pharmacokinetics (PK) studies for the HAPs chemicals, which could provide the basis for negotiation of enforcable consent agreements (ECAs). These PK studies would be used to conduct route-to-route extrapolation of toxicity data from routes other than inhalation to predict the effects of inhalation exposure, as an alternative to testing proposed under the HAPs rule.

On October 18, 1996, EPA extended the public comment period on the proposed rule from December 23, 1996 to January 31, 1997 (61 FR 54383) (FRL–5571–3). This extension was for the purpose of allowing more time for the submission of PK proposals and adequate time for comments on the proposed rule to be submitted after the Agency had responded to the proposals. EPA received several PK proposals. Due to the complexity of the issues raised by these proposals, EPA successively extended the public comment period (61 FR 67516, December 23, 1996 (FRL–5580–6); 62 FR 9142, February 28, 1997) to allow the Agency more time to respond to the PK proposals and to finalize the test guidelines to be referenced in the proposed HAPs test rule.

The HAPs proposed rule published on June 26, 1996 (61 FR 33178) provides that testing would be conducted using the harmonized guidelines developed by the Office of Prevention, Pesticides, and Toxic Substances (OPPTS) that were proposed on June 20, 1996 (61 FR 31522)(FRL–5367–7). The process of developing these guidelines is proceeding at the same time as the development of the HAPs test rule. For the purposes of the proposed HAPs test rule and testing under TSCA section 4(a), the Office of Pollution Prevention and Toxics (OPPT) intends to promulgate final TSCA test guidelines. The Agency will solicit public comment on the applicability of the test guidelines to the HAPs rule and will follow this practice with respect to all future TSCA section 4(a) test rules. These guidelines will be published in the **Federal Register** on or before May 30, 1997.

In addition, there has been a delay in finalizing Agency reviews of the PK proposals. EPA intends to provide comments to all submitters of PK proposals as soon as possible but, at any event prior to the close of the comment period. EPA also recognizes that submitters may need to revise their proposals based on EPA comments. In addition, the Agency believes that the public should have adequate opportunity to comment on the development of ECAs based on the PK proposals. If the Agency finds the original or revised PK proposals acceptable, EPA will therefore announce, in the **Federal Register**, one or more public meetings to discuss the proposals and to negotiate ECAs based on the proposals. In that notice, the Agency will solicit persons interested in participating in or monitoring negotiations for the development of ECAs based on the revised PK testing proposals. These negotiations will be conducted under the process described in subpart B of 40 CFR part 790.

The Agency emphasizes that the submission of proposals to develop ECAs to conduct alternative testing using PK is no guarantee that EPA and the submitters will, in fact, conclude such agreements. Therefore, EPA urges all submitters of PK proposals to comment on the HAPs proposed rule as an activity separate from the PK proposal/ECA process. Comments on the proposed rule should be submitted as described in the ''ADDRESSES'' section of this document prior to the close of the comment period.

Accordingly, EPA is extending the comment period on the proposed rule to June 30, 1997.

List of Subjects in 40 CFR Part 799

Environmental protection, Chemicals, Hazardous substances, Reporting and recordkeeping requirements.

Dated: March 24, 1997.

Charles M. Auer,

Director, Chemical Control Division, Office of Pollution Prevention and Toxics.

[FR Doc. 97–7815 Filed 3–27–97; 8:45 am]

BILLING CODE 6560–50–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 413

[BPD–808–P]

RIN 0938–AG70

Medicare and Medicaid Programs; Salary Equivalency Guidelines for Physical Therapy, Respiratory Therapy, Speech Language Pathology, and Occupational Therapy Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed rule.

SUMMARY: This proposed rule sets forth proposed revisions to the salary equivalency guidelines for Medicare payment for the reasonable costs of physical therapy and respiratory therapy services furnished under arrangements by an outside contractor. The proposed rule also sets forth proposed new salary equivalency guidelines for Medicare payment for the reasonable costs of speech language pathology and occupational therapy services furnished under arrangements by an outside contractor. The proposed guidelines do not apply to inpatient hospital services and hospice services. The guidelines would be used by Medicare fiscal intermediaries to determine the maximum allowable cost of those services.

