

## PROPOSED SUBSTITUTE HOUSE BILL 1152

By Representative Riccelli

### Original bill:

- Requires counties to form comprehensive public health districts beginning January 1, 2023.
  - Repeals provisions related to establishing and operating local boards of health, local health districts, local district boards of health, and city-county health departments.
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### Substitute bill compared to original bill:

- Eliminates provisions in the underlying bill related to:
  - establishing and operating comprehensive public health districts; and
  - repealing provisions providing for the establishment and operation of local boards of health, local health districts, local district boards of health, and city-county health departments.
- Establishes nine comprehensive health services districts and requires counties to form the districts by January 1, 2024.
- Establishes the duties and responsibilities for comprehensive health services districts, including developing a district plan to identify shared service delivery models, coordination with other districts, administering and allocating funding to each local health jurisdiction comprising the district, and reporting the adequacy of resources to the DOH.
- Modifies the composition of the workgroup to include members of the Foundation Public Health Services Steering Committee.
- Establishes the membership of each comprehensive health services district board of health.
- Requires the State Board of Health to adopt rules to regarding comprehensive health services districts and performance measures to track the effectiveness of local health jurisdictions, comprehensive health services districts, and the Department of Health (DOH).
- Requires each comprehensive health services district board to establish a district health fund and permits each district to own, purchase, and maintain real and personal property.
- Creates the six regional health officers within the DOH who are assigned to a comprehensive health services district.
- Modifies the membership of local boards of health to include a tribal representative and representatives with public health or medical backgrounds, consumers of public health, and other community stakeholders beginning July 1, 2022. City and county elected officials may not constitute a majority of the board, however, any decision regarding setting fees may only be determined by the city and county elected officials.
- Prohibits counties from making material changes to the county's public health governance structure unless the county notifies to state board of health and receives approval of the change until January 1, 2024. Counties that do not receive approval for material changes and make the change in violation of the act will no longer receive distributions from the state treasurer from the marijuana account or the liquor excise tax fund.

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*Committee: House Health Care & Wellness*

*Committee Staff: Kim Weidenaar (786-7120), Office of Program Research*

*Draft: H-0855.2/21*

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**BILL REQUEST - CODE REVISER'S OFFICE**

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BILL REQ. #: H-0855.2/21 2nd draft

ATTY/TYPIST: KB:akl

BRIEF DESCRIPTION: Establishing comprehensive health services districts.

1 AN ACT Relating to supporting measures to create comprehensive  
2 public health districts; amending RCW 43.70.515, 70.05.030,  
3 70.05.035, 70.46.020, 70.46.031, 70.05.130, 70.08.100, 70.46.090, and  
4 82.08.170; reenacting and amending RCW 69.50.540; adding new sections  
5 to chapter 43.20 RCW; adding new sections to chapter 70.05 RCW;  
6 adding a new section to chapter 43.70 RCW; creating a new section;  
7 repealing RCW 43.70.060, 43.70.064, 43.70.066, 43.70.068, and  
8 43.70.070; providing effective dates; and providing expiration dates.

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

10 NEW SECTION. **Sec. 1.** The legislature finds the COVID-19  
11 pandemic has been the most difficult challenge in Washington's public  
12 health history since the 1918 flu pandemic. More Americans have died  
13 from COVID-19 than the number of United States troops killed in  
14 combat during World War II. The COVID-19 pandemic response has  
15 stressed and strained every part of our society and far surpassed the  
16 capabilities of local, state, tribal, and even federal public health  
17 agencies. Before the COVID-19 pandemic, the legislature had initiated  
18 action to address the critical challenges Washington's public health  
19 system faces, including limited organizational capacity, financial  
20 resources, and understaffing through beginning to specifically fund  
21 foundational public health services. The COVID-19 pandemic laid bare

1 the shortcomings of Washington's current public health system which  
2 have been studied and identified for over a decade. Washington's  
3 current public health system was not able to consistently monitor and  
4 track the pandemic, staff the many required missions, adequately  
5 address the health inequities, and implement standard approaches to  
6 disease containment.

7 The legislature further finds that, in Washington, local health  
8 services are currently provided through a decentralized means by 35  
9 local health jurisdictions. In many cases, rural communities are  
10 served by smaller local health jurisdictions that have less capacity  
11 to provide the full spectrum of foundational public health services  
12 than their urban peers. Local health jurisdictions serving smaller  
13 populations face challenges providing the full spectrum of  
14 foundational public health services and activities to promote and  
15 protect the health of all people. In addition, local health  
16 jurisdictions are overseen by boards in which most the members do not  
17 have direct experience in public health or health care. Since April  
18 2020, a Kaiser health news investigation reports at least 181 local  
19 and state health leaders have resigned, retired, or been fired,  
20 including 11 local health leaders in Washington. Diseases do not  
21 respect borders or boundaries, yet the current decentralized system  
22 in Washington creates a patchwork approach with limited  
23 accountability and consistency. National peer-review studies report  
24 larger jurisdictions perform better on most foundational  
25 comprehensive public health services.

26 The COVID-19 pandemic has amplified the health and social  
27 inequities in Washington that existed before its emergence. There are  
28 vast inequities in per capita spending for local public health  
29 services by population size and geographic location. National peer-  
30 review studies report communities with limited public health systems  
31 experience low levels of activity participation, low perceived  
32 effectiveness, and sparse organizational networks compared to  
33 comprehensive public health systems. The inequitable distribution of  
34 morbidity and mortality between Black, indigenous, and people of  
35 color and other populations demonstrates the large health inequities  
36 that must be addressed. Therefore, the legislature finds the state  
37 must determine adequate funding of comprehensive health services  
38 districts from cities, counties, and the state, with the goal of  
39 providing all people with equitable access to foundational public  
40 health services, and once this funding is determined, the legislature

1 finds this investment in the public's health will continue to be  
2 prioritized.

3 The legislature recognizes that public health and health care  
4 staff have been overwhelmed, overworked, and their mental and  
5 physical health are at risk due to the pandemic. The legislature is  
6 thankful for the countless contributions that public health and  
7 health care staff have made to combat this deadly public health  
8 crisis and pandemic. These contributions and efforts have increased  
9 public awareness about the importance of strong infrastructure for  
10 our public health system. Therefore, the legislature finds that  
11 meaningful discourse about the current public health system is  
12 necessary to ensure public trust.

13 The legislature expects emergencies that threaten the health and  
14 well-being of all Washingtonians, emergent and routine, to increase.  
15 Restructuring state funding of foundational public health services is  
16 not enough to face these threats. The legislature intends for  
17 Washington to have a public health system that can respond to 21st  
18 century public health emergencies and public health issues, have the  
19 capacity to improve health outcomes of BIPOC communities, persons  
20 with disabilities, LGBTQ+, rural communities, limited English-  
21 speaking persons, and address health equity across the life span.

22 NEW SECTION. **Sec. 2.** A new section is added to chapter 43.20  
23 RCW to read as follows:

24 (1) A work group is created to develop and recommend to the state  
25 board a public health system to provide foundational public health  
26 services to all people in Washington through local health  
27 jurisdictions, comprehensive health services districts, and the  
28 department.

29 (2) Members of the work group must include:

30 (a) Two representatives from the senate;

31 (b) Two representatives from the house of representatives;

32 (c) Three representatives of local public health;

33 (d) Two representatives of state public health;

34 (e) Three representatives of counties;

35 (f) Two representatives of cities;

36 (g) One tribal representative;

37 (h) One representative with expertise in government finance;

38 (i) One state association representative from the foundational  
39 public health services steering committee;

1 (j) One public health representative from the foundational public  
2 health services steering committee;

3 (k) One tribal public health representative from the foundational  
4 public health services steering committee; and

5 (l) One technical work group member from the foundational public  
6 health services steering committee.

