RULES AND REGULATIONS

Title 25—ENVIRONMENTAL PROTECTION

ENVIRONMENTAL QUALITY BOARD

[25 PA. CODE CH. 86]

Unsuitable for Surface Mining; Muddy Run

The Environmental Quality Board (Board) amends § 86.130 (relating to areas designated as unsuitable for mining) to read as set forth in Annex A. The final-form rulemaking designates the surface mineable reserves of the Lower Kittanning, Clarion, Brookville and Mercer coals within the headwaters of the Muddy Run watershed, Reade Township, Cambria County as unsuitable for surface mining operations.

This order was adopted by the Board at its meeting of May 18, 2011.

A. *Effective Date*

The final-form rulemaking will be effective upon publication in the *Pennsylvania Bulletin*.

B. *Contact Persons*

For further information, contact Geoffrey Lincoln, Bureau of Mining and Reclamation, P. O. Box 8461, Rachel Carson State Office Building, Harrisburg, PA 17105-8461, (717) 787-5103; or Richard Morrison, Assistant Counsel, Bureau of Regulatory Counsel, P. O. Box 8464, Rachel Carson State Office Building, Harrisburg, PA 17105-8464, (717) 787-7060. Information regarding submitting comments on this final-form rulemaking appears in Section J of this preamble. Persons with a disability may use the AT&T Relay Service, (800) 654-5984 (TDD users) or (800) 654-5988 (voice users). This final-form rulemaking is available electronically through the Department of Environmental Protection's (Department) web site at http://www.dep.state.pa.us.

C. *Statutory Authority*

The final-form rulemaking is adopted under the authority of section 4.5 of the Surface Mining Conservation and Reclamation Act (act) (52 P. S. § 1396.4e); section 6.1 of the Coal Refuse Disposal Control Act (52 P. S. § 30.56a); and section 315(h)—(o) of The Clean Streams Law (35 P. S. § 691.315 (h)—(o)).

D. *Background and Summary*

Section 522 of the Surface Mining Control and Reclamation Act of 1977 (30 U.S.C.A. § 1272) requires each state seeking primary regulatory authority (primacy) over coal mining operations to establish a procedure for the designation of areas as unsuitable for mining. The State statutory authority for this procedure, referenced in Section C, was created in the 1980 amendments to the authorizing acts as part of the Commonwealth's effort to obtain primacy. On November 19, 1980, the Board adopted Chapters 86—90. Chapter 86, Subchapter D (relating to areas unsuitable for mining) contains the Department's regulations for procedures and criteria for the designation of areas as unsuitable for surface mining. Section 86.130 also contains a description of each area designated as unsuitable for mining (UFM) by the Board.

The Department is required to designate areas as unsuitable for surface mining when it determines that reclamation under the act is not technologically or economically feasible. In addition, the Department may designate an area as unsuitable for all or certain types of surface coal mining operations if the operations will: 1) be incompatible with existing State or local land use plans or programs; 2) affect fragile or historic lands where the operations would result in significant damage to important historical, cultural, scientific and aesthetic values and natural systems; 3) cause a substantial loss or reduction in long-range productivity of food or fiber products or water supply, including aquifers and aquifer recharge areas; or 4) substantially endanger life and property in natural hazard areas, including areas subject to frequent flooding and areas of unstable geology.

On March 21, 1996, under § 86.122 (relating to criteria for designating lands as unsuitable), the Reade Township Municipal Authority (RTMA) submitted a petition to the Department requesting that approximately 3,200 acres of the Muddy Run watershed be designated as "unsuitable for mining." The RTMA's stated purpose was the protection of their public water supply wells from potential adverse mining-related impacts. The RTMA's petition alleged that surface mining activities could destroy or seriously degrade the source aquifers tapped by Reade Township's public water supply wells and could adversely impact other local surface and groundwater resources. The RTMA provided supporting evidence documenting mining-related impacts to a private water well within the Muddy Run watershed and provided an outline of deleterious mining-induced impacts to Muddy Run and to adjacent watersheds.

The Department determined the petition to be complete and acceptable for technical study in April 1997. The petitioner was notified accordingly on May 1, 1997.

Technical study fieldwork, including water sampling and site reconnaissance, began in 1997. The technical study process was suspended in early 1999 and was reactivated in December 2003. This suspension occurred while the Department awaited the court's decision on a challenge to a previous UFM designation as an unconstitutional taking. The Pennsylvania Supreme Court decided, in *Machipongo Land and Coal Company, Inc. v. Dep't of Environmental Resources*, 569 Pa. 3 (2002), that a UFM designation was not an unconstitutional taking. The Muddy Run study was completed in October 2004. Copies of the two-volume technical study, entitled "A Petition to Designate Areas Unsuitable for Mining: Muddy Run Watershed," as well as the Comment and Response Document prepared to address public input are available from Geoffrey Lincoln. See section B of this preamble for contact information. The key findings of the technical study are as follows:

- The recharge area for the RTMA wells appears to be primarily from the area east of the well field along the upper flank of the Allegheny Mountain, where the source aquifers are at, or near, the surface. Additional recharge to these aquifers is from downward infiltration from closely overlying coal-bearing units. The downward infiltration of water is enhanced by numerous fractures and two regional faults in the area.

• Based on available information, including regional geochemical tracer studies confirming acidic mine water traveling significant horizontal and vertical distances in the subsurface, there is a potential for mining-related pollution of the RTMA wells. Groundwater tests conducted to date are not sufficient to characterize conditions beyond the immediate vicinity of the RTMA wells or to assess the impact of highly transmissive fractures. The potential exists for hydrologic exchange between the RTMA water supply aquifer and the potentially acidic overlying coal-bearing units. The only way to conclusively determine the existence of a hydrologic connection to the well is to conduct extensive draw down pump testing. However, these tests create an unacceptable risk because establishing the connection would destroy the public water supply wells.

• Overburden analysis results indicate the presence of high sulfur zones, with little or no alkaline strata, associated with the Lower Kittanning, Clarion, Brookville and Mercer coals. There is a very significant potential for production of acid mine water from surface mining of these coals.

• Coal mining has significantly impacted the water quality and aquatic community of Muddy Run. As a result of coal mining activities, all stream sections of Muddy Run and its tributaries within the study area, except for the headwaters in the eastern portion of the study area (the unmined RTMA wells' recharge area), are acidic with low pH and have high concentrations of aluminum, iron and manganese.

• Surface mining activities have significantly degraded groundwater resources within the technical study area, including numerous domestic and private water supplies.

The purpose to the final-form rulemaking is to protect the quality of surface water and groundwater in the Muddy Run watershed, including source aquifers for the RTMA wells. A secondary purpose is to help coal mine operators plan future mining activities by alerting potential mine permit applicants to the adverse hydrologic impacts associated with mining certain coal seams adjacent to the designated area.

E. *Summary of Comments and Responses*

The only comment the Board received during the 30-day public comment period for the proposed rulemaking was from the Pennsylvania State Association of Township Supervisors (PSATS). In their comments, PSATS stated their support of the rulemaking and noted that without the rulemaking, there most likely would be a detrimental effect on those municipalities within the watershed that rely on ground water for human consumption. In their comments, PSATS also acknowledged the responsibility of the RTMA to remedy any water contamination that may occur by potential mining activities, which, in their estimation, would result in substantial costs to the customers of the system. The Board appreciates the commentator's support of the rulemaking and notes that the Department has addressed the potential impacts of mining activities in the area in an UFM technical study, which is available from the Department upon request.