The guidelines will not be effective until at least 60 days after the date of publication of the final rule. However, to illustrate how the schedules would operate, we have calculated the proposed revised schedules for physical respiratory therapy services and proposed new schedules for speech-language pathology and occupational therapy services as if the guidelines were effective on April 1, 1997.

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on May 27, 1997.

ADDRESSES: Mail written comments (one original and three copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPD–808–P, PO. Box 7517, Baltimore, MD 21244–0517.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201, or

Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

If comments concern information collection or recordkeeping requirements, please address a copy of comments to the following address: Office of Management and Budget, Office of Information and Regulatory Affairs, Room 3206, New Executive Office Building, Washington, DC 20503, Attention: Allison Herron Eydt.

In commenting, please refer to file code BPD–808–P. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW, Washington, DC, on Monday

through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

Comments may also be submitted electronically to the following e-mail address: BPD–808–NC@hcfa.gov. E-mail comments must include the full name and address of the sender and must be submitted to the referenced address in order to be considered. All comments must be incorporated in the e-mail message because we may not be able to access attachments. Electronically submitted comments will be available for public inspection at the Independence Avenue address below.

Copies: To order copies of the **Federal Register** containing this document, send your request to: New Orders, Superintendent of Documents, PO. Box 371954, Pittsburgh, PA 15250–7954. Specify the date of the issue requested and enclose a check or money order payable to the Superintendent of Documents, or enclose your Visa or Master Card number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512–1800 or by faxing to (202) 512–2250. The cost for each copy is $8.00. As an alternative, you can view and photocopy the **Federal Register** document at most libraries designated as Federal Depository Libraries and at many other public and academic libraries throughout the country that receive the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Jackie Gordon, (410) 786–4517.

SUPPLEMENTARY INFORMATION:

I. Background

Section 1861(v)(5) of the Social Security Act (the Act) requires the Secretary to determine the reasonable cost of services furnished to Medicare beneficiaries ''under an arrangement'' with a provider of services, by therapists or other health-related personnel. The Health Care Financing Administration (HCFA) pays the provider directly for these services, rather than paying the therapist or supplying organization. Under section 1861(w)(1) of the Act, this payment discharges the beneficiary from liability to pay for the services. Section 1861(v)(5) of the Act also specifies that the reasonable costs for these services may not exceed an amount equal to the salary that would reasonably have been paid for the services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with a provider or other organization (rather than under such arrangement), plus allowances for certain expenses that may be incurred by the contracting therapy organization in furnishing the services as the Secretary in regulations determines to be appropriate.

These statutory requirements are implemented in existing regulations at 42 CFR 413.106. The regulations apply to the services of physical, occupational, speech, and other therapists and services of other health specialists (other than physicians) furnished under arrangements with a provider of services, a clinic, a rehabilitation agency, or a public health agency. The regulations provide for:

- Hourly salary equivalency amounts comprised of:

—A prevailing hourly salary rate based on the 75th percentile of the range of salaries paid to full-time employee therapists by providers in the geographic area, by type of therapy.

—Fringe benefit and expense factors to take into account fringe benefits generally received by an employee therapist, as well as expenses (such as maintaining an office, insurance, etc.) that a therapist or therapist organization might incur in furnishing services under arrangements.

- A standard travel allowance to recognize time spent in traveling to the provider's site or the patient's home.

- As provided for in existing regulations at § 413.106(e) and explained in section 1412 of the Provider Reimbursement Manual, the following are additional allowances for costs incurred for services furnished by an outside supplier. In addition to the guidelines established for the adjusted hourly salary equivalency amount and the travel allowance, the following costs incurred for services furnished by an outside supplier are recognized, provided the services are properly documented as having been received by the provider.

