred percent of the savings
37 that result from the state not having to pay its normal share of the

1 federal medical assistance percentage under this section, less the
2 cost to administer these claims, must be reinvested in the Indian
3 health improvement reinvestment account created in section 8 of this
4 act. Beginning July 1, 2018, one hundred percent of the savings that
5 result from the state not having to pay its normal share of the
6 federal medical assistance percentage under this section, less the
7 cost to administer these claims, must be reinvested in the Indian
8 health improvement reinvestment account pursuant to section 9 of this
9 act.

10 NEW SECTION. **Sec. 8.** (1) The Indian health improvement
11 reinvestment account is created in the state treasury. Moneys in the
12 account may be expended solely for improving outcomes related to the
13 following: (a) Reducing health inequities of American Indians and
14 Alaska Natives in the state; and (b) increasing access to quality and
15 culturally appropriate health care for American Indians and Alaska
16 Natives in the state.

17 (2) The following amounts must be deposited into the Indian
18 health improvement reinvestment account:

19 (a) All savings to the state general fund, pursuant to section 11
20 of this act, resulting from the one hundred percent federal medical
21 assistance percentage applicable to services which are received
22 through an Indian health service facility whether operated by the
23 Indian health service or by an Indian tribe or tribal organization
24 pursuant to 42 U.S.C. Sec. 1396d (b). The authority and the
25 department of social and health services must pursue such savings for
26 medicaid managed care premiums on an actuarial basis and in
27 consultation with tribes;

28 (b) Twelve percent of all state annual funding allocated to
29 community mental health funding; and

30 (c) Any other public or private funds appropriated to or
31 deposited in the account.

32 (3) The state must work with the tribes and Indian health care
33 providers to develop a tracking and data reporting system to track
34 claims and revenue generated under subsection (2) of this section.

35 (4) The Indian health improvement reinvestment account committee
36 established in section 3 of this act determines expenditures of funds
37 in the Indian health improvement reinvestment account. Funds in the
38 account may not be used for any purpose other than one or more of the
39 following programs or activities:

- 1 (a) Evaluation and treatment centers operated by a tribe or
2 tribal organization;
- 3 (b) Contracting with a third-party administrative entity to
4 provide, arrange, and make payment for services for American Indians
5 and Alaska Natives enrolled in the state's medicaid fee-for-service
6 program;
- 7 (c) Medicaid fee-for-service rate enhancement for providers who
8 are trained in providing trauma-informed and culturally appropriate
9 care to provide services to American Indians and Alaska Natives;
- 10 (d) Psychiatric services, including medication consultation,
11 provided by child and adult psychiatrists, and psychiatrists
12 certified in addiction or geriatric psychiatry;
- 13 (e) Designated crisis responders who are designated by the
14 state's behavioral health authority in consultation with specific
15 tribes;
- 16 (f) Licensing, training, and certification of designated crisis
17 responders who are designated by the state of Washington in
18 consultation with specific tribes;
- 19 (g) Traditional healing services;
- 20 (h) Development of a community health aide program, including a
21 community health aide certification board for the state consistent
22 with 25 U.S.C. Sec. 1616;
- 23 (i) Services of a community health aide program consistent with
24 25 U.S.C. Sec. 1616, including community health aides, behavioral
25 health aides, dental health aide therapists, and other types of aides
26 for which certifications or standards are established and enforced by
27 an Indian health service or tribal community health aide program
28 certification board;
- 29 (j) Health information technology capability within tribes and
30 urban Indian health programs to assure the technological capacity to:
- 31 (i) Produce sound evidence for Indian health care provider best
32 practices; (ii) effectively coordinate care between Indian health
33 care providers and non-Indian health care providers; (iii) provide
34 interoperability with state claims and reportable data systems, such
35 as for immunizations and reportable conditions; and (iv) support
36 patient-centered medical home models, including sufficient resources
37 to purchase and implement certified electronic health record systems,
38 such as hardware, software, training, and staffing;
- 39 (k) Indian health care provider care coordination administrative
40 duties to mitigate barriers to access to care for American Indians

1 and Alaska Natives. Such duties include, but are not limited to: (i)
2 Follow-up of referred appointments; (ii) routine follow-up care for
3 management of chronic disease; (iii) transportation; and (iv)
4 increasing patient understanding of provider instructions;

5 (l) Indian epidemiology centers to create a system of
6 epidemiological analysis that meets the needs of the state's American
7 Indian and Alaska Native population; and

8 (m) Other health care services and public health services that
9 contribute to reducing health inequities for American Indians and
10 Alaska Natives in the state and increasing access to quality,
11 culturally appropriate health care for American Indians and Alaska
12 Natives in the state.