The Independent Regulatory Review Commission (IRRC) issued no objections, comments or recommendations on the rulemaking and noted that the rulemaking would be deemed approved if the regulation is not amended and is retained in its proposed form. The Board has not made changes to the rulemaking based upon public comments.

F. *Benefits, Costs and Compliance*

Benefits

The final-form rulemaking would benefit the RTMA's customers by restricting mining on coal seams with high acid mine drainage potential in areas in close proximity to the RTMA water supply aquifers. Mining in close proximity could pollute the public water supply wells. The RTMA presently provides potable water to approximately 550 service accounts and provides water for local fire protection to Reade Township, including the towns of Blandburg, Hollentown, Fallentimber, Flinton and Van Ormer. The RTMA wells were drilled in 1993 and 1994 using part of a nearly $5 million grant provided by the Rural Economic Development Agency. The location and construction of the RTMA water supply wells was the result of several years of effort. Two previous attempts to develop water supply wells were not successful because of insufficient quantity or quality of local groundwater resources, in part due to aquifer degradation from previous surface coal mining. Based on available information, alternative well sites would be limited or nonexistent should the existing wells become contaminated.

The designation process also serves to aid coal operators in planning future mining activities. The UFM areas are explicitly delineated by regulation. This allows operators to avoid the cost of evaluating properties within designated areas and to avoid the subsequent costs of preparing permit applications for mine sites on similar coal seams adjacent to the designated area that are highly unlikely to be approved for surface mining activities.

The designation restricts mining by seam, and by type, within the boundaries of the technical study area. Therefore, the designation will benefit the surface water and groundwater quality of the Muddy Run watershed by eliminating or limiting the mining-related disturbance of high-sulfur acid mine drainage producing rock formations that have minimal or no neutralizing potential.

Compliance Costs

The regulation does not impose costs on the regulated community. The regulation benefits the regulated community by helping coal operators plan future mining activities. The UFM areas are explicitly delineated by regulation. This allows operators to avoid the cost of evaluating properties within designated areas and to avoid the subsequent costs of preparing permit applications for mine sites on similar coal seams adjacent to the designated area that are highly unlikely to be approved for surface mining activities.

Compliance Assistance Plan

The Department will provide written notification of the changes to the coal mining industry.

Paperwork Requirements

The only paperwork requirements imposed by the regulation are those necessary to make operators and Department personnel aware of the location of the designated area. Copies of the regulation containing a description of the area and a map of the location of the area will be held on file at the appropriate Department offices.

G. *Pollution Prevention*

The Pollution Prevention Act of 1990 (42 U.S.C.A. §§ 13101—13109) established a National policy that promotes pollution prevention as the preferred means for achieving state environmental protection goals. The Department encourages pollution prevention, which is the reduction or elimination of pollution at its source, through the substitution of environmentally-friendly materials, more efficient use of raw materials and the incorporation of energy efficiency strategies. Pollution prevention practices can provide greater environmental protection with greater efficiency because they can result in significant cost savings to facilities that permanently achieve or move beyond compliance. This regulation has incorporated the following pollution prevention incentives.

The designation of the headwaters of Muddy Run as UFM prevents pollution by prohibiting further coal mining in the area. The intent of the designation is to protect the public water supply wells of the RTMA.

H. *Sunset Review*

This regulation will be reviewed in accordance with the sunset review schedule published by the Department to determine whether the regulation effectively fulfills the goals for which it was intended.

I. *Regulatory Review*

Under section 5(a) of the Regulatory Review Act, on April 27, 2010, the Department submitted a copy of the notice of proposed rulemaking, published at 40 Pa.B. 2425 (May 8, 2010), to IRRC and the Chairpersons of the Senate and House Environmental Resources and Energy Committees for review and comment.

Under section 5(c) of the Regulatory Review Act, IRRC and the House and Senate Committees were provided with copies of the comments received during the public comment period, as well as other documents when requested. In preparing the final-form rulemaking, the Department has considered all comments from IRRC, the House and Senate Committees and the public.

Under section 5.1(j.2) of the Regulatory Review Act (71 P. S. § 745.5a(j.2)), on July 20, 2011, the final-form rulemaking was deemed approved by the House and Senate Committees. Under section 5(g) of the Regulatory Review Act, this final-form rulemaking was deemed approved by IRRC, effective July 20, 2011.

J. *Findings*

The Board finds that:

(1) Public notice of proposed rulemaking was given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and regulations promulgated thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered.

(3) This final-form rulemaking does not enlarge the purpose of the proposed rulemaking published at 40 Pa.B. 2425.

(4) This final-form rulemaking is necessary and appropriate for administration and enforcement of the authorizing acts identified in Section C of this preamble.

K. *Order*

The Board, acting under the authorizing statutes, orders that:

(a) The regulations of the Department, 25 Pa. Code Chapter 86, are amended by amending § 86.130 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(b) The Chairperson of the Board shall submit this order and Annex A to the Office of General Counsel and the Office of Attorney General for review and approval as to legality and form as required by law.

(c) The Chairperson of the Board shall submit this order and Annex A to IRRC and the Senate and House Environmental Resources and Energy Committees as required by the Regulatory Review Act.

(d) The Chairperson of the Board shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(e) This order shall take effect immediately.

MICHAEL L. KRANCER,
Chairperson

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 41 Pa.B. 4265 (August 6, 2011).)

Fiscal Note: Fiscal Note 7-456 remains valid for the final adoption of the subject regulation.

Annex A

TITLE 25. ENVIRONMENTAL PROTECTION

PART I. DEPARTMENT OF ENVIRONMENTAL PROTECTION

Subpart C. PROTECTION OF NATURAL RESOURCES

ARTICLE I. LAND RESOURCES

CHAPTER 86. SURFACE AND UNDERGROUND COAL MINING: GENERAL

Subpart D. AREAS UNSUITABLE FOR MINING

CRITERIA AND PROCEDURES FOR DESIGNATING AREAS AS UNSUITABLE FOR SURFACE MINING

§ 86.130. Areas designated as unsuitable for mining.

* * * * *

(b) The following is a list of descriptions of areas which are unsuitable for all or certain types of surface mining operations and where all or certain types of surface mining operations will not be permitted:

* * * * *

(18) The surface mineable coal reserves of the Lower Kittanning, Clarion, Brookville and Mercer coals in the Muddy Run watershed, Cambria County, located south of State Route 253, including Muddy Run and its eastern tributary, Curtis Run.

[Pa.B. Doc. No. 11-1457. Filed for public inspection August 26, 2011, 9:00 a.m.]

Title 49—PROFESSIONAL AND VOCATIONAL STANDARDS

STATE BOARD OF SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS AND PROFESSIONAL COUNSELORS

[49 PA. CODE CHS. 47, 48 AND 49]

Licensure by Endorsement; Hours of Supervised Clinical Experience

The State Board of Social Workers, Marriage and Family Therapists and Professional Counselors (Board) amends §§ 47.12c and 47.12d (relating to licensed clinical social worker; and standards for supervisors) and adds §§ 47.16, 48.17 and 49.18 (relating to licensure by endorsement) to read as set forth in Annex A.

Statutory authority

The act of July 9, 2008 (P. L. 929, No. 68) (Act 68) amended section 7(d) of the Social Workers, Marriage and Family Therapists and Professional Counselors Act (act) (63 P. S. § 1907(d)) to reduce the number of hours of supervised clinical experience required as a condition of licensure as a licensed clinical social worker from 3,600 to 3,000. Act 68 also added section 10.1 of the act (63 P. S. § 1910.1) to establish licensure by endorsement for clinical social workers, marriage and family therapists and professional counselors. Section 4 of Act 68 directs the Board to promulgate regulations to implement the addition of section 10.1 of the act within 3 years of the effective date of Act 68. The effective date of Act 68 was September 7, 2008. Section 6(2) of the act (63 P. S. § 1906(2)) authorizes the Board to adopt and, from time to time, revise rules and regulations as may be necessary to carry into effect provisions of the act.