7 (3) The governor shall appoint the members of the work group and  
8 ensure that members represent diverse geographic locations in both  
9 rural and urban communities.

10 (4) The work group shall develop a transparent process, including  
11 opportunities for public comment.

12 (5) By July 1, 2022, the work group must recommend to the state  
13 board the system for counties to form comprehensive health services  
14 districts as provided in section 6 of this act.

15 (6) By January 1, 2023, the work group must recommend performance  
16 measures and a measure set to the state board to track the efficiency  
17 and effectiveness of local health jurisdictions, comprehensive health  
18 services districts, and the department.

19 (7) By July 1, 2023, the work group must submit recommendations  
20 to the legislature on adequate funding of local health jurisdictions  
21 and comprehensive health services districts, including the following:

22 (a) Reasonable per capita estimates to deliver foundational  
23 public health services;

24 (b) How new sources of revenue should be allocated; and

25 (c) Adequate allocation levels to sustain the state public health  
26 system.

27 (8) This section expires December 31, 2024.

28 NEW SECTION. **Sec. 3.** A new section is added to chapter 43.20  
29 RCW to read as follows:

30 (1) The state board must adopt rules to provide foundational  
31 public health services to all people in Washington through local  
32 health jurisdictions, comprehensive health services districts, and  
33 the department. These rules must include:

34 (a) A system and process for counties to create comprehensive  
35 health services districts as required by section 6 of this act;

36 (b) Standard statewide performance measures and proposed  
37 benchmarks to track efficiency and effectiveness of local health  
38 jurisdictions, comprehensive health services districts, and the  
39 department. The performance measures must include dimensions of:

1 (i) Improving morbidity and mortality of marginalized  
2 communities;  
3 (ii) Improving health equity for all people;  
4 (iii) Data modernization and interoperability across the state  
5 public health system;  
6 (iv) Community engagement; and  
7 (v) Emergency preparedness and response;  
8 (c) A measure set that:  
9 (i) Is of manageable size;  
10 (ii) Is based on readily available data;  
11 (iii) Gives preference to nationally reported measures; and  
12 (iv) Focuses on the overall performance of the system, including  
13 outcomes and total costs;  
14 (d) A process for the department to certify comprehensive health  
15 services districts;  
16 (e) A process to evaluate local health jurisdictions,  
17 comprehensive health services districts, and department performance  
18 of the measure set developed under (c) of this subsection; and  
19 (f) A process for information and data elements to be reported by  
20 comprehensive health services districts to the department.  
21 (2) By November 1, 2024, the state board shall submit a report to  
22 the appropriate committees of the legislature on local health  
23 jurisdictions and comprehensive health services districts performance  
24 based on the performance measures established under subsection (1)(b)  
25 of this section.

26 **Sec. 4.** RCW 43.70.515 and 2019 c 14 s 2 are each amended to read  
27 as follows:

28 (1) With any state funding of foundational public health  
29 services, the state expects that measurable benefits will be realized  
30 to the health of communities in Washington as a result of the  
31 improved capacity of the governmental public health system. Close  
32 coordination and sharing of services are integral to increasing  
33 system capacity.

34 (2)(a) Funding for foundational public health services shall be  
35 appropriated to the office of financial management. The office of  
36 financial management may only allocate funding to the department if  
37 the department, after consultation with federally recognized Indian  
38 tribes pursuant to chapter 43.376 RCW, jointly certifies with a state  
39 association representing local health jurisdictions, comprehensive

1 health services districts, and the state board of health, to the  
2 office of financial management that they are in agreement on the  
3 distribution and uses of state foundational public health services  
4 funding across the public health system. The department must evaluate  
5 comprehensive health services districts' performances to satisfy the  
6 measure set identified in section 3 of this act before allocation on  
7 January 1, 2027, and biennially thereafter.

8 (b) If joint certification is provided, the department shall  
9 distribute foundational public health services funding according to  
10 the agreed-upon distribution and uses. If joint certification is not  
11 provided, appropriations for this purpose shall lapse.

12 (3) By October 1, 2020, the department, in partnership with  
13 sovereign tribal nations, local health jurisdictions, and the state  
14 board of health, shall report on:

15 (a) Service delivery models, and a plan for further  
16 implementation of successful models;

17 (b) Changes in capacity of the governmental public health system;  
18 and

19 (c) Progress made to improve health outcomes.

20 (4) For purposes of this section and sections 2 and 3 of this  
21 act:

22 (a) "Comprehensive health services districts" means the districts  
23 established under section 6 of this act to provide coordination and  
24 shared services to local health jurisdictions.

25 (b) "Foundational public health services" means a limited  
26 statewide set of defined public health services within the following  
27 areas:

28 (i) Control of communicable diseases and other notifiable  
29 conditions;

30 (ii) Chronic disease and injury prevention;

31 (iii) Environmental public health;

32 (iv) Maternal, child, and family health;

33 (v) Access to and linkage with medical, oral, and behavioral  
34 health services;

35 (vi) Vital records; and

36 (vii) Cross-cutting capabilities, including:

37 (A) Assessing the health of populations;

38 (B) Public health emergency planning;

39 (C) Communications;

40 (D) Policy development and support;



1 (E) Community partnership development; and

2 (F) Business competencies.

3 ((~~b~~)) (c) "Governmental public health system" means the state  
4 department of health, state board of health, local health  
5 jurisdictions, comprehensive health services districts, sovereign  
6 tribal nations, and Indian health programs located within Washington.

7 ((~~e~~)) (d) "Indian health programs" means tribally operated  
8 health programs, urban Indian health programs, tribal epidemiology  
9 centers, the American Indian health commission for Washington state,  
10 and the Northwest Portland area Indian health board.

11 ((~~d~~)) (e) "Local health jurisdictions" means a public health  
12 agency organized under chapter 70.05, 70.08, or 70.46 RCW.

13 ((~~e~~)) (f) "Service delivery models" means a systematic sharing  
14 of resources and function among state and local governmental public  
15 health entities, sovereign tribal nations, and Indian health programs  
16 to increase capacity and improve efficiency and effectiveness.

17 NEW SECTION. **Sec. 5.** A new section is added to chapter 70.05  
18 RCW to read as follows:

19 (1) Members of the comprehensive health services district board  
20 of health include:

21 (a) The following city and county elected officials:

22 (i) Each county in the district must have one elected official  
23 who serves on a local board of health chosen by that local board of  
24 health; and

25 (ii) One elected official from a city in the district that is  
26 selected by a statewide association representing cities;

27 (b) The regional health officer assigned for the district by the  
28 department;

29 (c) A tribal representative from within the district selected by  
30 the Indian health board and appointed by the governor;

31 (d) At least one representative from the following categories to  
32 be appointed by the governor:

33 (i) Public health, health care facilities, and providers. This  
34 category consists of persons practicing or employed in the county who  
35 are:

36 (A) Medical ethicists;

37 (B) Epidemiologists;

38 (C) Experienced in environmental public health, such as a  
39 registered sanitarian;