13 NEW SECTION. **Sec. 9.** (1) The legislature finds that the United
14 States funds the state of Washington at one hundred percent federal
15 medical assistance percentage for medicaid services provided through
16 an Indian health provider as part of the federal government's
17 responsibility to provide health care to American Indians and Alaska
18 Natives. This trust responsibility ensures that one hundred percent
19 of the medicaid costs for American Indians and Alaska Natives are
20 paid for by the federal government. State administration of medicaid
21 services to American Indians and Alaska Natives must be consistent
22 with the fulfillment of the trust responsibility to provide health
23 care to American Indians and Alaska Natives including removing
24 barriers to their participation in medicaid programs.

25 (2) The authority must, subject to federal restrictions,
26 reimburse tribes and Indian health service facilities at the
27 applicable encounter rate published annually in the federal register
28 by the Indian health service or the rate specified in the medicaid
29 state plan for services provided to non-American Indian and non-
30 Alaska Native patients, including medical, dental, and behavioral
31 health services provided to clinical family members of American
32 Indians and Alaska Natives.

33 (3) The authority must, subject to federal restrictions,
34 reimburse Indian health care providers at the Indian health services
35 outpatient encounter rate for up to five outpatient visits per
36 medicaid beneficiary per calendar day for professional services.

37 (4) The legislature recognizes that access to traditional healing
38 services and culturally appropriate care are essential components to
39 maintaining and sustaining health and wellness for American Indians

1 and Alaska Natives. The authority is directed to coordinate with the
2 federal centers for medicare and medicaid services to provide that
3 traditional healing services are eligible for federal funding of up
4 to one hundred percent.

5 (5) The authority is directed to coordinate with the federal
6 centers for medicare and medicaid services to provide that services
7 of community health aides certified under an Indian health service or
8 tribal community health aid program are eligible for federal funding
9 of up to one hundred percent. The authority may not require, as a
10 condition of reimbursement, additional licensure or certification of
11 such community health aides who are certified under an Indian health
12 services or tribal community health aide program.

13 NEW SECTION. **Sec. 10.** (1) American Indians and Alaska Natives
14 must be enrolled in the state medicaid fee-for-service system. The
15 authority must enable American Indian and Alaska Native beneficiaries
16 to enroll in medicaid managed care. American Indians and Alaska
17 Natives are eligible to select an Indian health care provider or a
18 fee-for-service provider as their behavioral health care provider or
19 their physical health provider. American Indians and Alaska Natives
20 may not be automatically assigned into medicaid managed care.

21 (2) The authority must provide notice to American Indian and
22 Alaska Native medicaid enrollees explaining that American Indians and
23 Alaska Natives may choose to opt-in to a managed care plan.

24 (3) The authority must contract with a third-party administrator
25 to:

26 (a) Provide, arrange, and make payment for services for American
27 Indians and Alaska Natives through the state medicaid fee-for-service
28 system;

29 (b) Recruit from existing tribes' purchased or referred care
30 program networks;

31 (c) Assure that claims submitted by nontribal providers to tribal
32 programs, such as the catastrophic health emergency fund, and
33 purchased and referred care programs, are paid at rates similar to
34 medicare;

35 (d) Provide or contract with Indian health care providers to
36 provide coordination of benefits for American Indian and Alaska
37 Native clients and repricing of purchased and referred care services;

38 (e) Contract with Indian health care providers to provide
39 services where possible;

1 (f) Prepare a report to Indian health care providers and to the
2 authority on various measures agreed upon with Indian health care
3 providers;

4 (g) Provide assistance with American Indian and Alaska Native and
5 non-American Indian and Alaska Native client eligibility to receive
6 care at different Indian health care providers;

7 (h) Maintain updated knowledge of Indian health care provider
8 eligibility requirements;

9 (i) Maintain an updated list from the northwest tribal registry
10 from the northwest Portland area Indian health board;

11 (j) If a client is not on the northwest tribal registry, validate
12 the client according to Indian health services requirements;

13 (k) Assign clients to Indian health care provider patient-
14 centered medical homes;

15 (l) Provide training for providers and staff on how to deliver
16 culturally appropriate services;

17 (m) Support bringing specialist services to Indian health care
18 providers rather than sending patients to specialists; and

19 (n) Monitor timeliness of access to care for referrals to non-
20 Indian health care providers.

21 (4) The authority must provide technical assistance to Indian
22 health care providers to develop networks that utilize federally
23 qualified health center rates and purchased and referred care rates
24 for services provided by non-Indian health care specialty providers
25 within the fee-for-service system and managed care programs.

26 NEW SECTION. **Sec. 11.** (1) The authority must require medicaid
27 managed care entities to pay directly to Indian health care providers
28 the applicable encounter rate published annually in the federal
29 register by the Indian health service or the rate specified in the
30 medicaid state plan. For any Indian health care provider that does
31 not have a published encounter rate, medicaid managed care entities
32 must pay the amount the Indian health care provider would receive if
33 the services were provided under the state plan's fee-for-service
34 payment methodology.

35 (2) Medicaid managed care entities must treat every Indian health
36 care provider as an in-network provider, whether participating or
37 not, to ensure timely access to services for Indian enrollees
38 eligible to receive services from such providers.