Background and Purpose

The final-form rulemaking is required to implement licensure by endorsement for clinical social workers, marriage and family therapists and professional counselors as required under section 10.1 of the act and to amend existing regulations to conform to the recent amendments to the act reducing the number of hours of supervised clinical experience required as a condition of licensure as a licensed clinical social worker from 3,600 to 3,000.

Summary of Comments and the Board's Response

The Board published a proposed rulemaking at 40 Pa.B. 2131 (April 24, 2010) with a 30-day public comment period. On April 26, 2010, the Board received public comment from the Pennsylvania Chapter of the National Association of Social Workers (NASW-PA). NASW-PA objected to the proposal in § 47.12c(b)(2) to reduce the number of hours of supervised clinical experience an applicant may earn during a 12-month period from 1,800 to 1,500 hours. The Board had intended to continue the existing regulatory scheme, whereby the required hours of supervised clinical experience shall be completed in no less than 2 years, with half of the hours completed in the first year and the remaining half completed in the second year. The Board recognized that many candidates for licensure are currently pursuing the required supervised clinical experience and proposed to amend subsection (c) to accept up to 1,800 hours in a given 12-month period that was completed prior to the effective date of this final-form rulemaking so that no one would be adversely affected by the change midstream. However, in response to the NASW-PA's comment, the Board agrees that the reduction in the maximum hours completed in any given 12-month period is not necessary to effectuate the overall statutory reduction to 3,000 total hours, and has amended the final-form rulemaking to continue to accept a maximum of 1,800 hours completed during a given year, with the understanding that the total of 3,000 hours shall be completed in no less than 2 years in accordance with § 47.12c(b)(9).

The House Professional Licensure Committee (HPLC) submitted only one comment questioning the lack of consistency with reference to the use of "state" and "jurisdiction" in §§ 47.16, 48.17 and 49.18. The HPLC also asked if the use of the word "state" includes a United States territory, possession or the District of Columbia. Section 1991 of 1 Pa.C.S. (relating to definitions) provides that the word "state" "[w]hen used in reference to the different parts of the United States, includes the District of Columbia and the several territories of the United States." To address the inconsistency pointed out by the HPLC, the Board amended all three sections to eliminate the use of the term "jurisdiction" in favor of "state" because that is the term used in Act 68 and defined in 1 Pa.C.S. § 1991.

Finally, the Independent Regulatory Review Commission (IRRC) submitted three comments for the Board's consideration. First, IRRC pointed out that deleting "3 years or" from § 47.12c(a)(5) would be inconsistent with the act. IRRC suggested that the Board retain this phrase and provide in the paragraph what is considered to be 3 years of experience acceptable to the Board to qualify the applicant for licensure. The Board's intent in eliminating "3 years or" was to avoid absurd interpretations by applicants who claim that they have completed 3 years of supervised clinical experience and therefore have met the statutory requirements for licensure when the applicant could demonstrate significantly less than 3,600 hours over the 3-year period. Taken to its extreme, an applicant could argue that they did 1 hour of supervised clinical experience each year for 3 years and should, therefore, qualify for licensure under the act. Standards for obtaining licensure should not be open to absurd interpretations. Section 1922(1) of 1 Pa.C.S. (relating to presumptions in ascertaining legislative intent) provides that "the General Assembly does not intend a result that is absurd . . . or unreasonable." In addition, it could not possibly have been the legislative intent to require similarly situated applicants to complete vastly differing amounts of supervised clinical experience. A majority of states that license clinical social workers require at least 3,000 hours of supervised clinical experience as a prerequisite to licensure. That is why an applicant for licensure by endorsement is also required to have completed at least 3,000 hours of supervised clinical experience. For these reasons, the Board sought to clarify the legislative intent by deleting from the regulations "3 years or" whichhas caused significant confusion for many years. However, in response to IRRC's comment, the Board has retained the phrase and, as suggested, added a sentence

clarifying that "3 years of supervised clinical experience" means three 12-month periods during each of which the applicant has completed at least 1,000 hours of supervised clinical experience meeting the requirements in § 47.12c(b).

IRRC also asked for an explanation of the need to amend the limit on the number of hours that can be counted in a 12-month period from 1,800 to 1,500. As previously discussed, the Board reconsidered its position in response to the comments by NASW-PA and IRRC and amended the final-form rulemaking to retain the 1,800-hour limit. Finally, like the HPLC, IRRC asked the Board to clarify its use of the word "state" and "jurisdiction" in the final-form rulemaking. As previously noted, the Board amended the final-form rulemaking to eliminate the use of "jurisdiction" in favor of the statutory term "state."

Description of Amendments to the Final Rulemaking

Section 47.12c(a) is amended to retain the requirement that an applicant for licensure as a licensed clinical social worker complete at least "3 years or" 3,000 hours of supervised clinical experience. The Board added a sentence defining what is meant by "3 years of supervised clinical experience" as three 12-month periods during each of which the applicant has completed at least 1,000 hours of supervised clinical experience meeting the requirements in subsection (b).

Section 47.12c(b)(9) is amended to retain the upper limit of 1,800 hours of supervised clinical experience that may be credited in any 12-month period. As a result, the proposed amendment to subsection (c) is unnecessary and subsection (c) is being deleted in its entirety.

Sections 47.16(4), 48.17(3) and 49.18(3) are amended to eliminate the use of "jurisdiction" in favor of the statutory term "state," which the Board interprets as defined in 1 Pa.C.S. § 1991 to include the District of Columbia and the United States territories.

Fiscal Impact and Paperwork Requirements

The final-form rulemaking requires the Board to create new application forms for licensure by endorsement. However, the final-form rulemaking should not create additional paperwork for the private sector with the exception of those individuals who apply for licensure by endorsement. The final-form rulemaking should not result in additional legal, accounting or reporting requirements for the Commonwealth or the regulated community.

Sunset Date

The Board continuously monitors the effectiveness of its regulations on a fiscal year and biennial basis. Therefore, a sunset date has not been assigned.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on April 8, 2010, the Board submitted a copy of the notice of proposed rulemaking, published at 40 Pa.B. 2131, to IRRC and the Chairpersons of the HPLC and the Senate Consumer Protection and Professional Licensure Committee (SCP/PLC) for review and comment.

Under section 5(c) of the Regulatory Review Act, IRRC, the HPLC and the SCP/PLC were provided with copies of the comments received during the public comment period, as well as other documents when requested. In preparing the final-form rulemaking, the Board has considered all comments from IRRC, the HPLC, the SCP/PLC and the public.

Under section 5.1(j.2) of the Regulatory Review Act (71 P. S. § 745.5a(j.2)), on June 22, 2011, the final-form rulemaking was approved by the HPLC. On July 20, 2011, the final-form rulemaking was deemed approved by the SCP/PLC. Under section 5.1(e) of the Regulatory Review Act, IRRC met on July 21, 2011, and approved the final-form rulemaking.

Contact Person

Further information may be obtained by contacting Beth Michlovitz, Counsel, State Board of Social Workers, Marriage and Family Therapists and Professional Counselors, P. O. Box 2649, Harrisburg, PA 17105-2649.

Findings

The Board finds that:

(1) Public notice of proposed rulemaking was given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations promulgated thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered.

(3) The amendments to the final-form rulemaking do not enlarge the purpose of proposed rulemaking published at 40 Pa.B. 2131.