—Overtime, if an outside supplier utilizes the services of its employees (including the services of aides and assistants) at an individual provider in excess of the provider's standard workweek;

—Administrative and supervisory duties, if an outside supplier provides more than one therapist and at least one therapist spends more than 20 percent of his or her time supervising other therapists and performing administrative duties;

—Depreciable or leased equipment, including maintenance costs of equipment remaining at the provider's site, that the outside supplier uses in furnishing direct services to the provider's patients (may also include equipment that is transported from one provider site to another but excludes equipment owned by the provider);

—Supplies furnished by the supplier for direct patient care (e.g., gases and sprays for respiratory therapy), excluding items such as envelopes, stamps, and typewriters that are reimbursed as overhead expenses and included in the fringe benefit and expense factor;

—Travel expenses, based on 10 times the General Services Administration mileage rate for each day an outside supplier travels to a provider site;

—Aides, who are paid as an add-on based on the wage rate of a comparable employee, such as a nurse's aide (all therapy types use aides); (Because we have received several inquiries regarding continuing to use wages of providers'' nurses aides as the basis for comparison, we welcome comments on other methods for determining guidelines for aides.)

—Assistants, who are paid as a function of the hourly salary equivalency amount at 75 percent of these amounts. (All therapy types use assistants except respiratory therapists.)

The provider must supply the intermediary with documentation that supports these additional costs to the intermediary's satisfaction. These are the only additional costs that will be recognized.

The regulations at 42 CFR 431.106 (b)(5) and (c) also provide for an exemption for limited part-time or intermittent services if the provider required the services of an outside supplier for a particular type of therapy service and the total hours of services performed for the provider, by type of service, average less than 15 hours per week for those weeks in the cost reporting period during which services were furnished by nonemployee therapists. (Travel time is not counted in the computation, even if the actual time is used.) If a provider qualifies for this exemption, the reasonable cost of such services is evaluated on a reasonable rate per unit of service basis, except that payment for these services in the aggregate, during the cost reporting period, may not exceed the amount that would be allowable had the provider purchased these services on a regular part-time basis for an average of 15 hours per week for the number of weeks in which services were furnished. Where the contract provides for a method of payment other than rate per unit of service (e.g., hourly rate or percentage of charges), payment cannot

exceed the guideline adjusted hourly amounts plus other allowable costs, even though the services are performed on a limited or intermittent part-time basis.

In addition, the regulations at § 413.106(f)(1) currently provide for an exception because of a binding contract. An exception may be granted to a provider that entered into a written binding contract with a therapist or contracting organization prior to the date the initial guidelines are published for a particular type of therapy. This exception would not apply to physical and respiratory therapy services furnished under arrangements because we have previously published initial guidelines for these services. Before the exception may be granted, however, the provider must submit the contract to its intermediary, subject to review and approval by the HCFA regional office. This exception may be granted for the contract period, but no longer than 1 year from the date the guidelines for the particular therapy are published. During the period in which a binding contract exception is in effect, the cost of the services will be evaluated under the prudent buyer concept. (Section 1414.1 of the Provider Reimbursement Manual contains instructions on this exception.) This exception does not apply to providers who enter into a contingency contract with a therapist or contracting organization or another provider. In a contingency contract, the provider and contractor agree that if Medicare does not reimburse the provider for the rate that the contract is set at the provider and contractor agree that the contractor will make up the difference. We do not consider a contingency contract a binding contract.

Also, the regulations at § 413.106(f)(2) provide for an exception for unique circumstances or special labor market conditions. An exception may be granted when a provider demonstrates that the costs for therapy services established by the guidelines are inappropriate to a particular provider because of some unique circumstances or special labor market conditions in the area. As explained in section 1414.2 of the Provider Reimbursement Manual, exceptions will be granted only in extraordinary circumstances. Before the exception may be granted, the provider must submit appropriate evidence to its intermediary to substantiate its claim. The provider's request for an exception, together with substantiating documentation, must be submitted to the intermediary each year, no later than 150 days after the close of the provider's cost reporting period. Because providers had been required to submit cost reports to intermediaries no later than 90 days after the close of their cost reporting periods, we had required that the provider's request for an exception, together with substantiating documentation, also be submitted to the intermediary no later than 90 days after the close of its cost reporting period. On June 27, 1995 (60 FR 33137), we changed the due date for submission of cost reports to 150 days after the close of the provider's cost reporting period. Accordingly, as explained under Section II.F. of this preamble, we are proposing to revise the time period for a provider's request for an exception, together with substantiating documentation, to 150 days after the close of its cost reporting period. If the circumstances giving rise to the exception remain unchanged from a prior cost reporting period, however, the provider need only submit evidence to the intermediary 150 days after the close of its cost reporting period to establish that fact.