- 1 (D) Community health workers;
- 2 (E) Holders of master's degrees or higher in public health or the  
3 equivalent;
- 4 (F) Employees of a hospital located in the county;
- 5 (G) Physicians or osteopathic physicians;
- 6 (H) Advanced registered nurse practitioners;
- 7 (I) Physician assistants or osteopathic physician assistants;
- 8 (J) Registered nurses;
- 9 (K) Dentists;
- 10 (L) Naturopaths; or
- 11 (M) Pharmacists;
- 12 (ii) Consumers of public health. This category consists of county  
13 residents who have self-identified as having faced significant health  
14 inequities or as having lived experiences with public health-related  
15 programs such as: The special supplemental nutrition program for  
16 women, infants, and children; the supplemental nutrition program;  
17 home visiting; or treatment services. It is strongly encouraged that  
18 individuals from historically marginalized and underrepresented  
19 communities are given preference. These individuals may not be  
20 elected officials and may not have any fiduciary obligation to a  
21 health facility or other health agency and may not have a material  
22 financial interest in the rendering of health services; and
- 23 (iii) Other community stakeholders. This category consists of  
24 persons representing the following types of organizations located in  
25 the county:
- 26 (A) Community-based organizations or nonprofits that work with  
27 populations experiencing health inequities in the county;
- 28 (B) The business community; or
- 29 (C) The environmental public health regulated community.
- 30 (2) In the event of a vacancy of a comprehensive health services  
31 district board position that was occupied by a member who was  
32 selected under subsection (1)(d) of this section, the board must  
33 promptly notify:
- 34 (a) Statewide organizations representing physicians, nurses,  
35 public health officials, counties, and cities;
- 36 (b) Accountable communities of health; and
- 37 (c) Any other organizations deemed appropriate by the board.
- 38 (3) City and county elected officials who are members of the  
39 comprehensive health services district board may not constitute a  
40 majority of the board.

1 (4) Governor appointed members may serve three-year terms and may  
2 serve two terms.

3 (5) The comprehensive health services district board may  
4 establish bylaws to govern the board.

5 NEW SECTION. **Sec. 6.** A new section is added to chapter 70.05  
6 RCW to read as follows:

7 (1) By January 1, 2024, counties must form comprehensive health  
8 services districts as established by this section. The department  
9 must certify each comprehensive health services district.

10 (2) The following nine comprehensive health services districts  
11 are established and consist of the following counties:

12 (a) Skamania, Clark, Cowlitz, and Wahkiakum;

13 (b) Lewis, Thurston, Mason, Pacific, and Grays Harbor;

14 (c) Jefferson, Clallam, and Kitsap;

15 (d) Pierce and King;

16 (e) Island, Snohomish, Skagit, Whatcom, and San Juan;

17 (f) Chelan, Okanogan, Douglas, and Grant;

18 (g) Ferry, Stevens, Pend Oreille, Spokane, Lincoln, Adams, and  
19 Whitman;

20 (h) Benton, Franklin, Walla Walla, Columbia, Garfield, and  
21 Asotin; and

22 (i) Kittitas, Yakima, and Klickitat.

23 (3) Counties with a population over 800,000 may be considered a  
24 comprehensive health services district without joining with other  
25 counties when the county legislative authority of the county passes a  
26 resolution or ordinance to organize a comprehensive health services  
27 district under this section.

28 NEW SECTION. **Sec. 7.** A new section is added to chapter 70.05  
29 RCW to read as follows:

30 (1) Comprehensive health services districts are established to  
31 help diversify and stabilize funding services for public health and  
32 to encourage the systemic sharing of resources and functions among  
33 state and local governmental public health entities, sovereign tribal  
34 nations, and Indian health programs to increase capacity and improve  
35 efficiency and effectiveness.

36 (2) Comprehensive health services districts shall:

37 (a) Provide a mechanism for local health jurisdictions in each  
38 comprehensive health services district to convene, collaborate, plan,

1 and work together with the goal of delivering foundational public  
2 health services equitably across the region;

3 (b) Develop a district plan for identification and implementation  
4 of shared service delivery options, models, and strategies;

5 (c) Coordinate with other comprehensive health services  
6 districts, to identify strategies to coordinate public health  
7 services and programs within the region;

8 (d) Identify what programs and services can be delivered through  
9 a shared or regional system within the district such as data  
10 collection, regional assessment-focused epidemiologists, regional  
11 health assessments, foodborne illness, health care associated  
12 infection programs, vaccine preventable disease investigation,  
13 emergency strike teams, and toxicology;

14 (e) Administer and allocate foundational public health services  
15 funding to each local health jurisdiction comprising the district;

16 (f) Provide funding to local health jurisdictions to deliver or  
17 purchase shared services from other local health jurisdictions,  
18 districts, counties, nonprofits, or other jurisdictions, businesses,  
19 or entities;

20 (g) Undertake accountability measures for implementation of  
21 foundational public health services within the district;

22 (h) Report the adequacy of foundational public health services  
23 resources for the district to the department; and

24 (i) As authorized by the district board of health, provide direct  
25 or shared services to local health jurisdictions within the district  
26 or to other districts through contracts or other agreements  
27 including, but not limited to:

28 (i) Public health services;

29 (ii) Business, fiscal, and administrative services;

30 (iii) Acquisition of capital and equipment;

31 (iv) Communications; and

32 (v) Data collection.

33 NEW SECTION. **Sec. 8.** A new section is added to chapter 70.05  
34 RCW to read as follows:

35 (1) Each comprehensive health services district shall establish a  
36 district health fund in the custody of the county treasurer of the  
37 county in which the headquarters office of the comprehensive health  
38 services district is located. All receipts received by the district  
39 must be deposited into the fund. Expenditures by the district must be

1 authorized by the district board of health and must be disbursed  
2 through the fund. The county auditor of the county shall keep the  
3 record of the receipts and disbursements.

4 (2) The treasurer shall keep all funds and moneys of the district  
5 separate and apart from all other funds and moneys in the treasurer's  
6 custody.

7 NEW SECTION. **Sec. 9.** A new section is added to chapter 70.05  
8 RCW to read as follows:

9 A comprehensive health services district may own, construct,  
10 purchase, lease, add to, and maintain any real and personal property  
11 or property rights necessary to conduct the affairs of the district.  
12 A comprehensive health services district may sell, lease, convey, or  
13 otherwise dispose of any district real or personal property no longer  
14 necessary to conduct district affairs. A comprehensive health  
15 services district may enter into contracts to carry out this section.

16 NEW SECTION. **Sec. 10.** A new section is added to chapter 70.05  
17 RCW to read as follows:

18 Notwithstanding any provisions to the contrary contained in any  
19 city or county charter, and to the extent provided by the city and  
20 the county under appropriate legislative enactment, employees of the  
21 comprehensive health services district may be included in the  
22 personnel system or civil service and retirement plans of the city or  
23 the county or a personnel system for the comprehensive health  
24 services district that is separate from the personnel system or civil  
25 service of either county or city if residential requirements for  
26 these positions are coextensive with the county boundaries. The city  
27 or county may pay parts of the expense of operating and maintaining  
28 the personnel system or civil service and retirement system and  
29 contribute to the retirement fund on behalf of employees sums as may  
30 be agreed upon between the legislative authorities of the city and  
31 county.

32 NEW SECTION. **Sec. 11.** A new section is added to chapter 70.05  
33 RCW to read as follows:

34 The administrative officer, an employee of the comprehensive  
35 health services district, shall act as executive secretary and  
36 administrative officer for the comprehensive health services district  
37 and shall be responsible for administering the operations of the

1 district. The administrative officer's salary must be paid by the  
2 department.

3 NEW SECTION. **Sec. 12.** A new section is added to chapter 43.70  
4 RCW to read as follows:

5 The position of regional health officer is created within the  
6 department. The secretary shall appoint six regional health officers,  
7 who are each assigned to a comprehensive health services district.