(4) This final-form rulemaking is necessary and appropriate for administering and enforcing the authorizing act identified this preamble.

Order

The Board, acting under its authorizing statutes, orders that:

(a) The regulations of the Board, 49 Pa. Code Chapters 47, 48 and 49, are amended by amending §§ 47.12c and 47.12d and by adding §§ 47.16, 48.17 and 49.18 to read as set forth in Annex A.

(b) The Board shall submit this order and Annex A to the Office of General Counsel and the Office of Attorney General as required by law.

(c) The Board shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(d) This order shall take effect upon publication in the *Pennsylvania Bulletin*.

DONNA A. TONREY, LMFT,
Chairperson

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 41 Pa.B. 4265 (August 6, 2011).)

Fiscal Note: Fiscal Note 16A-6916 remains valid for the final adoption of the subject regulations.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 47. STATE BOARD OF SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS AND PROFESSIONAL COUNSELORS

LICENSURE

§ 47.12c. Licensed clinical social worker.

(a) *Conditions for licensure*. To be issued a license to hold oneself out as a licensed clinical social worker, an applicant shall provide proof satisfactory to the Board, that the applicant has met the following conditions:

(1) Satisfied the general requirements for licensure of § 47.12 (relating to qualifications for licensure).

(2) Holds a master's degree in social work or social welfare or a doctoral degree in social work from a school accredited by the Council on Social Work Education. An applicant who is a graduate of a foreign school shall submit to the Board an evaluation of foreign credentials performed by the Council on Social Work Education, which assesses the foreign credentials to be the equivalent of the curriculum policy of an accredited graduate school during the same time period, to be considered as meeting the requirements of having earned a master's degree in social work or social welfare from an accredited school.

(3) Is licensed under the act as a social worker.

(4) Passed the examination required under § 47.11 (relating to licensure examination).

(5) Completed at least 3 years or 3,000 hours of supervised clinical experience meeting the criteria in subsection (b) after completion of the master's degree in social work. For purposes of this paragraph, "3 years of supervised clinical experience" means three 12-month periods during each of which the applicant has completed at least 1,000 hours of supervised clinical experience meeting the requirements in subsection (b). Supervision for the clinical experience shall be provided by a supervisor as defined in §§ 47.1 and 47.1a (relating to definitions; and qualifications for supervisors).

(b) *Supervised clinical experience*. Experience acceptable to the Board means experience as a supervisee in a setting that is organized to prepare the applicant for the practice of clinical social work consistent with the applicant's education and training, and conforms to the following:

(1) At least 1/2 of the experience shall consist of providing services in one or more of the following areas:

(i) Assessment.

(ii) Psychotherapy.

(iii) Other psychosocial-therapeutic interventions.

(iv) Consultation.

(v) Family therapy.

(vi) Group therapy.

(2) Supervision for the clinical experience shall be provided by a supervisor as defined in §§ 47.1 and 47.1a. However, at least 1,500 hours shall be supervised by a supervisor meeting the qualifications in § 47.1a(1) and (3).

(3) A supervisee shall disclose his status as a supervisee to each patient and obtain written permission to discuss the patient's case with the supervisor.

(4) The supervisor shall oversee, direct, recommend and instruct the clinical social work activities of the supervisee.

(i) A supervisor who is temporarily unable to provide supervision shall designate another supervisor as a substitute.

(ii) Although the supervisor shall continue to bear the ultimate responsibility for supervision, those to whom supervisory responsibilities are delegated shall be individually responsible for activities of the supervisee performed under their supervision.

(5) The supervisor, or one to whom supervisory responsibilities have been delegated, shall meet with the supervisee for a minimum of 2 hours for every 40 hours of supervised clinical experience. At least 1 of the 2 hours shall be with the supervisee individually and in person, and 1 of the 2 hours may be with the supervisee in a group setting and in person.

(6) A supervisor shall supervise no more than 6 supervisees at the same time. If this provision creates an undue hardship on a supervisee, the supervisor and supervisee may request an exception to this provision. The request shall state, in writing, the reasons why this provision creates a hardship on the supervisee and why the supervisee is not able to obtain a supervisor who meets the requirements of this provision. Before making a determination, the Board may require a personal appearance by the supervisee and supervisor.

(7) A supervisor who wishes to terminate supervision during the training period shall give the supervisee 2 weeks written notice to enable the supervisee to obtain another qualified supervisor. A supervisor may not terminate supervision when termination would result in abandonment of the supervisee's client/patient.

(8) Supervised work activity will be counted toward satisfying the experience requirement only if it takes place in a single setting for either, first, at least 30 hours per week but no more than 50 hours per week during at least a 3 month period or, second, at least 15 hours per week for a period of at least 6 months.

(9) The supervised clinical experience shall be completed in no less than 2 years and no more than 6 years, except that at least 500 hours and no more than 1,800 hours may be credited in any 12-month period.

§ 47.12d. Standards for supervisors.

Supervisors, and those to whom supervisory responsibilities are delegated, under § 47.12c(a)(5) (relating to licensed clinical social worker) shall comply with the standards in this section. Supervisors will be asked to attest to compliance on the verification of experience form which shall accompany the supervisee's application for licensure. The Board reserves the right to require a supervisor by documentation or otherwise to establish to the Board's satisfaction that compliance occurred.

* * * * *

(6) The supervisor shall be empowered to recommend the interruption or termination of the supervisee's activities in providing services to a client/patient and, if necessary, to terminate the supervisory relationship. Any

hours accumulated for activities not approved by the supervisor will not count toward satisfying the 3,000 hours of supervised experience.

* * * * *

§ 47.16. Licensure by endorsement.

To be issued a license by endorsement without examination as a licensed clinical social worker, an applicant shall provide proof satisfactory to the Board, that the applicant has met the following conditions:

(1) Satisfied the general requirements for licensure of § 47.12 (relating to qualifications for licensure).

(2) Holds a master's degree in social work or social welfare or a doctoral degree in social work from a school accredited by the Council on Social Work Education. An applicant who is a graduate of a foreign school shall submit to the Board an evaluation of foreign credentials performed by the Council on Social Work Education, which assesses the foreign credentials to be the equivalent of the curriculum policy of an accredited graduate school during the same time period, that is, as meeting the requirements of having earned a master's degree in social work or social welfare from an accredited school.

(3) Passed a clinical social work examination acceptable to the Board. The Board will accept an applicant's examination grades taken in another jurisdiction, as furnished through the professional examination reporting service or from the jurisdiction that administered the examination. The applicant shall demonstrate that the examination taken in the other jurisdiction is similar to the one offered by the Commonwealth, and that the applicant passed the examination with a grade at least equal to the passing grade set by the Commonwealth.

(4) Holds a clinical social work license that is in good standing from another state. The applicant shall provide a letter from the other state's licensing authority where the clinical social worker is licensed certifying licensure and reporting any disciplinary history.

(5) Demonstrates to the Board's satisfaction that the applicant has completed a minimum of 3,000 hours of supervised clinical experience that conforms to the requirements of the state in which the applicant is currently licensed.

CHAPTER 48. STATE BOARD OF SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS AND PROFESSIONAL COUNSELORS—LICENSURE OF MARRIAGE AND FAMILY THERAPISTS

LICENSURE

§ 48.17. Licensure by endorsement.

To be issued a license by endorsement without examination as a marriage and family therapist, an applicant shall provide proof satisfactory to the Board, that the applicant has met the following conditions:

(1) Satisfied the general requirements for licensure of § 48.12 (relating to general qualifications for licensure).