1 (3) Medicaid managed care entities must include all Indian health
2 care providers on any in-network provider lists via their web sites
3 and through their customer service lines. The authority must provide
4 medicaid managed care entities with an updated Indian health care
5 provider list.

6 (4) Medicaid managed care entities must ensure that American
7 Indian and Alaska Native enrollees may: (a) Obtain covered services
8 from any Indian health care provider, regardless of whether the
9 Indian health care provider participates in the network of the
10 medicaid managed care entities; and (b) choose an Indian health care
11 provider as his or her primary care provider if he or she is eligible
12 to receive primary care services from that Indian health care
13 provider and that Indian health care provider is participating as an
14 in-network provider.

15 (5) Medicaid managed care entities must pay every Indian health
16 care provider for covered services provided to American Indian and
17 Alaska Native enrollees who are eligible to receive services from
18 that Indian health care provider as follows:

19 (a) When an Indian health care provider is not enrolled in
20 medicaid as a federally qualified health center, regardless of
21 whether or not it participates in the network of the medicaid managed
22 care entity, the medicaid managed care entity must pay the Indian
23 health care provider the full applicable Indian health services
24 encounter rate published annually in the federal register by the
25 Indian health service, or in the absence of a published encounter
26 rate, the amount it would receive if the services were provided under
27 medicaid fee-for-service (the applicable Indian health care provider
28 rate) provided that, when the amount an Indian health care provider
29 receives from the medicaid managed care entity is less than the full
30 applicable Indian health care provider rate, the authority must make
31 a supplemental payment to the Indian health care provider to make up
32 the difference between the amount the medicaid managed care entity
33 pays and the amount the Indian health care provider would have
34 received under medicaid fee-for-service or the applicable encounter
35 rate.

36 (b) When an Indian health care provider is enrolled in medicaid
37 as a federally qualified health center and is a participating
38 provider of the medicaid managed care entity, the medicaid managed
39 care entity must pay the Indian health care provider at a rate
40 negotiated between the medicaid managed care entity and the Indian

1 health care provider or, in the absence of a negotiated rate, at a
2 rate not less than the level and amount of payment that the medicaid
3 managed care entity would make for the services to a participating
4 provider which is a federally qualified health center but not an
5 Indian health care provider.

6 (c) The United States, including the Indian health service, each
7 tribe, and each tribal organization has the right to recover from
8 liable third parties, including the medicaid managed care entity,
9 notwithstanding network restrictions, pursuant to 25 U.S.C. Sec.
10 1621e.

11 (d) Any contract between the authority or the department of
12 social and health services and a medicaid managed care entity must
13 require that as a condition of receiving payment under such contract,
14 the medicaid managed care entity agrees to make prompt payment to
15 Indian health care providers, whether such Indian health care
16 providers are participating providers or nonparticipating providers.

17 (e) A medicaid managed care entity may not require prior
18 authorization for any services provided by an Indian health care
19 provider to an American Indian or Alaska Native enrollee by referral
20 from an Indian health care provider.

21 (6) A medicaid managed care entity must accept referrals by an
22 Indian health care provider, regardless of whether the Indian health
23 care provider participates in the network of the medicaid managed
24 care entity, for an American Indian and Alaska Native enrollee to
25 receive services from a network provider without requiring prior
26 authorization or a referral from a participating network provider for
27 the same or substantially similar service. A medicaid managed care
28 entity may not require documentation from an Indian health care
29 provider that is more burdensome than documentation required from
30 non-Indian health care providers or non-American Indian or Alaska
31 Native enrollees.

32 (7) Medicaid managed care entities must provide only the services
33 requested by the Indian health care provider or the American Indian
34 or Alaska Native enrollee and maintain the Indian health care
35 provider as the American Indian or Alaska Native enrollee's medical
36 home through care coordination with the Indian health care provider
37 including the Indian health care provider's purchased and referred
38 care program. The medicaid managed care entity must provide non-
39 Indian health care providers with the authority's written guidance on
40 the critical role played by Indian health care providers for the care

1 of American Indian and Alaska Native enrollees. Subject to the
2 American Indian and Alaska Native enrollee's release of information,
3 the medicaid managed care entity must require non-Indian health care
4 providers to deliver progress notes, including any referrals made, to
5 the American Indian or Alaska Native enrollee's Indian health care
6 provider medical home.

7 (8) Medicaid managed care entities must require staff to receive,
8 at least once per calendar year, Indian health care delivery system
9 and cultural humility training that is applicable to the respective
10 American Indian and Alaska Native communities they serve. Each
11 medicaid managed care entity must provide written documentation of
12 efforts to obtain this training from tribes and urban Indian health
13 programs in the medicaid managed care entity's service area, the
14 American Indian health commission for Washington state, the Indian
15 policy advisory committee, or the department of social and health
16 service's office of Indian policy.