8 **Sec. 13.** RCW 70.05.030 and 1995 c 43 s 6 are each amended to  
9 read as follows:

10 (1) In counties without a home rule charter, the board of county  
11 commissioners, a tribal appointee selected by the Indian health  
12 board, and members selected under subsection (2) of this section,  
13 shall constitute the local board of health, unless the county is part  
14 of a health district pursuant to chapter 70.46 RCW. The jurisdiction  
15 of the local board of health shall be coextensive with the boundaries  
16 of said county.

17 (2) (a) The remaining board members must be persons who are not  
18 elected officials and must be selected from the following categories:

19 (i) Public health, health care facilities, and providers. This  
20 category consists of persons practicing or employed in the county who  
21 are:

22 (A) Medical ethicists;

23 (B) Epidemiologists;

24 (C) Experienced in environmental public health, such as a  
25 registered sanitarian;

26 (D) Community health workers;

27 (E) Holders of master's degrees or higher in public health or the  
28 equivalent;

29 (F) Employees of a hospital located in the county;

30 (G) Physicians or osteopathic physicians;

31 (H) Advanced registered nurse practitioners;

32 (I) Physician assistants or osteopathic physician assistants;

33 (J) Registered nurses;

34 (K) Dentists;

35 (L) Naturopaths; or

36 (M) Pharmacists;

37 (ii) Consumers of public health. This category consists of county  
38 residents who have self-identified as having faced significant health

1 inequities or as having lived experiences with public health-related  
2 programs such as: The special supplemental nutrition program for  
3 women, infants, and children; the supplemental nutrition program;  
4 home visiting; or treatment services. It is strongly encouraged that  
5 individuals from historically marginalized and underrepresented  
6 communities are given preference. These individuals may not be  
7 elected officials and may not have any fiduciary obligation to a  
8 health facility or other health agency, and may not have a material  
9 financial interest in the rendering of health services; and

10 (iii) Other community stakeholders. This category consists of  
11 persons representing the following types of organizations located in  
12 the county:

13 (A) Community-based organizations or nonprofits that work with  
14 populations experiencing health inequities in the county;

15 (B) The business community; or

16 (C) The environmental public health regulated community.

17 (b) The board members selected under this subsection must be  
18 approved by a majority vote of the board of county commissioners.

19 (c) In the event of a vacancy of a board position that was  
20 occupied by a member who was selected under this subsection, the  
21 board must promptly notify:

22 (i) Statewide organizations representing physicians, nurses,  
23 public health officials, counties, and cities;

24 (ii) Accountable communities of health; and

25 (iii) Any other organizations deemed appropriate by the board.

26 (d) If the number of board members selected under this subsection  
27 is evenly divisible by three, there must be an equal number of  
28 members selected from each of the three categories.

29 (e) If the number of board members selected under this subsection  
30 is not evenly divisible by three, there must be an equal number of  
31 members selected from each of the three categories up to the nearest  
32 multiple of three. If there is one member over the nearest multiple  
33 of three, that member may be selected from any of the three  
34 categories. If there are two members over the nearest multiple of  
35 three, each member over the nearest multiple of three must be  
36 selected from a different category.

37 (3) The board of county commissioners may, at its discretion,  
38 adopt an ordinance expanding the size and composition of the board of  
39 health to include elected officials from cities and towns and persons  
40 other than elected officials as members so long as ((persons—other

1 ~~than~~) the city and county elected officials do not constitute a  
2 majority of the total membership of the board.

3 ~~((An))~~ (4) Except as provided in subsection (2) of this section,  
4 an ordinance adopted under this section shall include provisions for  
5 the appointment, term, and compensation, or reimbursement of  
6 expenses.

7 (5) The number of city and county elected officials on the board  
8 of health may not constitute a majority of the board.

9 (6) Any decision by the board of health related to the setting or  
10 modification of permit, licensing, and application fees may only be  
11 determined by the city and county elected officials on the board.

12 **Sec. 14.** RCW 70.05.035 and 1995 c 43 s 7 are each amended to  
13 read as follows:

14 (1) In counties with a home rule charter, the county legislative  
15 authority shall establish a local board of health and may prescribe  
16 the membership and selection process for the board, a tribal  
17 appointee selected by the Indian health board, and members selected  
18 under subsection (2) of this section.

19 (2)(a) The remaining board members must be persons who are not  
20 elected officials and must be selected from the following categories:

21 (i) Public health, health care facilities, and providers. This  
22 category consists of persons practicing or employed in the county who  
23 are:

24 (A) Medical ethicists;

25 (B) Epidemiologists;

26 (C) Experienced in environmental public health, such as a  
27 registered sanitarian;

28 (D) Community health workers;

29 (E) Holders of master's degrees or higher in public health or the  
30 equivalent;

31 (F) Employees of a hospital located in the county;

32 (G) Physicians or osteopathic physicians;

33 (H) Advanced registered nurse practitioners;

34 (I) Physician assistants or osteopathic physician assistants;

35 (J) Registered nurses;

36 (K) Dentists;

37 (L) Naturopaths; or

38 (M) Pharmacists;



1 (ii) Consumers of public health. This category consists of county  
2 residents who have self-identified as having faced significant health  
3 inequities or as having lived experiences with public health-related  
4 programs such as: The special supplemental nutrition program for  
5 women, infants, and children; the supplemental nutrition program;  
6 home visiting; or treatment services. It is strongly encouraged that  
7 individuals from historically marginalized and underrepresented  
8 communities are given preference. These individuals may not be  
9 elected officials and may not have any fiduciary obligation to a  
10 health facility or other health agency, and may not have a material  
11 financial interest in the rendering of health services; and

12 (iii) Other community stakeholders. This category consists of  
13 persons representing the following types of organizations located in  
14 the county:

15 (A) Community-based organizations or nonprofits that work with  
16 populations experiencing health inequities in the county;

17 (B) The business community; or

18 (C) The environmental public health regulated community.

19 (b) The board members selected under this subsection must be  
20 approved by a majority vote of the board of county commissioners.

21 (c) In the event of a vacancy of a board position that was  
22 occupied by a member who was selected under this subsection, the  
23 board must promptly notify:

24 (i) Statewide organizations representing physicians, nurses,  
25 public health officials, counties, and cities;

26 (ii) Accountable communities of health; and

27 (iii) Any other organizations deemed appropriate by the board.

28 (d) If the number of board members selected under this subsection  
29 is evenly divisible by three, there must be an equal number of  
30 members selected from each of the three categories.

31 (e) If the number of board members selected under this subsection  
32 is not evenly divisible by three, there must be an equal number of  
33 members selected from each of the three categories up to the nearest  
34 multiple of three. If there is one member over the nearest multiple  
35 of three, that member may be selected from any of the three  
36 categories. If there are two members over the nearest multiple of  
37 three, each member over the nearest multiple of three must be  
38 selected from a different category.

39 (3) The county legislative authority may appoint to the board of  
40 health elected officials from cities and towns and persons other than

1 elected officials as members so long as (~~persons other than~~) the  
2 city and county elected officials do not constitute a majority of the  
3 total membership of the board.

4 ((The)) (4) Except as provided in subsection (2) of this section,  
5 the county legislative authority shall specify the appointment, term,  
6 and compensation or reimbursement of expenses.

7 (5) The jurisdiction of the local board of health shall be  
8 coextensive with the boundaries of the county.

9 (6) The local health officer, as described in RCW 70.05.050,  
10 shall be appointed by the official designated under the provisions of  
11 the county charter. The same official designated under the provisions  
12 of the county charter may appoint an administrative officer, as  
13 described in RCW 70.05.045.

14 (7) The number of city and county elected officials on the board  
15 of health may not constitute a majority of the board.

16 (8) Any decision by the board of health related to the setting or  
17 modification of permit, licensing, and application fees may only be  
18 determined by the city and county elected officials on the board.