In order to establish an exception for unique circumstances, the provider must submit evidence to establish that it has some unique method of delivering therapy or other services, which affects its costs, that is different from the other providers in the area. The exception will be effective no earlier than the onset of the unique circumstances.

In order to substantiate an exception for special labor market conditions, the provider must submit evidence enabling the intermediary to establish that the going rate in the area for a particular type of service is higher than the guideline limit and that such services are unavailable at the guideline amounts. It is the duty of the provider to prove to the satisfaction of the intermediary that it has reasonably exhausted all possible sources of this service without success.

The intermediary collects information on the rates that other providers in the area generally pay therapists or other health care specialists. Once this information is collected, the intermediary will determine whether other providers in the area, in comparison to the provider requesting the exception, generally pay therapists or other health care specialists higher rates than the guideline amounts. (As discussed in section II.F.3. of this notice, we specifically invite comments on the exception process.)

Under § 413.106(b)(6), HCFA issues guidelines establishing the hourly salary equivalency amounts in geographical areas for therapy services furnished to Medicare beneficiaries under arrangements. These guidelines apply only to the amount of payment the Medicare program makes to a provider for therapy services obtained under arrangements. The guidelines are not intended to dictate or otherwise interfere in the terms of a contract that a provider may wish to enter into with a therapist or therapist organization. The guidelines do not apply to services furnished by employees of a hospital or employees of other providers. There is also an exception to the guidelines for inpatient hospital services provided by hospitals paid under the prospective payment system or subject to rate of increase limits (§ 413.106(f)(4), in which case the services are evaluated under the Medicare program's reasonable cost provisions as described at § 413.5). However, as explained under section II.F. of this preamble, we are proposing regulations that would provide that the salary equivalency guidelines will apply in situations where compensation, at least in part, to a therapist employed by the provider is based on a fee-for-service or on a percentage of income (or commission). The entire compensation would be subject to the guidelines in cases where the nature of the arrangements are most like an under ''arrangement'' situation, although technically the provider may treat the therapists as employees. The guidelines would be applied in this situation so that an employment relationship is not being used to circumvent the guidelines. The guidelines would apply to skilled nursing facilities (SNFs) providing therapy services under arrangements that elect prospective payment under section 1888(d) of the Act because that prospective payment system only applies to routine and capital services and does not apply to ancillary services which include therapy services.

Section 413.106(d) provides that, prior to the beginning of a period to which a guideline will be applied, HCFA will publish a notice in the **Federal Register** establishing the guideline amounts to be applied to each geographical area by type of therapy. We have issued schedules of salary equivalency guidelines for the reasonable costs of physical therapy services since 1975, and for respiratory therapy services since 1978. On September 30, 1983, we published a final notice (48 FR 44922) that revised the methodology used to establish the schedules, as well as the guidelines themselves. The guidelines continue to apply to physical therapy and respiratory therapy services provided under arrangements, as set forth in § 413.106, with hospitals, home health agencies (HHAs), SNFs, hospital-based HHAs, hospital-based SNFs,

comprehensive outpatient rehabilitation facilities (CORFs), and outpatient rehabilitation providers (ORPs). (Since we are now proposing to issue guidelines for occupational therapists, the guidelines will also apply to community mental health centers that provide occupational therapy services furnished under arrangements.)

The September 30, 1983 final notice provided that, for providers with cost reporting periods beginning after October 1, 1982, the published guidelines would be revised upward by the projected 0.6 percent monthly inflation rate, not compounded. It also provided that, if for any reason we did not publish a new schedule of guidelines to be effective for cost reporting periods beginning on or after October 1, 1983 or did not announce other changes in the existing schedule, the existing guidelines would remain in effect, increased by the projected 0.6 percent monthly inflation rate, not compounded, until a new schedule of guidelines was issued. This monthly inflation rate was based on a Data Resources Incorporated (DRI) forecast of the annual rate of increase in each component of the salary equivalency amounts (that is, salary, fringe benefits, rent, and other expenses), with each component weighted to form a composite rate of increase for the 12-month period ending March 31, 1984.