17 (9) Each medicaid managed care entity must develop protocols with
18 each tribe in the medicaid managed care entity's service area for
19 accessing tribal land to provide crisis services, including
20 coordination of outreach and debriefing of crisis review and outcome
21 with the Indian health care provider. The protocols must include
22 agreed upon time frames and participation for debrief and review, in
23 compliance with the health insurance portability and accountability
24 act (P.L. 104-191; 110 Stat. 1936) and 42 C.F.R. Part 2 requirements.

25 (10) To the extent permitted by law, medicaid managed care
26 entities must make reasonable efforts to require participating
27 psychiatric hospitals and evaluation and treatment facilities to
28 notify and coordinate discharge planning with Indian health care
29 providers for Indian health service eligible American Indian and
30 Alaska Native clients.

31 (11) Each medicaid managed care entity must designate a tribal
32 liaison to facilitate resolution of any issue between a medicaid
33 managed care entity and an Indian health care provider including, but
34 not limited to, billing and provider enrollment or credentialing. The
35 tribal liaison's function may be an additional duty assigned to
36 existing medicaid managed care entity staff. The medicaid managed
37 care entity must document with the authority every such issue
38 presented by an Indian health care provider or identified by the
39 tribal liaison. The medicaid managed care entity must make the tribal
40 liaison available for training by tribes and urban Indian health

1 programs in the medicaid managed care entity's service area, the
2 Indian policy advisory committee of the department of social and
3 health services, or the American Indian health commission for
4 Washington state.

5 (12) The authority must establish a resolution process for each
6 Indian health care provider to submit complaints to the authority
7 regarding unresolved issues including, but not limited to, crisis
8 coordination between the Indian health care providers and a medicaid
9 managed care entity. The authority must facilitate resolution
10 directly with the medicaid managed care entity. The medicaid managed
11 care entity must include reference in any contract between the
12 medicaid managed care entity and the Indian health care provider to
13 the resolution process maintained by the authority. Prior to the
14 development of any plan with an Indian health care provider that is
15 required by the state agreement with the medicaid managed care
16 entity, the medicaid managed care entity must meet with the authority
17 and the Indian health care provider to identify and resolve issues
18 related to the medicaid managed care entity's performance of services
19 under its agreement with the authority.

20 (13) A medicaid managed care entity is subject to corrective
21 action and penalties against the medicaid managed care entity by the
22 authority if the medicaid managed care entity fails to: (a) Perform
23 any obligation under the medicaid managed care entity state agreement
24 or the requirements within this section; or (b) ensure that American
25 Indians and Alaska Natives are afforded access to care, rights, and
26 benefits on par with all other medicaid managed care entity
27 enrollees.

28 (14) To the extent that such reporting does not risk exposure of
29 personal information, the authority must, in consultation with tribes
30 and conferral with Indian health care providers, prepare reports on
31 Indian health care providers and the American Indian and Alaska
32 Native population using data on American Indian and Alaska Native
33 enrollment and the health care effectiveness data and information
34 set measures that the medicaid managed care entities are required to
35 report to the authority. The authority must provide these reports to
36 each tribe and Indian health care provider within the state.

37 (15)(a) The authority must submit a report to all Indian health
38 care providers in the state detailing its implementation and
39 coordination of efforts with the tribes on managing the care of
40 American Indians and Alaska Natives in a format to be agreed upon by

1 the authority and the tribes and Indian health care providers in the
2 state. The reporting is required to occur no less than annually. The
3 reports must include at a minimum:

4 (i) Description of concerns raised by the tribes and Indian
5 health care providers and the authority's efforts to address each
6 concern;

7 (ii) Managed care entities' compliance with section 1932(h) of
8 the social security act and 42 C.F.R. Sec. 438.14;

9 (iii) Information on Indian health care providers and the Indian
10 population using data on Indian enrollment and the behavioral health
11 performance measures that the medicaid managed care entities are
12 required by contract to report to the authority. Such reporting must
13 not risk exposure of personal information; and

14 (iv) The effect of medicaid waivers on the accessibility and
15 quality of services as well as the anticipated impact of the project
16 on the state's medicaid program as required. Such analysis must
17 include the impacts that the expansion of managed care will have upon
18 the fee-for-service system.

19 (b) The authority must allow tribes and Indian health care
20 providers the opportunity to provide recommendations at least sixty
21 days prior to finalizing each report.

22 (16) The authority must consult with the tribes and seek advice
23 regarding the state agreements with medicaid managed care entities.

24 (17) The authority must meet with and solicit advice and guidance
25 from the tribes and urban Indian health programs on at least a
26 quarterly basis to ensure that American Indians and Alaska Natives
27 receive access to quality care in a timely manner. These meetings are
28 not a substitute for formal government-to-government tribal
29 consultation.

30 NEW SECTION. **Sec. 12.** (1) The authority, in consultation with
31 tribes and urban Indian health programs, must develop a plan to
32 assure written and verbal technical assistance is available to
33 support the incorporation of cultural awareness and development of
34 strategies to address historical trauma and intergenerational trauma
35 in treatment planning for services covered by medicaid and other
36 services provided by the state.