19 **Sec. 15.** RCW 70.46.020 and 1995 c 43 s 10 are each amended to  
20 read as follows:

21 (1) Health districts consisting of two or more counties may be  
22 created whenever two or more boards of county commissioners shall by  
23 resolution establish a district for such purpose. Such a district  
24 shall consist of all the area of the combined counties.

25 (2) The district board of health of such a district shall consist  
26 of not less than five members for districts of two counties and seven  
27 members for districts of more than two counties, including two  
28 representatives from each county who are members of the board of  
29 county commissioners and who are appointed by the board of county  
30 commissioners of each county within the district, a tribal appointee  
31 selected by the Indian health board, and members selected under  
32 subsection (3) of this section, and shall have a jurisdiction  
33 coextensive with the combined boundaries.

34 (3) (a) The remaining board members must be persons who are not  
35 elected officials and must be selected from the following categories:

36 (i) Public health, health care facilities, and providers. This  
37 category consists of persons practicing or employed in the county who  
38 are:

39 (A) Medical ethicists;

- 1       (B) Epidemiologists;  
2       (C) Experienced in environmental public health, such as a  
3 registered sanitarian;  
4       (D) Community health workers;  
5       (E) Holders of master's degrees or higher in public health or the  
6 equivalent;  
7       (F) Employees of a hospital located in the county;  
8       (G) Physicians or osteopathic physicians;  
9       (H) Advanced registered nurse practitioners;  
10       (I) Physician assistants or osteopathic physician assistants;  
11       (J) Registered nurses;  
12       (K) Dentists;  
13       (L) Naturopaths; or  
14       (M) Pharmacists;  
15       (ii) Consumers of public health. This category consists of county  
16 residents who have self-identified as having faced significant health  
17 inequities or as having lived experiences with public health-related  
18 programs such as: The special supplemental nutrition program for  
19 women, infants, and children; the supplemental nutrition program;  
20 home visiting; or treatment services. It is strongly encouraged that  
21 individuals from historically marginalized and underrepresented  
22 communities are given preference. These individuals may not be  
23 elected officials, and may not have any fiduciary obligation to a  
24 health facility or other health agency, and may not have a material  
25 financial interest in the rendering of health services; and  
26       (iii) Other community stakeholders. This category consists of  
27 persons representing the following types of organizations located in  
28 the county:  
29       (A) Community-based organizations or nonprofits that work with  
30 populations experiencing health inequities in the county;  
31       (B) The business community; or  
32       (C) The environmental public health regulated community.  
33       (b) The board members selected under this subsection must be  
34 approved by a majority vote of the board of county commissioners.  
35       (c) In the event of a vacancy of a board position that was  
36 occupied by a member who was selected under this subsection, the  
37 board must promptly notify:  
38       (i) Statewide organizations representing physicians, nurses,  
39 public health officials, counties, and cities;  
40       (ii) Accountable communities of health; and

1 (iii) Any other organizations deemed appropriate by the board.

2 (d) If the number of board members selected under this subsection  
3 is evenly divisible by three, there must be an equal number of  
4 members selected from each of the three categories.

5 (e) If the number of board members selected under this subsection  
6 is not evenly divisible by three, there must be an equal number of  
7 members selected from each of the three categories up to the nearest  
8 multiple of three. If there is one member over the nearest multiple  
9 of three, that member may be selected from any of the three  
10 categories. If there are two members over the nearest multiple of  
11 three, each member over the nearest multiple of three must be  
12 selected from a different category.

13 (4) The boards of county commissioners may by resolution or  
14 ordinance provide for elected officials from cities and towns and  
15 persons other than elected officials as members of the district board  
16 of health so long as ((persons other than)) the city and county  
17 elected officials do not constitute a majority of the total  
18 membership of the board.

19 ((A)) (5) Except as provided in subsection (3) of this section, a  
20 resolution or ordinance adopted under this section must specify the  
21 provisions for the appointment, term, and compensation, or  
22 reimbursement of expenses. ((Any multicounty health district existing  
23 on the effective date of this act shall continue in existence unless  
24 and until changed by affirmative action of all boards of county  
25 commissioners or one or more counties withdraws [withdraw] pursuant  
26 to RCW 70.46.090.))

27 (6) At the first meeting of a district board of health the  
28 members shall elect a chair to serve for a period of one year.

29 (7) The number of city and county elected officials on the board  
30 of health may not constitute a majority of the board.

31 (8) Any decision by the board of health related to the setting or  
32 modification of permit, licensing, and application fees may only be  
33 determined by the city and county elected officials on the board.

34 **Sec. 16.** RCW 70.46.031 and 1995 c 43 s 11 are each amended to  
35 read as follows:

36 (1) A health district to consist of one county may be created  
37 whenever the county legislative authority of the county shall pass a  
38 resolution or ordinance to organize such a health district under  
39 chapter 70.05 RCW and this chapter.

1        ~~(The)~~ Except as provided in subsection (3) of this section, the  
2 resolution or ordinance may specify the membership, representation on  
3 the district health board, or other matters relative to the formation  
4 or operation of the health district.

5        (2) (a) In addition to the membership of the district health board  
6 determined through resolution or ordinance under subsection (1) of  
7 this section, the board must also include a tribal appointee selected  
8 by the Indian health board, and members selected under (b) of this  
9 subsection.

10        (b) The remaining board members must be persons who are not  
11 elected officials and must be selected from the following categories:

12        (i) Public health, health care facilities, and providers. This  
13 category consists of persons practicing or employed in the county who  
14 are:

15        (A) Medical ethicists;

16        (B) Epidemiologists;

17        (C) Experienced in environmental public health, such as a  
18 registered sanitarian;

19        (D) Community health workers;

20        (E) Holders of master's degrees or higher in public health or the  
21 equivalent;

22        (F) Employees of a hospital located in the county;

23        (G) Physicians or osteopathic physicians;

24        (H) Advanced registered nurse practitioners;

25        (I) Physician assistants or osteopathic physician assistants;

26        (J) Registered nurses;

27        (K) Dentists;

28        (L) Naturopaths; or

29        (M) Pharmacists;

30        (ii) Consumers of public health. This category consists of county  
31 residents who have self-identified as having faced significant health  
32 inequities or as having lived experiences with public health-related  
33 programs such as: The special supplemental nutrition program for  
34 women, infants, and children; the supplemental nutrition program;  
35 home visiting; or treatment services. It is strongly encouraged that  
36 individuals from historically marginalized and underrepresented  
37 communities are given preference. These individuals may not be  
38 elected officials and may not have any fiduciary obligation to a  
39 health facility or other health agency, and may not have a material  
40 financial interest in the rendering of health services; and

1 (iii) Other community stakeholders. This category consists of  
2 persons representing the following types of organizations located in  
3 the county:

4 (A) Community-based organizations or nonprofits that work with  
5 populations experiencing health inequities in the county;

6 (B) The business community; or

7 (C) The environmental public health regulated community.

8 (c) The board members selected under this subsection must be  
9 approved by a majority vote of the board of county commissioners.

10 (d) In the event of a vacancy of a board position that was  
11 occupied by a member who was selected under this subsection, the  
12 board must promptly notify:

13 (i) Statewide organizations representing physicians, nurses,  
14 public health officials, counties, and cities;

15 (ii) Accountable communities of health; and

16 (iii) Any other organizations deemed appropriate by the board.

17 (e) If the number of board members selected under this subsection  
18 is evenly divisible by three, there must be an equal number of  
19 members selected from each of the three categories.