(2) Satisfied the educational requirements in section 7(e)(2) of the act (63 P. S. § 1907(e)(2)) and § 48.13(a)(3) (relating to licensed MFT).

(3) Holds a marriage and family therapy license that is in good standing from another state. The applicant shall provide a letter from the other state's licensing authority where the marriage and family therapist is licensed certifying licensure and reporting any disciplinary history.

(4) Demonstrates to the Board's satisfaction that the applicant has completed a minimum of 3,000 hours of supervised clinical experience that conforms to the licensure requirements of the state in which the applicant is currently licensed.

(5) Demonstrates to the Board's satisfaction that the applicant has, at a minimum, been actively engaged in the practice of marriage and family therapy for 5 of the last 7 years immediately preceding the filing of the application for licensure by endorsement with the Board.

CHAPTER 49. STATE BOARD OF SOCIAL WORKERS, MARRIAGE AND FAMILY THERAPISTS AND PROFESSIONAL COUNSELORS—LICENSURE OF PROFESSIONAL COUNSELORS

LICENSE

§ 49.18. Licensure by endorsement.

To be issued a license by endorsement without examination as a professional counselor, an applicant shall provide proof satisfactory to the Board, that the applicant has met the following conditions:

(1) Satisfied the general requirements for licensure of § 49.12 (relating to general qualifications for licensure).

(2) Satisfied the educational requirements in section 7(f)(2) of the act (63 P. S. § 1907(f)(2)) and § 49.13(a)(3) (relating to licensed professional counselor).

(3) Holds a professional counselor license that is in good standing from another state. The applicant shall provide a letter from the other state's licensing authority where the professional counselor is licensed certifying licensure and reporting any disciplinary history.

(4) Demonstrates to the Board's satisfaction that the applicant has completed a minimum of 3,000 hours of supervised clinical experience that conforms to the requirements of the state in which the applicant is currently licensed.

(5) Demonstrates to the Board's satisfaction that the applicant has, at a minimum, been actively engaged in the practice of professional counseling for 5 of the last 7 years immediately preceding the filing of the application for licensure by endorsement with the Board.

[Pa.B. Doc. No. 11-1458. Filed for public inspection August 26, 2011, 9:00 a.m.]

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CHS. 1187 AND 1189]

Transition to RUG-III Version 5.12 and Latest Assessment

The Department of Public Welfare (Department) amends Chapters 1187 and 1189 (relating to nursing facility services; and county nursing facility services) under the authority of sections 201(2), 206(2), 403(b) and 443.1 of the Public Welfare Code (code) (62 P. S. §§ 201(2), 206(2), 403(b) and 443.1). The proposed rulemaking was published at 40 Pa.B. 6525 (November 13, 2010).

Purpose of Final-Form Rulemaking

The purpose of this final-form rulemaking is to amend the payment methodology for Medical Assistance (MA)

nursing facility services to phase-in the use of the Resource Utilization Group III (RUG-III) classification system, version (v.) 5.12 44 Grouper and the most recent classifiable resident assessments in determining the case-mix indices that are used in setting case-mix per diem rates for nonpublic nursing facilities and in making certain incentive payments to county nursing facilities.

This final-form rulemaking is needed to modify the version of the RUG-III classification system used by the Department in the case-mix payment system and in making county nursing facility pay for performance (P4P) payments as a result of the implementation of Minimum Data Set (MDS) 3.0 by the Centers for Medicare and Medicaid Services (CMS), effective October 1, 2010. In addition, the final-form rulemaking will permit the Department to use a more timely measurement of a nursing facility resident's care needs by permitting the use of the most recent classifiable resident assessment of any type when classifying residents into groups and assigning a Case-Mix Index (CMI) score. The proposed rulemaking stated the Department would use the most recent resident assessment of any type. However, the Department has found that not all resident assessments are classifiable under MDS 3.0 as they were under MDS 2.0; therefore, the Department will use the most recent classifiable resident assessment of any type.

The following is a summary of the major provisions in the final-form rulemaking.

§§ 1187.2 and 1187.33 (relating to definitions; and resident data and picture date reporting requirements)—Resident assessment

The Department amended the definition of "resident assessment" in § 1187.2 by deleting "comprehensive" from the definition. Section 1187.33(a)(6) is amended by removing the language regarding Medicare assessments.

Nursing facilities are required to conduct and electronically submit assessments other than "comprehensive assessments" for their residents. These assessments contain all MDS data elements needed to calculate each resident's RUG category and CMI score. When these assessments are completed after the latest comprehensive assessment, they provide more current information on a resident's condition and care needs than the resident's "comprehensive assessment."

The Department determines the RUG category and CMI score for each nursing facility resident using the assessment data from the resident's most recent comprehensive MDS assessment as submitted by the nursing facility. Using the CMI scores calculated for each resident, the Department calculates a total facility CMI score and a facility MA CMI score for each nursing facility and a Statewide average MA CMI score.

Rather than continuing to use older assessment data to determine a resident's RUG category and CMI score, the Department is amending its regulations to require use of the most recent classifiable assessment of any type for each resident, whether the assessment is comprehensive, effective July 1, 2010. This change will enable the Department to make acuity adjustments and P4P payments using the most up-to-date resident data available without additional administrative burdens or costs to either nursing facilities or the Department.

The CMI scores will be used to calculate the total facility CMIs and the MA CMIs for setting nonpublic nursing facility rates effective on and after July 1, 2010. In addition, the CMI scores will be used in determining which county nursing facilities are eligible to receive P4P payments beginning with the July 1—September 30, 2010, P4P payment period.

§ 1187.93 (relating to CMI calculations) and Chapter 1187, Appendix A (relating to resource utilization group index scores for case-mix adjustment in the nursing facility reimbursement system)—Case-mix classification tool

CMS developed a new version of the MDS resident assessment, MDS 3.0, which nursing facilities participating in the Medicare or MA Program, or both, were required to use effective October 1, 2010. The new version of the MDS has been designed to improve the reliability, accuracy and usefulness of the assessment tool, to include the resident in the assessment process and to incorporate the use of standard protocols used in other health care settings. According to CMS, the enhanced accuracy of the MDS 3.0 will improve clinical assessments and bolster programs that rely on the MDS for assessing the needs of consumers.

The MDS 3.0 assessment does not contain all the elements necessary for resident classification with the RUG-III v. 5.01 44 Grouper, which has been used to set nonpublic nursing facility rates since January 1, 1996. CMS no longer supports this Grouper with implementation of MDS 3.0. The Department changed the Grouper used in determining nursing facility residents' CMI scores effective for rate setting periods on and after July 1, 2010, to the RUG-III v. 5.12 44 Grouper. This RUG-III version, which is compatible with the MDS 3.0, is based on updated time studies conducted in 1995 and 1997 and reflects changes in nursing facility resident conditions and care since the original studies conducted in 1990. The combination of the use of the latest classifiable assessment to more accurately measure current resident acuity and a classification system based on more recent time studies will result in better distribution of scarce MA resources.

The Department amended § 1187.93 and Chapter 1187, Appendix A to reflect both the associated Nursing Only CMI scores established by CMS for the RUG-III v. 5.12 44 Grouper classification system and the CMI scores normalized for nursing facilities in this Commonwealth. Normalization of CMI scores is a common process used by states when implementing a RUG-III based case-mix payment system or when changing to a new RUG version. Scores are normalized so that the average Statewide CMI score equals 1.00. The normalized CMI scores the Department will use range from 0.48 to 1.75.