37 (2) The department of social and health services must require all
38 designated crisis responders to receive training in historical trauma
39 and intergenerational trauma and ensure that historical trauma and

1 intergenerational trauma are addressed in treatment planning for
2 services covered by medicaid.

3 NEW SECTION. **Sec. 13.** (1) The secretary of the department of
4 health shall include tribes in the development of a public health
5 system that acknowledges tribal authority and responsibility for
6 their community.

7 (2) The department of health, in consultation with the tribes and
8 conferral with Indian health care providers, must identify and define
9 how: (a) The department of health funding and delivery framework
10 apply to Indian public health programs; and (b) the tribes, Indian
11 public health programs, the department of health, and local health
12 jurisdictions can work together to serve all people in Washington.

13 (3) The department of health must work with tribes and Indian
14 health care providers to establish an Indian health care provider
15 track within the state's efforts to transform the practice of health
16 care professionals. The Indian health care provider track must assure
17 an appropriate level of expertise on Indian health and the capacity
18 to properly assist Indian health care providers.

19 (4) The department of health must work with tribes and Indian
20 health care providers to assure that state resources for improving
21 population health include tribally determined practices and resources
22 that support tribal concepts of health using the "pulling together
23 for wellness" framework, which is a tribally driven, culturally
24 grounded prevention framework developed through the guidance of
25 Washington tribal and urban Indian leaders, adapting evidence-based
26 practice by integrating western science and native epistemology.

27 (5) The department of health must work with Indian epidemiology
28 centers to create a system of epidemiological analysis that meets the
29 needs of the state's tribal population.

30 NEW SECTION. **Sec. 14.** Sections 1 through 13 of this act
31 constitute a new chapter in Title 70 RCW.

32 **Sec. 15.** RCW 38.52.040 and 2015 c 274 s 17 are each amended to
33 read as follows:

34 (1) There is hereby created the emergency management council
35 (hereinafter called the council), to consist of not more than
36 seventeen members who shall be appointed by the adjutant general. The
37 membership of the council shall include, but not be limited to,

1 representatives of city (~~and~~), county, and tribal governments,
2 sheriffs and police chiefs, the Washington state patrol, the military
3 department, the department of ecology, state and local fire chiefs,
4 seismic safety experts, state and local emergency management
5 directors, search and rescue volunteers, medical professions who have
6 expertise in emergency medical care, building officials, and private
7 industry. The representatives of private industry shall include
8 persons knowledgeable in emergency and hazardous materials
9 management. The councilmembers shall elect a chair from within the
10 council membership. The members of the council shall serve without
11 compensation, but may be reimbursed for their travel expenses
12 incurred in the performance of their duties in accordance with RCW
13 43.03.050 and 43.03.060 as now existing or hereafter amended.

14 (2) The emergency management council shall advise the governor
15 and the director on all matters pertaining to state and local
16 emergency management. The council may appoint such ad hoc committees,
17 subcommittees, and working groups as are required to develop specific
18 recommendations for the improvement of emergency management
19 practices, standards, policies, or procedures. The council shall
20 ensure that the governor receives an annual assessment of statewide
21 emergency preparedness including, but not limited to, specific
22 progress on hazard mitigation and reduction efforts, implementation
23 of seismic safety improvements, reduction of flood hazards, and
24 coordination of hazardous materials planning and response activities.
25 The council shall review administrative rules governing state and
26 local emergency management practices and recommend necessary
27 revisions to the director.

28 (3) The council or a council subcommittee shall serve and
29 periodically convene in special session as the state emergency
30 response commission required by the emergency planning and community
31 right-to-know act (42 U.S.C. Sec. 11001 et seq.). The state emergency
32 response commission shall conduct those activities specified in
33 federal statutes and regulations and state administrative rules
34 governing the coordination of hazardous materials policy including,
35 but not limited to, review of local emergency planning committee
36 emergency response plans for compliance with the planning
37 requirements in the emergency planning and community right-to-know
38 act (42 U.S.C. Sec. 11001 et seq.). Committees shall annually review
39 their plans to address changed conditions, and submit their plans to
40 the state emergency response commission for review when updated, but

1 not less than at least once every five years. The department may
2 employ staff to assist local emergency planning committees in the
3 development and annual review of these emergency response plans, with
4 an initial focus on the highest risk communities through which trains
5 that transport oil in bulk travel. By March 1, 2018, the department
6 shall report to the governor and legislature on progress towards
7 compliance with planning requirements. The report must also provide
8 budget and policy recommendations for continued support of local
9 emergency planning.

10 (4)(a) The intrastate mutual aid committee is created and is a
11 subcommittee of the emergency management council. The intrastate
12 mutual aid committee consists of not more than five members who must
13 be appointed by the council chair from council membership. The chair
14 of the intrastate mutual aid committee is the military department
15 representative appointed as a member of the council. Meetings of the
16 intrastate mutual aid committee must be held at least annually.