Since the last schedules of guidelines were issued in 1983, we have received periodic comments on the methodology used to develop the guidelines. Some of the issues raised in these comments concerned limitations in the data available to us on therapists' salaries and other expenses incurred in furnishing services under arrangements with providers. We have received comments that payments for therapy services performed in different provider settings and in urban and rural areas differ and that the guidelines should reflect those differences. Other commenters have expressed concern that the factors used to update the fringe benefits and expense factors are not adequate. In addition, some commenters raised concerns about more technical aspects of the methodology, such as the method used to update the salary equivalency amounts to account for inflation. We address all these concerns in this proposed rule.

We have never issued schedules of salary equivalency guidelines for speech language pathology and occupational therapy services provided under arrangements even though section 1861(v)(5) of the Act explicitly authorizes the Secretary to do so. Currently, payment for these services is based on reasonable cost. However, we are aware that without introducing guidelines for contracted speech-language pathology and occupational therapy services, the Medicare program could be paying for costs that are unreasonable and in excess of what Congress intended under section 1861(v)(5) of the Act. In fact, as evidence of this, the General Accounting Office (GAO) Report, ''Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy In Nursing Homes'' (GAO/HEHS–95–23, March 1995) also found that nursing homes may be claiming substantial amounts of unallowable or unreasonable costs, or both, for therapy services provided to Medicare beneficiaries. The GAO recommended ways that HCFA could curb Medicare losses on payments for rehabilitation therapies provided to nursing home residents. GAO concluded that, without salary equivalency guidelines for all therapy services provided under arrangements to nursing homes, Medicare has little control over payments to providers. In response to GAO's recommendations, we indicated that, until guidelines were developed for all therapy services, providers' therapy costs were subject to the test of reasonableness as required by regulations at 42 CFR 413.9. We also indicated that we were working on developing revised salary equivalency guidelines for physical therapy and respiratory services and developing guidelines for speech-language pathology and occupational therapy services.

II. Provisions of the Proposed Rule

In this proposed rule, we would revise the methodology for establishing the schedules for the maximum payment for physical therapy and respiratory therapy services. We propose to revise the determination of reasonable cost for physical therapy and respiratory therapy furnished under arrangements by an outside contractor by rebasing the guideline amounts.

We also propose to establish salary equivalency guidelines for speech language pathology and occupational therapy services furnished under arrangements by an outside contractor using the same methodology we propose to use for determining reasonable cost for physical therapy and respiratory therapy services.

In addition, we are proposing to: (1) Eliminate the exception to the salary equivalency guidelines for a provider that entered into a written binding contract with a therapist or contracting organization prior to the date the initial guidelines are published; (2) apply the salary equivalency guidelines in situations where compensation, at least in part, to a therapist employed by the provider is based on a fee-for-service or on a percentage of income (or commission). (Section II.F. of this preamble contains a detailed discussion of these proposals and other proposals we're seeking comments on.)

A. Data Sources for Schedules

In all previously issued salary equivalency guideline notices, we have used the Bureau of Labor Statistics (BLS) hospital and nursing home industry wage survey data as our sole source in accordance with the Senate Committee on Finance recommendation (S. Rept. No. 1230, 92nd Cong., 2nd Sess. 251 (1972)). Specifically, the Committee recommended that, to the extent feasible, timely and accurate salary data compiled by BLS on the 75th percentile of salaries should be used in determining the prevailing salary amounts. However, in this proposed rule we have decided not to use the BLS data as our sole, or even as our primary source for developing the guidelines. We have a number of reasons for this decision.

First, BLS issued its last hospital industry wage surveys in 1989 and 1991 and has discontinued conducting its survey of hospital wages. Accordingly, even if we had chosen to use BLS survey data as our primary source for this proposed rule, we would have needed to investigate other therapy survey data sources for use in future guidelines. In addition, although, the BLS survey data continue to meet the rigorous publication standards of BLS and provide the only national data that we are aware of for wages by occupation that are statistically reliable, questions have been raised as to whether the BLS data meet the Senate Committee on Finance's recommendation on timeliness. We have taken this concern into consideration in this proposed rule. Furthermore, the BLS hospital industry wage surveys of 1989 and 1991 include only hospital data. (The last BLS nursing home industry wage survey was performed in 1985.) We believe it is reasonable to include data on combined hospital and SNF wages in the determination of the guidelines as was done previously because therapy wage levels are primarily determined in occupational labor markets, not industry labor markets. (We also needed to review the SNF therapy data so that we could determine the wage levels in SNFs holding all other factors (including local labor market conditions and working conditions) constant.