The Department will use the RUG-III v. 5.12 44 Grouper classification system in determining the CMIs of residents of both nonpublic and county nursing facilities. The CMI scores will be used to calculate the total facility CMIs and the MA CMIs used in setting nonpublic nursing facility rates effective on and after July 1, 2010. In addition, the CMI scores are used in determining which county nursing facilities are eligible to receive P4P payments beginning with the July 1—September 30, 2010, P4P payment period. The CMIs include the February 1, 2010, picture date total facility CMI and MA CMI; the total facility CMI for the February 1 picture dates from all of the cost report periods of the MA cost reports used in the July 1, 2010, rate setting database; the MA CMIs from the May 1, 2010, picture date, the August 1, 2010, picture date, the November 1, 2010, picture date; and the total facility CMIs and MA CMIs for all subsequent picture dates.

§ 1187.96 (relating to price- and rate-setting computations)—Phase-In—RUG-III v. 5.12 44 Grouper and the most recent resident assessment

The Department recognizes that the change in RUG-III Grouper and use of the most recent classifiable resident assessment of any type may cause a reduction in per diem rates for some nonpublic nursing facilities. Because there may be an adverse impact on nonpublic nursing facilities, the Department is applying a 3-year phase-in for the transition to the RUG-III v. 5.12 44 Grouper and the use of the most recent classifiable resident assessment for rate setting periods beginning July 1, 2010, and ending June 30, 2013. Phasing in the amendments provides nursing facilities the opportunity to gain competency using MDS 3.0 and become familiar with the new RUG-III Grouper and resident assessment selection process. The Department amended § 1187.96 to specify that for July 1, 2010, through June 30, 2013, unless the nursing facility is a new facility, the resident care rate that the Department will use to establish a nursing facility's case-mix per diem rate will be a blended resident care rate that will consist of a portion of a 5.01 resident care rate and a portion of a 5.12 resident care rate.

A phase-in provision, however, will not be applied to new nonpublic nursing facilities since the phase-in period is for a transition from one system to another. Therefore, the Department amended § 1187.97 (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) to specify that new facilities will be assigned a Statewide average MA CMI calculated using the RUG-III v. 5.12 44 group values in Chapter 1187, Appendix A and the most recent classifiable assessments. When a new nursing facility's assessment data is used in a rate determination the CMI values used to determine the new nursing facility's total facility CMIs and MA CMIs will be the RUG-III v. 5.12 44 group values in Chapter 1187, Appendix A and the most recent classifiable assessment.

§ 1189.105 (relating to incentive payments)—County nursing facilities—P4P payments

The Department calculates MA CMI scores for county nursing facilities and uses the scores in determining which county nursing facilities are eligible to receive quarterly P4P payments. To be eligible for a P4P payment, a county nursing facility must meet the definition of a "county nursing facility" at the time the quarterly P4P payment is being made. In addition, the county nursing facility's MA CMI for a picture date must be higher than the facility's MA CMI for the previous picture date. Since county nursing facility MA CMIs are used only for this limited purpose, the Department will not provide for a phase-in of the changes. The Department amended § 1189.105 to specify that, in determining whether a county nursing facility qualifies for a quarterly P4P incentive for P4P periods beginning on and after July 1, 2010, the facility's MA CMI for a picture date equals the arithmetic mean of the individual CMIs for MA residents identified in the facility's CMI report for the picture date and an MA resident's CMI is calculated using the RUG-III v. 5.12 44 group values in Chapter 1187, Appendix A and the most recent classifiable assessment of any type for the resident.

Affected Individuals and Organizations

This final-form rulemaking affects nonpublic nursing facilities enrolled in the MA Program and county nursing facilities that seek to qualify for P4P payments under § 1189.105(b).

Accomplishments and Benefits

This final-form rulemaking benefits MA nursing facility residents in this Commonwealth by assuring they will continue to have access to medically necessary nursing facility services while providing for reasonable and adequate payments to MA nursing facility providers consistent with the fiscal resources of this Commonwealth.

Fiscal Impact

There is no fiscal impact for Fiscal Year 2010-2011. The fiscal impact will remain budget neutral as long as the budget adjustment factor (BAF) is reauthorized. The fiscal impact after 2010-2011 makes the assumption that the BAF is not reauthorized beyond June 30, 2011. The implication of the change of the 5.12 is that nursing facilities' rates would be reduced by approximately $166.912 million ($74.994 million in State funds) on an annual basis.

Paperwork Requirements

There are no new or additional paperwork requirements.

Public Comment

The Department received one public comment letter from PANPHA, an association of Pennsylvania nonprofit aging services providers. The Independent Regulatory Review Commission (IRRC) also commented on the proposed rulemaking.

Discussion of Comments and Major Changes

Following is a summary of the comments received during the public comment period following publication of the proposed rulemaking and the Department's responses to those comments. A summary of major changes from proposed rulemaking is also included.

General—Use of RUG-III v. 5.12 44 Grouper and Most Recent Assessment

PANPHA is generally supportive of using the RUG-III v. 5.12 44 Grouper and the most recent assessment for rate-setting to better align resources with the most recently available data. PANPHA commented that while this change may have a negative short-term effect on some nursing facilities, residents should ultimately benefit by more accurately measuring resident acuity and, therefore, better reflect the needs and necessary resources than the current regulations.

Response

The Department recognizes that with almost 600 nonpublic nursing facilities enrolled in the MA Program, these changes may have a negative short-term effect on some nursing facilities. However, the 3-year phase-in, suggested by the industry, for the transition to the RUG-III v. 5.12 44 Grouper and the use of the most recent classifiable resident assessment should mitigate any adverse effect and provide nursing facilities the opportunity to gain competency using MDS 3.0 and become familiar with the new RUG-III Grouper and resident assessment selection process. Moreover, the combination of the use of the latest assessment to more accurately measure current resident acuity and a classifi-

cation system based on more recent time studies will ultimately result in better distribution of the scarce MA resources.

General—Phasing-in Reimbursement Changes

PANPHA also supports the concept of phasing-in the reimbursement changes. However, PANPHA asked that the Department and stakeholders continue to monitor and address the effects of the new system and the phase-in to determine if any of these components cause a degree of variability that is too unpredictable for effective operation of facilities or that cause other unanticipated adverse effects.

Response

The Department will review the regulations on an ongoing basis to ensure compliance with Federal and State law and to assess the appropriateness and effectiveness of the regulations. In addition, if specific regulatory issues are raised by the Medical Assistance Advisory Committee (MAAC) and the Long-Term Care Delivery System Subcommittee of the MAAC, those issues will be researched and addressed as needed. The Department will also monitor the impact of the regulations through regular audits and utilization management reviews to determine the effectiveness of the regulations with respect to consumers of long-term care services and the industry.

§§ 1187.93, 1187.96 and 1187.97, Chapter 1187, Appendix A and § 1189.105—Implementation procedures

IRRC asked that the Department clarify how the new rates will occur retroactive to July 1, 2010.

Response

Currently, nonpublic nursing facilities enrolled in the MA program are being paid at their respective April 1, 2010, rates. The Department submitted a State Plan Amendment (SPA) to CMS to phase-in the use of the most recent classifiable resident assessments and the RUG-III classification system v. 5.12 44 Grouper in determining nursing facility residents' CMIs used in setting case-mix per diem rates for nonpublic nursing facilities and in making P4P incentive payments to county nursing facilities. The SPA was approved by CMS on October 27, 2010. Once this final-form rulemaking is promulgated, the Department will prepare rate adjustments retroactive to July 1, 2010, under §§ 1187.96 and 1187.97. A rate adjustment schedule will be sent by e-mail to the nursing facility providers and nursing facility associations and will be posted to the Department's web site. In addition, files will be created for the time periods (quarters) to be adjusted and will be loaded into PROMISe (claims processing system). Based on these files, a remittance advice will be generated for each nursing facility provider and the Treasury Department will generate the appropriate payment to the nursing facility providers.