17 (b) In support of the intrastate mutual aid system established in
18 chapter 38.56 RCW, the intrastate mutual aid committee shall develop
19 and update guidelines and procedures to facilitate implementation of
20 the intrastate mutual aid system by member jurisdictions, including
21 but not limited to the following: Projected or anticipated costs;
22 checklists and forms for requesting and providing assistance;
23 recordkeeping; reimbursement procedures; and other implementation
24 issues. These guidelines and procedures are not subject to the rule-
25 making requirements of chapter 34.05 RCW.

26 **Sec. 16.** RCW 41.05.690 and 2014 c 223 s 6 are each amended to
27 read as follows:

28 (1) There is created a performance measures committee, the
29 purpose of which is to identify and recommend standard statewide
30 measures of health performance to inform public and private health
31 care purchasers and to propose benchmarks to track costs and
32 improvements in health outcomes.

33 (2) Members of the committee must include representation from
34 state agencies, small and large employers, health plans, patient
35 groups, federally recognized tribes, consumers, academic experts on
36 health care measurement, hospitals, physicians, and other providers.
37 The governor shall appoint the members of the committee, except that
38 a statewide association representing hospitals may appoint a member
39 representing hospitals, and a statewide association representing

1 physicians may appoint a member representing physicians. The governor
2 shall ensure that members represent diverse geographic locations and
3 both rural and urban communities. The chief executive officer of the
4 lead organization must also serve on the committee. The committee
5 must be chaired by the director of the authority.

6 (3) The committee shall develop a transparent process for
7 selecting performance measures, and the process must include
8 opportunities for public comment.

9 (4) By January 1, 2015, the committee shall submit the
10 performance measures to the authority. The measures must include
11 dimensions of:

12 (a) Prevention and screening;

13 (b) Effective management of chronic conditions;

14 (c) Key health outcomes;

15 (d) Care coordination and patient safety; and

16 (e) Use of the lowest cost, highest quality care for preventive
17 care and acute and chronic conditions.

18 (5) The committee shall develop a measure set that:

19 (a) Is of manageable size;

20 (b) Is based on readily available claims and clinical data;

21 (c) Gives preference to nationally reported measures and, where
22 nationally reported measures may not be appropriate, measures used by
23 state agencies that purchase health care or commercial health plans;

24 (d) Focuses on the overall performance of the system, including
25 outcomes and total cost;

26 (e) Is aligned with the governor's performance management system
27 measures and common measure requirements specific to medicaid
28 delivery systems under RCW 70.320.020 and 43.20A.895;

29 (f) Considers the needs of different stakeholders and the
30 populations served; and

31 (g) Is usable by multiple payers, providers, hospitals,
32 purchasers, public health, and communities as part of health
33 improvement, care improvement, provider payment systems, benefit
34 design, and administrative simplification for providers and
35 hospitals.

36 (6) State agencies shall use the measure set developed under this
37 section to inform and set benchmarks for purchasing decisions.

38 (7) The committee shall establish a public process to
39 periodically evaluate the measure set and make additions or changes
40 to the measure set as needed.

1 (8) Because performance measures are publicly reported and can be
2 integrated in financial incentive programs or value-based payment
3 models, it is important that they accurately convey relative provider
4 performance and appropriately consider providers' patient
5 populations. To control for the effect of factors outside of the
6 control of providers, including patient-related factors, the
7 committee must establish a risk adjustment methodology that risk
8 adjusts performance measure results when calculating results.

9 (9) The committee must identify a range of tools and policies
10 that can address potential unintended consequences resulting from the
11 use of performance measures including, but not limited to, the
12 following:

13 (a) Identifying and adequately paying for nonmedical support
14 services that have been shown to improve patient outcomes for people
15 who face economic and social barriers to good health;

16 (b) On a targeted basis, financially rewarding improvement in
17 quality performance more strongly than absolute goals;

18 (c) Comparing the performance of clinics that have similar
19 features and see similar types of patients; and

20 (d) Examining the unmeasured impact of patient-complexity factors
21 that include a broader range of sociodemographic characteristics,
22 such as patients facing housing and food insecurity, patients who are
23 suffering from historical trauma, or patients who are more likely to
24 experience disparities in health outcomes.

25 **Sec. 17.** RCW 70.320.020 and 2017 c 226 s 8 are each amended to
26 read as follows:

27 (1) The authority and the department shall base contract
28 performance measures developed under RCW 70.320.030 on the following
29 outcomes when contracting with service contracting entities:
30 Improvements in client health status and wellness; increases in
31 client participation in meaningful activities; reductions in client
32 involvement with criminal justice systems; reductions in avoidable
33 costs in hospitals, emergency rooms, crisis services, and jails and
34 prisons; increases in stable housing in the community; improvements
35 in client satisfaction with quality of life; and reductions in
36 population-level health disparities.