For the above reasons we determined that we would not use the BLS survey as the sole source of data for determining the guidelines. We, therefore, decided to seek other survey data sources of hospital and SNF industry specific occupational wage information. Regulations at 42 CFR 413.106(b)(6) provide that the guidelines may be derived from other statistically valid survey data, in lieu of HCFA guidelines, provided that the study designs, questionnaires, and instructions, as well as the resultant survey data, are submitted to and approved in advance by HCFA. Beginning in 1994, we solicited the therapy industry for such statistically valid survey data. The therapy industry had long held that nursing home wages for therapists were higher than hospital wages for therapists because it was more difficult to hire and retain therapists in nursing homes. However, other individuals with experience in the therapy industry have indicated that some therapists prefer working in nursing homes for the following reasons: Preference for working with elderly; location of SNF closer to home; more opportunities for physical therapy work in SNF; and working flexible hours. The therapy industry initially provided us data in 1995, but after our analysis we found the data to be inadequate for use at the regional or national level for several reasons: The sample was not representative; the data were not documented or audited; and primarily large firms paid under contract to the SNF were surveyed.

In March 1996, the National Association for the Support of Long Term Care (NASL), representing portions of the therapy industry, submitted an October 1995 sample survey of salaried therapists in hospitals and nursing homes to HCFA, as allowed under our regulations. This survey did not meet the requirements of the regulations at § 413.106(b)(6), since the survey design, questionnaires, and instructions were not approved by HCFA prior to the start of the survey. Nevertheless, the survey did provide data that were current in SNFs and hospitals. We, therefore, conducted a special analysis of this NASL survey data, including a limited audit of the survey records. Based on this analysis and limited audit, we determined that the survey was not adequate as a sole or primary source of data in determining the guidelines, but could be useful in combination with other data sources. There were several reasons for this determination:

- The data were not audited or certified by an independent party. We were permitted to conduct an audit of the survey records only under stringent restrictions designed to protect the confidentiality of the survey respondents. Those restrictions made it impossible for us to verify the survey results. For example, we were unable to compare submitted survey data with data from other sources.
- The verification survey, conducted to determine the reliability of data submitted by mail, did not appear to be adequate. Only five providers were included in the verification survey. Specifically, we were not satisfied that the verification sample was either sufficiently large or adequately representative.
- The survey is not sufficiently representative. There were variable response rates for hospitals and SNFs. The response rate for hospitals was 10.8 percent and the response rate for SNFs was 29.9 percent. In addition, the sample seemed to include an overrepresentation of large hospitals and chain-affiliated SNFs.

Because there is an underrepresentation of small hospitals and non-chain SNFs in the NASL survey, we cannot be assured with this small response rate that the large hospitals and chain-affiliated SNFs will adequately represent the small hospitals and non-chain SNFs not included in the survey. (The GAO stated in its report, ''Medicare Early Resolution of Overcharges for Therapy in Nursing Homes is Unlikely'', August 16, 1996, p. 7, regarding the NASL survey data, ''However, the survey response rate was low (10 percent for hospitals and 30 percent for SNFs), which raises questions about how representative the data are.'' In a footnote on that page, GAO points out, ''Official government surveys generate a much higher response rate. The BLS White Collar Pay Survey (one component of which was the hospital salary data survey on which the draft guidelines were based) had an overall response rate of 82 percent. Typically, BLS response rates exceed 80 percent).''

- Despite requests for the raw unedited data file, the file was not provided to us.
- We have questions about the validity of certain edits.
- We were also concerned that supervisory time and compensation in lieu of benefits were not consistently reported. Additionally, we were concerned that the supervisory time included in the NASL survey was above a certain threshold that we use in developing the guidelines.