Retroactive payments will not be made to county nursing facilities as a result of this final-form rulemaking. Under existing § 1189.105(b), incentive payments are made in accordance with the formula and qualifying criteria in the Commonwealth's State Plan. The Department submitted a SPA containing the formula as provided in amended § 1189.105(b). This SPA was approved by CMS on October 27, 2010. Therefore, payments were made in accordance with the approved State Plan and retroactive payments are not necessary.

Additional Changes

As previously stated, the Department has found that not all resident assessments are classifiable under MDS 3.0 as they were under MDS 2.0. Therefore, the Department changed the language to "the most recent classifiable resident assessment of any type." In addition, the Department made a correction to § 1187.97(1)(i)(A). This section incorrectly cited § 1187.96(s)(5) instead of § 1187.96(a)(5). The Department also eliminated the numbering of the paragraphs in § 1189.105(b) to clarify that the items are not mutually exclusive and the P4P incentive payment is dependent upon an approved state plan.

Regulatory Review Act

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on June 16, 2011, the Department submitted a copy of the final-form rulemaking to IRRC and the Chairpersons of the House Committee on Human Services and the Senate Committee on Public Health and Welfare for review and comment.

Under section 5(c) of the Regulatory Review Act, IRRC and the House and Senate Committees were provided with copies of the comments received during the public comment period, as well as other documents when requested. In preparing the final-form rulemaking, the Department has considered all comments from IRRC, the House and Senate Committees and the public.

Under section 5.1(j.2) of the Regulatory Review Act (71 P. S. § 745.5a(j.2)), on July 20, 2011, the final-form rulemaking was deemed approved by the House and Senate Committees. Under section 5.1(e) of the Regulatory Review Act, IRRC met on July 21, 2011, and approved the final-form rulemaking.

Findings

The Department finds that:

(1) Public notice of intention to amend the administrative regulation by this order has been given sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations promulgated thereunder, 1 Pa. Code §§ 7.1 and 7.2.

(2) Adoption of this final-form rulemaking in the manner provided by this order is necessary and appropriate for the administration and enforcement of the code.

Order

The Department, acting under sections 201(2), 206(2), 403(b) and 443.1 of the code, orders that:

(a) The regulations of the Department, 55 Pa. Code Chapters 1187 and 1189, are amended by amending §§ 1187.2, 1187.33 and 1187.93 and Chapter 1187, Appendix A to read as set forth at 40 Pa.B. 6525 and by amending §§ 1187.96, 1187.97 and 1189.105 to read as set forth in Annex A, with ellipses referring to the existing text of the regulations.

(b) The Secretary of the Department shall submit this order, 40 Pa.B. 6525 and Annex A to the Offices of General Counsel and Attorney General for approval as to legality and form as required by law.

(c) The Secretary of the Department shall certify and deposit this order, 40 Pa.B. 6525 and Annex A with the Legislative Reference Bureau as required by law.

(d) This order shall take effect retroactive to July 1, 2010.

GARY D. ALEXANDER,
Secretary

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 41 Pa.B. 4265 (August 6, 2011).)

Fiscal Note: Fiscal Note 14-520 remains valid for the final adoption of the subject regulation.

Annex A

TITLE 55. PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE MANUAL

CHAPTER 1187. NURSING FACILITY SERVICES

Subchapter G. RATE SETTING

§ 1187.96. Price- and rate-setting computations.

(a) Using the NIS database in accordance with this subsection and § 1187.91 (relating to database), the Department will set prices for the resident care cost category.

(1) The Department will use each nursing facility's cost reports in the NIS database to make the following computations:

(i) The total resident care cost for each cost report will be divided by the total facility CMI from the available February 1 picture date closest to the midpoint of the cost report period to obtain case-mix neutral total resident care cost for the cost report year.

(ii) The case-mix neutral total resident care cost for each cost report will be divided by the total actual resident days for the cost report year to obtain the case-mix neutral resident care cost per diem for the cost report year.

(iii) The Department will calculate the 3-year arithmetic mean of the case-mix neutral resident care cost per diem for each nursing facility to obtain the average case-mix neutral resident care cost per diem of each nursing facility.

(2) The average case-mix neutral resident care cost per diem for each nursing facility will be arrayed within the respective peer groups, and a median determined for each peer group.

(3) For rate years 2006-2007, 2007-2008, 2009-2010, 2010-2011 and 2011-2012, the median used to set the resident care price will be the phase-out median as determined in accordance with § 1187.98 (relating to phase-out median determination).

(4) The median of each peer group will be multiplied by 1.17, and the resultant peer group price assigned to each nursing facility in the peer group.

(5) The price derived in paragraph (4) for each nursing facility will be limited by § 1187.107 (relating to limitations on resident care and other resident related cost centers) and the amount will be multiplied each quarter by the respective nursing facility MA CMI to determine the nursing facility resident care rate. The MA CMI picture date data used in the rate determination are as follows: July 1 rate—February 1 picture date; October 1 rate—May 1 picture date; January 1 rate—August 1 picture date; and April 1 rate—November 1 picture date.

(6) For rate years 2010-2011, 2011-2012 and 2012-2013, unless the nursing facility is a new nursing facility, the resident care rate used to establish the nursing facility's case-mix per diem rate will be a blended resident care rate.

(i) The nursing facility's blended resident care rate for the 2010-2011 rate year will equal 75% of the nursing facility's 5.01 resident care rate calculated in accordance with subparagraph (iv) plus 25% of the nursing facility's 5.12 resident care rate calculated in accordance with subparagraph (iv).

(ii) The nursing facility's blended resident care rate for the 2011-2012 rate year will equal 50% of the nursing facility's 5.01 resident care rate calculated in accordance with subparagraph (v) and 50% of the nursing facility's 5.12 resident care rate calculated in accordance with subparagraph (v).

(iii) The nursing facility's blended resident care rate for the 2012-2013 rate year will equal 25% of the nursing facility's 5.01 resident care rate calculated in accordance with subparagraph (v) and 75% of the nursing facility's 5.12 resident care rate calculated in accordance with subparagraph (v).

(iv) For the rate year 2010-2011, each nursing facility's blended resident care rate will be determined based on the following calculations:

(A) For the first quarter of the rate year (July 1, 2010—September 30, 2010), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a 5.12 resident care rate for each nursing facility in accordance with paragraphs (1)—(5). The CMI values the Department will use to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93 (relating to CMI calculations), will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a 5.01 resident care rate for each nursing facility in accordance with paragraphs (1)—(5). The CMI values the Department will use to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.01 44-group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent comprehensive resident assessment.

(III) The nursing facility's blended resident care rate for the quarter beginning July 1, 2010, and ending September 30, 2010, will be the sum of the nursing facility's 5.01 resident care rate multiplied by 0.75 and the nursing facility's 5.12 resident care rate multiplied by 0.25.

(B) For the remaining 3 quarters of the 2010-2011 rate year (October 1 through December 31; January 1 through March 31; April 1 through June 30), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a quarterly adjusted 5.12 resident care rate for each nursing facility in accordance with paragraph (5). The CMI values used to determine each nursing facility's MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a quarterly adjusted 5.01 resident care rate for each nursing facility by multiplying the nursing facility's prior quarter 5.01 resident care rate by the percentage change between the nursing facility's current quarter 5.12 resident care rate and the nursing facility's previous quarter 5.12 resident care rate. The percentage change will be determined by dividing the nursing facility's current quarter 5.12 resident care rate by the nursing facility's previous quarter 5.12 resident care rate.