37 (2) The performance measures must demonstrate the manner in which
38 the following principles are achieved within each of the outcomes
39 under subsection (1) of this section:

1 (a) Maximization of the use of evidence-based practices will be
2 given priority over the use of research-based and promising
3 practices, and research-based practices will be given priority over
4 the use of promising practices. The agencies will develop strategies
5 to identify programs that are effective with ethnically diverse
6 clients and to consult with tribal governments, experts within
7 ethnically diverse communities and community organizations that serve
8 diverse communities;

9 (b) The maximization of the client's independence, recovery, and
10 employment;

11 (c) The maximization of the client's participation in treatment
12 decisions; and

13 (d) The collaboration between consumer-based support programs in
14 providing services to the client.

15 (3) In developing performance measures under RCW 70.320.030, the
16 authority and the department shall consider expected outcomes
17 relevant to the general populations that each agency serves. The
18 authority and the department may adapt the outcomes to account for
19 the unique needs and characteristics of discrete subcategories of
20 populations receiving services, including ethnically diverse
21 communities.

22 (4) The authority and the department shall coordinate the
23 establishment of the expected outcomes and the performance measures
24 between each agency as well as each program to identify expected
25 outcomes and performance measures that are common to the clients
26 enrolled in multiple programs and to eliminate conflicting standards
27 among the agencies and programs.

28 (5)(a) The authority and the department shall establish timelines
29 and mechanisms for service contracting entities to report data
30 related to performance measures and outcomes, including phased
31 implementation of public reporting of outcome and performance
32 measures in a form that allows for comparison of performance measures
33 and levels of improvement between geographic regions of Washington.

34 (b) The authority and the department may not release any public
35 reports of client outcomes unless the data has been deidentified and
36 aggregated in such a way that the identity of individual clients
37 cannot be determined through directly identifiable data or the
38 combination of multiple data elements.

39 (6) The authority and department must establish a performance
40 measure to be integrated into the statewide common measure set which

1 tracks effective integration practices of behavioral health services
2 in primary care settings.

3 (7) The authority and the department must develop performance
4 measures and a risk adjustment methodology for all medicaid
5 enrollees, including American Indian and Alaska Native enrollees,
6 that meets the requirements of RCW 41.05.690.

7 **Sec. 18.** RCW 43.84.092 and 2017 3rd sp.s. c 25 s 50, 2017 3rd
8 sp.s. c 12 s 12, and 2017 c 290 s 8 are each reenacted and amended to
9 read as follows:

10 (1) All earnings of investments of surplus balances in the state
11 treasury shall be deposited to the treasury income account, which
12 account is hereby established in the state treasury.

13 (2) The treasury income account shall be utilized to pay or
14 receive funds associated with federal programs as required by the
15 federal cash management improvement act of 1990. The treasury income
16 account is subject in all respects to chapter 43.88 RCW, but no
17 appropriation is required for refunds or allocations of interest
18 earnings required by the cash management improvement act. Refunds of
19 interest to the federal treasury required under the cash management
20 improvement act fall under RCW 43.88.180 and shall not require
21 appropriation. The office of financial management shall determine the
22 amounts due to or from the federal government pursuant to the cash
23 management improvement act. The office of financial management may
24 direct transfers of funds between accounts as deemed necessary to
25 implement the provisions of the cash management improvement act, and
26 this subsection. Refunds or allocations shall occur prior to the
27 distributions of earnings set forth in subsection (4) of this
28 section.

29 (3) Except for the provisions of RCW 43.84.160, the treasury
30 income account may be utilized for the payment of purchased banking
31 services on behalf of treasury funds including, but not limited to,
32 depository, safekeeping, and disbursement functions for the state
33 treasury and affected state agencies. The treasury income account is
34 subject in all respects to chapter 43.88 RCW, but no appropriation is
35 required for payments to financial institutions. Payments shall occur
36 prior to distribution of earnings set forth in subsection (4) of this
37 section.

38 (4) Monthly, the state treasurer shall distribute the earnings
39 credited to the treasury income account. The state treasurer shall

1 credit the general fund with all the earnings credited to the
2 treasury income account except:

3 (a) The following accounts and funds shall receive their
4 proportionate share of earnings based upon each account's and fund's
5 average daily balance for the period: The aeronautics account, the
6 aircraft search and rescue account, the Alaskan Way viaduct
7 replacement project account, the brownfield redevelopment trust fund
8 account, the budget stabilization account, the capital vessel
9 replacement account, the capitol building construction account, the
10 Cedar River channel construction and operation account, the Central
11 Washington University capital projects account, the charitable,
12 educational, penal and reformatory institutions account, the Chehalis
13 basin account, the cleanup settlement account, the Columbia river
14 basin water supply development account, the Columbia river basin
15 taxable bond water supply development account, the Columbia river
16 basin water supply revenue recovery account, the common school
17 construction fund, the community forest trust account, the connecting
18 Washington account, the county arterial preservation account, the
19 county criminal justice assistance account, the deferred compensation
20 administrative account, the deferred compensation principal account,
21 the department of licensing services account, the department of
22 retirement systems expense account, the developmental disabilities
23 community trust account, the diesel idle reduction account, the
24 drinking water assistance account, the drinking water assistance
25 administrative account, the early learning facilities development
26 account, the early learning facilities revolving account, the Eastern
27 Washington University capital projects account, the Interstate 405
28 express toll lanes operations account, the education construction
29 fund, the education legacy trust account, the election account, the
30 electric vehicle charging infrastructure account, the energy freedom
31 account, the energy recovery act account, the essential rail
32 assistance account, The Evergreen State College capital projects
33 account, the federal forest revolving account, the ferry bond
34 retirement fund, the freight mobility investment account, the freight
35 mobility multimodal account, the grade crossing protective fund, the
36 public health services account, (~~the high capacity transportation~~
37 ~~account,~~) the state higher education construction account, the
38 higher education construction account, the highway bond retirement
39 fund, the highway infrastructure account, the highway safety fund,
40 the high occupancy toll lanes operations account, the hospital safety