20 (f) If the number of board members selected under this subsection  
21 is not evenly divisible by three, there must be an equal number of  
22 members selected from each of the three categories up to the nearest  
23 multiple of three. If there is one member over the nearest multiple  
24 of three, that member may be selected from any of the three  
25 categories. If there are two members over the nearest multiple of  
26 three, each member over the nearest multiple of three must be  
27 selected from a different category.

28 (3) The county legislative authority may appoint elected  
29 officials from cities and towns and persons other than elected  
30 officials as members of the health district board so long as  
31 ((persons other than)) the city and county elected officials do not  
32 constitute a majority of the total membership of the board.

33 (4) The number of city and county elected officials on the board  
34 of health may not constitute a majority of the board.

35 (5) Any decision by the board of health related to the setting or  
36 modification of permit, licensing, and application fees may only be  
37 determined by the city and county elected officials on the board.

38 ((Any single county health district existing on the effective  
39 date of this act shall continue in existence unless and until changed  
40 by affirmative action of the county legislative authority.))

1       **Sec. 17.** RCW 70.05.130 and 1993 c 492 s 242 are each amended to  
2 read as follows:

3       All expenses incurred by the state, health district, or county in  
4 carrying out the provisions of (~~chapters 70.05 and~~) this chapter  
5 and chapter 70.46 RCW or any other public health law, (~~or~~) the  
6 rules of the department of health enacted under such laws, or  
7 enforcing proclamations of the governor during a public health  
8 emergency, shall be paid by the (~~county~~) comprehensive health  
9 services district the county is located in and such expenses shall  
10 constitute a claim against the general fund as provided in this  
11 section.

12       NEW SECTION.   **Sec. 18.** A new section is added to chapter 43.20  
13 RCW to read as follows:

14       (1) A county may not make a material change to its public health  
15 governance structure unless:

16       (a) The county notifies the state board of its intention to make  
17 the material change. The notification must, at a minimum, include:

18       (i) A description of the current governance structure, including  
19 the relationships between its component parts;

20       (ii) Whether the current governance structure is meeting the  
21 county's governance, legal requirements, and objectives;

22       (iii) The county's rationale for the planned material change,  
23 including:

24       (A) Opportunities for new collaborations or funding; and

25       (B) Effects on health and equity;

26       (iv) The impact the planned material change will have on current  
27 public health programs, staffing, or funding; and

28       (v) The populations most likely to be affected by the planned  
29 material change, including:

30       (A) How the change would change staffing and capacity;

31       (B) How the change in staffing capacity will affect services to  
32 the community; and

33       (C) The communities that will be most directly affected;

34       (b) The state board has found that the planned material change  
35 would not have an adverse effect on health disparities, social  
36 determinants of health, or the provision of public health services in  
37 the county. For a combined city-county health department established  
38 under chapter 70.08 RCW, the state board has also found that the  
39 planned material change would not have an adverse effect on health

1 disparities, social determinants of health, or the provision of  
2 public health services in the partner city; and

3 (c) Based on the findings in (b) of this subsection, the state  
4 board has approved the material change.

5 (2) Prior to making a material change to a county's public health  
6 governance structure, the county legislative authority shall:

7 (a) Provide notice and a meaningful opportunity for the public to  
8 comment on the material change including, but not limited to, at  
9 least two public meetings held at different locations within the  
10 county. For a combined city-county health department established  
11 under chapter 70.08 RCW, the county and city must jointly conduct a  
12 third public meeting within the boundaries of the partner city;

13 (b) Participate in good faith in a mediation process with any  
14 affected county, city, or town that objects to the material change.  
15 The mediator must be appointed by the state board and be paid for by  
16 the county seeking the material change; and

17 (c) Approve the material change by a majority vote of the county  
18 legislative authority taken in an open public meeting. Upon approval  
19 of the material change under subsection (1)(c) of this section, the  
20 county legislative authority shall immediately transmit notice of the  
21 approval to the state board.

22 (3) The material change may not go into effect less than 12  
23 months after the vote of the county legislative authority under  
24 subsection (1) of this section. The county may not reduce the amount  
25 of funding it appropriates for public health purposes for at least 36  
26 months after the vote of the county legislative authority under  
27 subsection (1) of this section.

28 (4) For purposes of this section, a material change to a county's  
29 public health governance structure includes, but is not limited to:

30 (a) Joining or withdrawing from a local health district under  
31 chapter 70.46 RCW;

32 (b) Entering or terminating an agreement for a combined city-  
33 county health department under chapter 70.08 RCW; or

34 (c) Amending the county charter or enacting an ordinance altering  
35 the composition of the local board of health.

36 (5) This section expires January 1, 2024.

37 NEW SECTION. **Sec. 19.** A new section is added to chapter 43.20  
38 RCW to read as follows:



1 (1) The state board shall monitor the implementation of any  
2 material change to a county's public health governance structure to  
3 ensure the county's compliance with section 18 of this act.

4 (2) If the state board determines that the county has not  
5 complied with section 18 of this act, it shall issue a preliminary  
6 notice of violation to the county.

7 (3) Upon receipt of a preliminary notice of violation, the county  
8 must immediately cease all activities related to the material change  
9 and cure the violation within 30 calendar days.

10 (4) If the county fails to cure the violation within 30 calendar  
11 days, the state board shall issue a final notice of violation to the  
12 county and send a copy of the final notice to the state treasurer.

13 (5) This section expires January 1, 2024.

14 **Sec. 20.** RCW 70.08.100 and 1949 c 46 s 10 are each amended to  
15 read as follows:

16 Agreement to operate a combined city and county health department  
17 made under this chapter may after two years from the date of such  
18 agreement, be terminated by either party at the end of any calendar  
19 year upon notice in writing given at least (~~six~~) 12 months prior  
20 thereto. The termination of such agreement shall not relieve either  
21 party of any obligations to which it has been previously committed.  
22 Termination of the agreement is subject to the requirements of  
23 section 18 of this act.

24 **Sec. 21.** RCW 70.46.090 and 1993 c 492 s 251 are each amended to  
25 read as follows:

26 Any county may withdraw from membership in said health district  
27 any time after it has been within the district for a period of two  
28 years, but no withdrawal shall be effective except at the end of the  
29 calendar year in which the county gives at least (~~six~~) 12 months'  
30 notice of its intention to withdraw at the end of the calendar year.  
31 No withdrawal shall entitle any member to a refund of any moneys paid  
32 to the district nor relieve it of any obligations to pay to the  
33 district all sums for which it obligated itself due and owing by it  
34 to the district for the year at the end of which the withdrawal is to  
35 be effective. Any county which withdraws from membership in said  
36 health district shall immediately establish a health department or  
37 provide health services which shall meet the standards for health  
38 services promulgated by the state board of health. No local health

1 department may be deemed to provide adequate public health services  
2 unless there is at least one full time professionally trained and  
3 qualified physician as set forth in RCW 70.05.050. Withdrawal from a  
4 health district is subject to the requirements of section 18 of this  
5 act.