As we analyzed the NASL survey data, which as discussed above, was submitted for the purpose of being used to develop the guideline amounts, we also studied several other surveys of hospitals and nursing homes, each of which are more recent than the BLS surveys, although none was specifically submitted to be used in developing the guidelines.

We analyzed five additional data sources for hospital wage rates and two for freestanding SNF wage rates. The additional hospital data sources examined were: the University of Texas National Hospital Survey (1994 National Survey of Hospital and Medical School Salaries, University of Texas Medical Branch, Galveston, TX, 1994, pp. 15–19); the American Rehabilitation Association (ARA) Surveys of Freestanding Hospitals and of Rehabilitation Units (1995 Salary Survey, American Rehabilitation Association, pp. 53–59 and 94–101); the Maryland Health Services Cost Review Commission's census of hospitals; the American Health Care Association's (AHCA) report that includes hospital data profile (1994 AHCA Survey, Sec. 1, p. 10, Buck Associates); and the NASL 1995 survey of hospitals. For SNFs, we analyzed data from the 1995 NASL survey of SNFs, the January 1995 AHCA survey of SNFs (1995 AHCA Survey, Sec. 3, p. 3, Buck Associates), and the 1996 survey of SNFs by Mutual of Omaha, a Medicare intermediary. Several of these data sources had regional wage levels. We drew the following conclusions about the merits of these data sources for our purposes in determining appropriate therapy salary guidelines (that is, not in relation to the original purposes of the surveys):

- The University of Texas National Hospital Survey data are from October 1994. This annual voluntary hospital survey was conducted for many years for hospitals in various regions of the country to use to benchmark regional wage levels for specific health professional occupations. While there are data from all regions of the United States, the survey was not designed to be representative or statistically valid at the regional level. It appears to give fairly reasonable levels at the national level.
- The American Health Care Association's report includes data on both hospitals and SNFs. The SNF data for January 1995 are both current and industry-specific. The data for SNFs, however, are unevenly edited and appear to include some supervisors and additional salary in lieu of benefits. The sample is heavily weighted by large chains that are members of the Association. The SNF data appear as both employee-weighted and facility-

weighted averages, and do not permit computation of accurate median and 75th percentile levels.

- The Maryland Health Services Cost Review Commission conducts a census of all Maryland hospitals yearly. We analyzed data from the 1995 census. While this is a complete census covering over 50 hospitals, it is for Maryland only. In addition, speech-language pathologists are not included as a separate occupational category.
- The American Rehabilitation Association's survey of its members and prospective members collected July 1994 data. The response rate was low, and the Association indicated in its report that these data cannot be presumed to represent the full population of rehabilitation facilities. No information on SNFs was reported due to an inadequate sample. This survey appears to give reasonable wage levels at the national level when compared to other data sources.
- Mutual of Omaha conducted a 1995 survey of 2,000 SNF Medicare providers that it services. The data are current and industry-specific, but include only information on occupational therapists and speech language pathologists. The survey was national in scope. Although the survey's response rate was very high, only a small percentage of records contained information on wage rates for full-time employed therapists.

Our conclusion from this analysis was that none of the available data sources met the statistical validity criteria recommended in the Senate Committee on Finance Report and specified in the regulations sufficiently well to serve as the sole or even primary source of data for establishing the guidelines. Based on this examination, we determined that a different approach was necessary. As we examined all these potential data sources, we found that mean wage levels at the national level for the most part clustered when adjustments were made for definitional differences. This observation suggested to us that, while no one of the data sources was adequate as a sole or primary source of data for establishing the guidelines, employing all these sources together could provide a useful and valid basis for the guidelines to be used by intermediaries determining the maximum allowable cost of therapy services furnished under arrangements. Therefore, we concluded that we could blend data from the several sources to develop a national ''best estimate'' of prevailing salary levels as the basis for the guidelines. Under this approach, we give weight to each data source, but preferential status to none. None of the data sources or the average of all of the sources could provide regional variations. A new method would have to be used for regional variations.