(III) The nursing facility's blended resident care rate for the 3 remaining quarters of the rate year will be the sum of the nursing facility's quarterly adjusted 5.01 resident care rate multiplied by 0.75 and the nursing facility's quarterly adjusted 5.12 resident care rate multiplied by 0.25.

(v) For rate years 2011-2012 and 2012-2013, each nursing facility's blended resident care rate will be determined based on the following calculations:

(A) For the first quarter of each rate year (July 1—September 30), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a 5.12 resident care rate for each nursing facility in accordance with paragraphs (1)—(5). The CMI values used to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a 5.01 resident care rate for each nursing facility by multiplying the nursing facility's prior April 1st quarter 5.01 resident care rate by the percentage change between the nursing facility's current 5.12 resident care rate and the nursing facility's prior April 1st quarter 5.12 resident care rate. The percentage change will be determined by dividing the nursing facility's current 5.12 resident care by the nursing facility's April 1st quarter 5.12 resident care rate.

(III) The nursing facility's blended resident care rate for the quarter beginning July 1, 2011, and ending September 30, 2011, will be the sum of the nursing facility's 5.01 resident care rate multiplied by 0.50 and the nursing facility's 5.12 resident care rate multiplied by 0.50.

(IV) The nursing facility's blended resident care rate for the quarter beginning July 1, 2012, and ending September 30, 2012, will be the sum of the nursing facility's 5.01 resident care rate multiplied by 0.25 and the nursing facility's 5.12 resident care rate multiplied by 0.75.

(B) For the remaining 3 quarters of each rate year (October 1 through December 31; January 1 through March 31; April 1 through June 30), the Department will calculate each nursing facility's blended resident care rate as follows:

(I) The Department will calculate a quarterly adjusted 5.12 resident care rate for each nursing facility in accordance with paragraph (5). The CMI values used to determine each nursing facility's MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

(II) The Department will calculate a quarterly adjusted 5.01 resident care rate for each nursing facility by multiplying the nursing facility's prior quarter 5.01 resident care rate by the percentage change between the nursing facility's current quarter 5.12 resident care rate and the nursing facility's previous quarter 5.12 resident care rate. The percentage change will be determined by dividing the nursing facility's current quarter 5.12 resident care rate by the nursing facility's previous quarter 5.12 resident care rate.

(III) For the remaining 3 quarters of rate year 2011-2012 (October 1 through December 31; January 1 through March 31; April 1 through June 30), each nursing facility's blended resident care rate will be the sum of the nursing facility's quarterly adjusted 5.01 resident care rate multiplied by 0.50 and the nursing facility's quarterly adjusted 5.12 resident care rate multiplied by 0.50.

(IV) For the remaining 3 quarters of rate year 2012-2013 (October 1 through December 31; January 1 through March 31; April 1 through June 30), each nursing facility's blended resident care rate will be the sum of the nursing facility's quarterly adjusted 5.01 resident care rate multiplied by 0.25 and the facility's quarterly adjusted 5.12 resident care rate multiplied by 0.75.

(7) Beginning with rate year 2013-2014, and thereafter, the Department will calculate each nursing facility's resident care rate in accordance with paragraphs (1)—(5). The CMI values used to determine each nursing facility's total facility CMIs and facility MA CMI, computed in accordance with § 1187.93, will be the RUG-III version 5.12 44 group values as set forth in Appendix A. The resident assessment that will be used for each resident will be the most recent classifiable resident assessment of any type.

* * * * *

(e) The following applies to the computation of nursing facilities' per diem rates:

(1) The nursing facility per diem rate will be computed by adding the resident care rate, the other resident related rate, the administrative rate and the capital rate for the nursing facility.

(2) For each quarter of the 2006-2007 and 2007-2008 rate-setting years, the nursing facility per diem rate will be computed as follows:

(i) *Generally*. If a nursing facility is not a new nursing facility or a nursing facility experiencing a change of ownership during the rate year, that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with subsections (a)—(d) and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(ii) *New nursing facilities*. If a nursing facility is a new nursing facility for purposes of § 1187.97(1) (relating to rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities) that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with § 1187.97(1), and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(iii) *Nursing facilities with a change of ownership and reorganized nursing facilities*. If a nursing facility under-

goes a change of ownership during the rate year, that nursing facility's resident care rate, other resident related rate, administrative rate and capital rate will be computed in accordance with § 1187.97(2), and the nursing facility's per diem rate will be the sum of those rates multiplied by a budget adjustment factor determined in accordance with subparagraph (iv).

(iv) *Budget adjustment factor*. The budget adjustment factor for the rate year will be determined in accordance with the formula set forth in the Commonwealth's approved State Plan.

(3) For rate years 2010-2011, 2011-2012 and 2012-2013, unless the nursing facility is a new nursing facility, the nursing facility per diem rate will be computed by adding the blended resident care rate, the other resident related rate, the administrative rate and the capital rate for the nursing facility.

§ 1187.97. Rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities.

The Department will establish rates for new nursing facilities, nursing facilities with a change of ownership, reorganized nursing facilities and former prospective payment nursing facilities as follows:

(1) *New nursing facilities.*

(i) The net operating portion of the case-mix rate is determined as follows:

(A) A new nursing facility, unless a former county nursing facility, will be assigned the Statewide average MA CMI until assessment data submitted by the nursing facility under § 1187.33 (relating to resident data and picture date reporting requirements) is used in a rate determination under § 1187.96(a)(5) (relating to price- and rate-setting computations). Beginning, July 1, 2010, the Statewide average MA CMI assigned to a new nursing facility will be calculated using the RUG-III version 5.12 44 group values in Appendix A and the most recent classifiable assessments of any type. When a new nursing facility has submitted assessment data under § 1187.33, the CMI values used to determine the new nursing facility's total facility CMIs and MA CMI will be the RUG-III version 5.12 44 group values and the resident assessment that will be used for each resident will be the most recent classifiable assessment of any type.

(B) For a former county nursing facility, the county nursing facility's assessment data and MA CMI will be transferred to the new nursing facility.

(C) The nursing facility will be assigned to the appropriate peer group. The peer group price for resident care, other resident related and administrative costs will be assigned to the nursing facility until there is at least one audited nursing facility cost report used in the rebasing process. Beginning July 1, 2010, a new nursing facility will be assigned the peer group price for resident care that will be calculated using the RUG-III version 5.12 44 group values in Appendix A and the most recent classifiable assessments of any type.

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CHAPTER 1189. COUNTY NURSING FACILITY SERVICES

Subchapter E. PAYMENT CONDITIONS, LIMITATIONS AND ADJUSTMENTS

§ 1189.105. Incentive payments.

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(b) *Pay for performance incentive payment*. The Department will establish pay for performance measures that will qualify a county nursing facility for additional incentive payments in accordance with the formula and qualifying criteria in the Commonwealth's approved State Plan. For pay for performance payment periods beginning on or after July 1, 2010, in determining whether a county nursing facility qualifies for a quarterly pay for performance incentive, the facility's MA CMI for a picture date will equal the arithmetic mean of the individual CMIs for MA residents identified in the facility's CMI report for the picture date. An MA resident's CMI will be calculated using the RUG-III version 5.12 44 group values in Chapter 1187, Appendix A (relating to resource utilization group index scores for case-mix adjustment in the nursing facility reimbursement system) and the most recent classifiable assessment of any type for the resident.

[Pa.B. Doc. No. 11-1459. Filed for public inspection August 26, 2011, 9:00 a.m.]