6 **Sec. 22.** RCW 69.50.540 and 2020 c 357 s 916 and 2020 c 236 s 4  
7 are each reenacted and amended to read as follows:

8 The legislature must annually appropriate moneys in the dedicated  
9 marijuana account created in RCW 69.50.530 as follows:

10 (1) For the purposes listed in this subsection (1), the  
11 legislature must appropriate to the respective agencies amounts  
12 sufficient to make the following expenditures on a quarterly basis or  
13 as provided in this subsection:

14 (a) (~~One hundred twenty-five thousand dollars~~) \$125,000 to the  
15 health care authority to design and administer the Washington state  
16 healthy youth survey, analyze the collected data, and produce  
17 reports, in collaboration with the office of the superintendent of  
18 public instruction, department of health, department of commerce,  
19 family policy council, and board. The survey must be conducted at  
20 least every two years and include questions regarding, but not  
21 necessarily limited to, academic achievement, age at time of  
22 substance use initiation, antisocial behavior of friends, attitudes  
23 toward antisocial behavior, attitudes toward substance use, laws and  
24 community norms regarding antisocial behavior, family conflict,  
25 family management, parental attitudes toward substance use, peer  
26 rewarding of antisocial behavior, perceived risk of substance use,  
27 and rebelliousness. Funds disbursed under this subsection may be used  
28 to expand administration of the healthy youth survey to student  
29 populations attending institutions of higher education in Washington;

30 (b) (~~Fifty thousand dollars~~) \$50,000 to the health care  
31 authority for the purpose of contracting with the Washington state  
32 institute for public policy to conduct the cost-benefit evaluation  
33 and produce the reports described in RCW 69.50.550. This  
34 appropriation ends after production of the final report required by  
35 RCW 69.50.550;

36 (c) (~~Five thousand dollars~~) \$5,000 to the University of  
37 Washington alcohol and drug abuse institute for the creation,  
38 maintenance, and timely updating of web-based public education

1 materials providing medically and scientifically accurate information  
2 about the health and safety risks posed by marijuana use;

3 (d) (i) An amount not less than (~~one million two hundred fifty~~  
4 ~~thousand dollars~~) \$1,250,000 to the board for administration of this  
5 chapter as appropriated in the omnibus appropriations act;

6 (ii) (~~One million three hundred twenty-three thousand dollars~~)  
7 \$1,323,000 for fiscal year 2020 to the health professions account  
8 established under RCW 43.70.320 for the development and  
9 administration of the marijuana authorization database by the  
10 department of health;

11 (iii) (~~Two million four hundred fifty-three thousand dollars~~)  
12 \$2,453,000 for fiscal year 2020 and (~~two million seven hundred~~  
13 ~~ninety-three thousand dollars~~) \$2,793,000 for fiscal year 2021 to  
14 the Washington state patrol for a drug enforcement task force. It is  
15 the intent of the legislature that this policy will be continued in  
16 the 2021-2023 fiscal biennium; and

17 (iv) (~~Ninety-eight thousand dollars~~) \$98,000 for fiscal year  
18 2019 to the department of ecology for research on accreditation of  
19 marijuana product testing laboratories;

20 (e) (~~Four hundred sixty-five thousand dollars~~) \$465,000 for  
21 fiscal year 2020 and (~~four hundred sixty-four thousand dollars~~)  
22 \$464,000 for fiscal year 2021 to the department of ecology for  
23 implementation of accreditation of marijuana product testing  
24 laboratories;

25 (f) (~~One hundred eighty-nine thousand dollars~~) \$189,000 for  
26 fiscal year 2020 to the department of health for rule making  
27 regarding compassionate care renewals;

28 (g) (~~Eight hundred eight thousand dollars~~) \$808,000 for fiscal  
29 year 2020 and (~~eight hundred eight thousand dollars~~) \$808,000 for  
30 fiscal year 2021 to the department of health for the administration  
31 of the marijuana authorization database;

32 (h) (~~Six hundred thirty-five thousand dollars~~) \$635,000 for  
33 fiscal year 2020 and (~~six hundred thirty-five thousand dollars~~)  
34 \$635,000 for fiscal year 2021 to the department of agriculture for  
35 compliance-based laboratory analysis of pesticides in marijuana;

36 (i) (~~One million one hundred thousand dollars~~) \$1,100,000  
37 annually to the department of commerce to fund the marijuana social  
38 equity technical assistance competitive grant program under RCW  
39 43.330.540; and

1 (j) (~~One million one hundred thousand dollars~~) \$1,100,000 for  
2 fiscal year 2021 to the department of commerce to fund the marijuana  
3 social equity technical assistance competitive grant program under  
4 Engrossed Second Substitute House Bill No. 2870 (marijuana retail  
5 licenses); and

6 (2) From the amounts in the dedicated marijuana account after  
7 appropriation of the amounts identified in subsection (1) of this  
8 section, the legislature must appropriate for the purposes listed in  
9 this subsection (2) as follows:

10 (a)(i) Up to (~~fifteen~~) 15 percent to the health care authority  
11 for the development, implementation, maintenance, and evaluation of  
12 programs and practices aimed at the prevention or reduction of  
13 maladaptive substance use, substance use disorder, substance abuse or  
14 substance dependence, as these terms are defined in the Diagnostic  
15 and Statistical Manual of Mental Disorders, among middle school and  
16 high school-age students, whether as an explicit goal of a given  
17 program or practice or as a consistently corresponding effect of its  
18 implementation, mental health services for children and youth, and  
19 services for pregnant and parenting women; PROVIDED, That:

20 (A) Of the funds appropriated under (a)(i) of this subsection for  
21 new programs and new services, at least (~~eighty-five~~) 85 percent  
22 must be directed to evidence-based or research-based programs and  
23 practices that produce objectively measurable results and, by  
24 September 1, 2020, are cost-beneficial; and

25 (B) Up to (~~fifteen~~) 15 percent of the funds appropriated under  
26 (a)(i) of this subsection for new programs and new services may be  
27 directed to proven and tested practices, emerging best practices, or  
28 promising practices.

29 (ii) In deciding which programs and practices to fund, the  
30 director of the health care authority must consult, at least  
31 annually, with the University of Washington's social development  
32 research group and the University of Washington's alcohol and drug  
33 abuse institute.

34 (iii) For each fiscal year, the legislature must appropriate a  
35 minimum of (~~twenty-five million five hundred thirty-six thousand~~  
36 ~~dollars~~) \$25,536,000 under this subsection (2)(a);

37 (b)(i) Up to (~~ten~~) 10 percent to the department of health for  
38 the following, subject to (b)(ii) of this subsection (2):

1 (A) Creation, implementation, operation, and management of a  
2 marijuana education and public health program that contains the  
3 following:

4 (I) A marijuana use public health hotline that provides referrals  
5 to substance abuse treatment providers, utilizes evidence-based or  
6 research-based public health approaches to minimizing the harms  
7 associated with marijuana use, and does not solely advocate an  
8 abstinence-only approach;

9 (II) A grants program for local health departments or other local  
10 community agencies that supports development and implementation of  
11 coordinated intervention strategies for the prevention and reduction  
12 of marijuana use by youth; and

13 (III) Media-based education campaigns across television,  
14 internet, radio, print, and out-of-home advertising, separately  
15 targeting youth and adults, that provide medically and scientifically  
16 accurate information about the health and safety risks posed by  
17 marijuana use; and

18 (B) The Washington poison control center.

19 (ii) For each fiscal year, the legislature must appropriate a  
20 minimum of (~~nine million seven hundred fifty thousand dollars~~)  
21 \$9,750,000 under this subsection (2) (b);

22 (c) (i) Up to six-tenths of one percent to the University of  
23 Washington and four-tenths of one percent to Washington State  
24 University for research on the short and long-term effects of  
25 marijuana use, to include but not be limited to formal and informal  
26 methods for estimating and measuring intoxication and impairment, and  
27 for the dissemination of such research.