1 net assessment fund, the Indian health improvement reinvestment
2 account, the industrial insurance premium refund account, the judges'
3 retirement account, the judicial retirement administrative account,
4 the judicial retirement principal account, the local leasehold excise
5 tax account, the local real estate excise tax account, the local
6 sales and use tax account, the marine resources stewardship trust
7 account, the medical aid account, the mobile home park relocation
8 fund, the money-purchase retirement savings administrative account,
9 the money-purchase retirement savings principal account, the motor
10 vehicle fund, the motorcycle safety education account, the multimodal
11 transportation account, the multiuse roadway safety account, the
12 municipal criminal justice assistance account, the natural resources
13 deposit account, the oyster reserve land account, the pension funding
14 stabilization account, the perpetual surveillance and maintenance
15 account, the pollution liability insurance agency underground storage
16 tank revolving account, the public employees' retirement system plan
17 1 account, the public employees' retirement system combined plan 2
18 and plan 3 account, the public facilities construction loan revolving
19 account beginning July 1, 2004, the public health supplemental
20 account, the public works assistance account, the Puget Sound capital
21 construction account, the Puget Sound ferry operations account, the
22 Puget Sound taxpayer accountability account, the real estate
23 appraiser commission account, the recreational vehicle account, the
24 regional mobility grant program account, the resource management cost
25 account, the rural arterial trust account, the rural mobility grant
26 program account, the rural Washington loan fund, the sexual assault
27 prevention and response account, the site closure account, the
28 skilled nursing facility safety net trust fund, the small city
29 pavement and sidewalk account, the special category C account, the
30 special wildlife account, the state employees' insurance account, the
31 state employees' insurance reserve account, the state investment
32 board expense account, the state investment board commingled trust
33 fund accounts, the state patrol highway account, the state route
34 number 520 civil penalties account, the state route number 520
35 corridor account, the state wildlife account, the supplemental
36 pension account, the Tacoma Narrows toll bridge account, the
37 teachers' retirement system plan 1 account, the teachers' retirement
38 system combined plan 2 and plan 3 account, the tobacco prevention and
39 control account, the tobacco settlement account, the toll facility
40 bond retirement account, the transportation 2003 account (nickel

1 account), the transportation equipment fund, the transportation
2 future funding program account, the transportation improvement
3 account, the transportation improvement board bond retirement
4 account, the transportation infrastructure account, the
5 transportation partnership account, the traumatic brain injury
6 account, the tuition recovery trust fund, the University of
7 Washington bond retirement fund, the University of Washington
8 building account, the volunteer firefighters' and reserve officers'
9 relief and pension principal fund, the volunteer firefighters' and
10 reserve officers' administrative fund, the Washington judicial
11 retirement system account, the Washington law enforcement officers'
12 and firefighters' system plan 1 retirement account, the Washington
13 law enforcement officers' and firefighters' system plan 2 retirement
14 account, the Washington public safety employees' plan 2 retirement
15 account, the Washington school employees' retirement system combined
16 plan 2 and 3 account, the Washington state health insurance pool
17 account, the Washington state patrol retirement account, the
18 Washington State University building account, the Washington State
19 University bond retirement fund, the water pollution control
20 revolving administration account, the water pollution control
21 revolving fund, the Western Washington University capital projects
22 account, the Yakima integrated plan implementation account, the
23 Yakima integrated plan implementation revenue recovery account, and
24 the Yakima integrated plan implementation taxable bond account.
25 Earnings derived from investing balances of the agricultural
26 permanent fund, the normal school permanent fund, the permanent
27 common school fund, the scientific permanent fund, the state
28 university permanent fund, and the state reclamation revolving
29 account shall be allocated to their respective beneficiary accounts.

30 (b) Any state agency that has independent authority over accounts
31 or funds not statutorily required to be held in the state treasury
32 that deposits funds into a fund or account in the state treasury
33 pursuant to an agreement with the office of the state treasurer shall
34 receive its proportionate share of earnings based upon each account's
35 or fund's average daily balance for the period.

36 (5) In conformance with Article II, section 37 of the state
37 Constitution, no treasury accounts or funds shall be allocated
38 earnings without the specific affirmative directive of this section.

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