28 (ii) For each fiscal year, except for the 2017-2019 and 2019-2021  
29 fiscal biennia, the legislature must appropriate a minimum of (~~one  
30 million twenty-one thousand dollars~~) \$1,021,000 to the University of  
31 Washington. For each fiscal year, except for the 2017-2019 and  
32 2019-2021 fiscal biennia, the legislature must appropriate a minimum  
33 of (~~six hundred eighty-one thousand dollars~~) \$681,000 to Washington  
34 State University under this subsection (2) (c). It is the intent of  
35 the legislature that this policy will be continued in the 2019-2021  
36 fiscal biennium;

37 (d) Fifty percent to the state basic health plan trust account to  
38 be administered by the Washington basic health plan administrator and  
39 used as provided under chapter 70.47 RCW;

1 (e) Five percent to the Washington state health care authority to  
2 be expended exclusively through contracts with community health  
3 centers to provide primary health and dental care services, migrant  
4 health services, and maternity health care services as provided under  
5 RCW 41.05.220;

6 (f) (i) Up to three-tenths of one percent to the office of the  
7 superintendent of public instruction to fund grants to building  
8 bridges programs under chapter 28A.175 RCW.

9 (ii) For each fiscal year, the legislature must appropriate a  
10 minimum of (~~five hundred eleven thousand dollars~~) \$511,000 to the  
11 office of the superintendent of public instruction under this  
12 subsection (2) (f); and

13 (g) At the end of each fiscal year, the treasurer must transfer  
14 any amounts in the dedicated marijuana account that are not  
15 appropriated pursuant to subsection (1) of this section and this  
16 subsection (2) into the general fund, except as provided in (g) (i) of  
17 this subsection (2).

18 (i) (~~Beginning~~) Except as provided in (g) (iv) of this  
19 subsection (2), beginning in fiscal year 2018, if marijuana excise  
20 tax collections deposited into the general fund in the prior fiscal  
21 year exceed (~~twenty-five million dollars~~) \$25,000,000, then each  
22 fiscal year the legislature must appropriate an amount equal to  
23 (~~thirty~~) 30 percent of all marijuana excise taxes deposited into  
24 the general fund the prior fiscal year to the treasurer for  
25 distribution to counties, cities, and towns as follows:

26 (A) Thirty percent must be distributed to counties, cities, and  
27 towns where licensed marijuana retailers are physically located. Each  
28 jurisdiction must receive a share of the revenue distribution under  
29 this subsection (2) (g) (i) (A) based on the proportional share of the  
30 total revenues generated in the individual jurisdiction from the  
31 taxes collected under RCW 69.50.535, from licensed marijuana  
32 retailers physically located in each jurisdiction. For purposes of  
33 this subsection (2) (g) (i) (A), (~~one hundred~~) 100 percent of the  
34 proportional amount attributed to a retailer physically located in a  
35 city or town must be distributed to the city or town.

36 (B) Seventy percent must be distributed to counties, cities, and  
37 towns ratably on a per capita basis. Counties must receive (~~sixty~~)  
38 60 percent of the distribution, which must be disbursed based on each  
39 county's total proportional population. Funds may only be distributed

1 to jurisdictions that do not prohibit the siting of any state  
2 licensed marijuana producer, processor, or retailer.

3 (ii) Distribution amounts allocated to each county, city, and  
4 town must be distributed in four installments by the last day of each  
5 fiscal quarter.

6 (iii) By September 15th of each year, the board must provide the  
7 state treasurer the annual distribution amount, if any, for each  
8 county and city as determined in (g)(i) of this subsection (2).

9 (iv) The total share of marijuana excise tax revenues distributed  
10 to counties and cities in (g)(i) of this subsection (2) may not  
11 exceed (~~(fifteen million dollars)~~) \$15,000,000 in fiscal years 2018,  
12 2019, 2020, and 2021, and (~~(twenty million dollars)~~) \$20,000,000 per  
13 fiscal year thereafter. It is the intent of the legislature that the  
14 policy for the maximum distributions in the subsequent fiscal biennia  
15 will be no more than (~~(fifteen million dollars)~~) \$15,000,000 per  
16 fiscal year.

17 (v) Upon receipt of a final notice from the state board of health  
18 under section 19(4) of this act that a county has failed to comply  
19 with section 18 of this act, the treasurer shall cease all future  
20 distributions to the county under this subsection (2).

21 **Sec. 23.** RCW 82.08.170 and 2020 c 357 s 919 are each amended to  
22 read as follows:

23 (1) Except as provided in subsections (4) (~~(and (5))~~) through (6)  
24 of this section, during the months of January, April, July, and  
25 October of each year, the state treasurer must make the transfers  
26 required under subsections (2) and (3) of this section from the  
27 liquor excise tax fund and then the apportionment and distribution of  
28 all remaining moneys in the liquor excise tax fund to the counties,  
29 cities, and towns in the following proportions: (a) (~~(Twenty)~~) 20  
30 percent of the moneys in the liquor excise tax fund must be divided  
31 among and distributed to the counties of the state in accordance with  
32 the provisions of RCW 66.08.200; and (b) (~~(eighty)~~) 80 percent of the  
33 moneys in the liquor excise tax fund must be divided among and  
34 distributed to the cities and towns of the state in accordance with  
35 the provisions of RCW 66.08.210.

36 (2) Each fiscal quarter and prior to making the (~~(twenty)~~) 20  
37 percent distribution to counties under subsection (1)(a) of this  
38 section, the treasurer shall transfer to the liquor revolving fund  
39 created in RCW 66.08.170 sufficient moneys to fund the allotments

1 from any legislative appropriations for county research and services  
2 as provided under chapter 43.110 RCW.

3 (3) During the months of January, April, July, and October of  
4 each year, the state treasurer must transfer (~~two million five~~  
5 ~~hundred thousand dollars~~) \$2,500,000 from the liquor excise tax fund  
6 to the state general fund.

7 (4) During calendar year 2012, the October distribution under  
8 subsection (1) of this section and the July and October transfers  
9 under subsections (2) and (3) of this section must not be made.  
10 During calendar year 2013, the January, April, and July distributions  
11 under subsection (1) of this section and transfers under subsections  
12 (2) and (3) of this section must not be made.

13 (5) During the 2015-2017 and 2019-2021 fiscal biennia, the liquor  
14 excise tax fund may be appropriated for the local government fiscal  
15 note program in the department of commerce. It is the intent of the  
16 legislature to continue this policy in the subsequent fiscal  
17 biennium.

18 (6) Upon receipt of a final notice from the state board of health  
19 under section 19(4) of this act that a county has failed to comply  
20 with section 18 of this act, the treasurer shall cease all future  
21 distributions to the county under this section.

22 NEW SECTION. **Sec. 24.** The following acts or parts of acts are  
23 each repealed:

24 (1) RCW 43.70.060 (Duties of department—Promotion of health care  
25 cost-effectiveness) and 1989 1st ex.s. c 9 s 108;

26 (2) RCW 43.70.064 (Health care quality—Findings and intent—  
27 Requirements for conducting study under RCW 43.70.066) and 1995 c 267  
28 s 3;

29 (3) RCW 43.70.066 (Study—Uniform quality assurance and  
30 improvement program—Reports to legislature—Limitation on rule  
31 making) and 1998 c 245 s 72, 1997 c 274 s 3, & 1995 c 267 s 4;

32 (4) RCW 43.70.068 (Quality assurance—Interagency cooperation) and  
33 1997 c 274 s 4 & 1995 c 267 s 5; and

34 (5) RCW 43.70.070 (Duties of department—Analysis of health  
35 services) and 1995 c 269 s 2202 & 1989 1st ex.s. c 9 s 109.

36 NEW SECTION. **Sec. 25.** (1) Sections 4 and 17 of this act take  
37 effect January 1, 2024.



1           (2) Sections 13 through 16 of this act take effect July 1, 2022.

2           NEW SECTION.   **Sec. 26.**   Sections 20 through 23 of this act expire  
3   January 1, 2024.

--- **END** ---