In an occupational market, wage levels across settings for the same occupation should bear rational relationships in competitive labor markets when adjustments are made for compensating differentials for fringe benefits, working conditions, risk of injury, and geographic areas. This implies that therapists working in hospital and SNF settings can migrate between practice settings with relatively little difficulty. Because of the ease of mobility, labor market forces that affect one therapist practice setting also influence other practice settings. This is not to say that therapists' practice activities in all settings are exactly the same. In setting the guideline amounts, we acknowledged that, because of the ease of mobility of licensed therapy workers across settings, a salary equivalency rate that is too high could put upward pressure on the wages paid to therapists in the larger hospital sector. Similarly, a rate that is too low could make it difficult for providers subject to the guidelines to attract therapists from the hospital setting.

We have decided, for the reasons discussed, not to use the NASL industry survey as the sole or primary data source for setting the guidelines. However, we do believe that it has sufficient strength to include its data along with data from the other sources in a blend as the basis for the salary equivalency guidelines. We have used a blend of hospital and SNF therapist wages in the past to reflect occupational markets and the associated mobility between the two settings. We had considered at one point including a differential between therapist wages in hospitals and nursing homes in the guideline amounts. We reconsidered when we looked across all of the other data sources which included all provider types. We noted clustering of wage levels across provider types that made such a differential inappropriate for occupational labor markets when adjustments are made for locality. We believe that proposing to use the 75th percentile of blended hospital and SNF wage data (weighted by relative employment levels in hospitals and SNFs) to measure the occupational market for therapy services is equitable. Our new approach in which all appropriate data sources were used but adjusted for the mix of SNF and hospital therapy employees will, therefore, provide a buffer for costs that SNFs and other providers may incur in furnishing therapy services to Medicare beneficiaries. We invite comments on this methodology, which is described in more detail in section II.B. of this preamble.

We could not use Medicare cost report information for wage rates because the cost reports for SNFs and other providers do not have hourly wage rates for employees. The cost reports do provide aggregate salaries of employees and costs other than salaries that would include contract labor cost. However, they do not provide the hours worked either by staff or contractors, except for contracted physical and respiratory therapy services for which we have developed salary equivalency guidelines for the services and do require hourly time records.

We did use 1994 Medicare predominantly settled cost report data for prospective payment systems (PPS) hospitals to obtain fringe benefit information. We used Worksheet S–3, Part II from form HCFA–2552. These data are used to adjust the labor portion of hospital payments under the PPS. We believe their use is also appropriate here. We use the 1994 Medicare predominantly settled cost report data, because this is the same data that HCFA used for its wage index update for prospective payment system hospitals for FY 1997. This is the most recent Medicare predominantly settled cost report data that has undergone special scrutiny for the purpose of wage survey data. Moreover, BLS Employment Cost Index information for March 1994 show that fringe benefits in hospitals and SNFs are similar for professional and technical workers.

B. Methodology

In order to determine the hourly salary equivalency amounts, we determined the ''best estimate'' of wages for both hospitals and SNFs. We first found mean wage rates for each of the data sources listed above.

BLS surveyed average hourly earnings (AHE) for all four therapies in 1989. However, their January 1991 survey included the average hourly earnings only for full-time physical and respiratory therapists. (BLS January 1991 average hourly earnings for full-time physical and respiratory therapists were found in the BLS Occupational Wage Survey: Hospitals, January 1991, pp. 36–119. The hospitals in this survey employed 50 or more workers.) We, therefore, needed to estimate 1991 average hourly wages for speech language pathology and occupational therapy. To do so, we started with the BLS 1989 survey of all four therapies as a baseline (BLS Industry Wage Survey: Hospitals, March 1989 (the latest previous survey), pp 33–118). The

hospitals in the 1989 survey employed 100 or more workers. Our analysis of the University of Texas data for U.S. hospitals indicated that the wages for speech language pathology and respiratory therapy increased at a similar rate between 1989 and 1993. Wages for occupational therapy and physical therapy also increased at a similar rate during that period. Therefore, we determined that we could employ the 1989 ratios of speech language pathology to respiratory therapy, and of occupational therapy to physical therapy, in order to estimate 1991 wage levels for speech language pathology and occupational therapy. Specifically, multiplying the ratio of 1989 average hourly occupational therapy wages to 1989 average hourly physical therapy wages by 1991 physical therapy wages yielded estimated 1991 occupational therapy wages. The following formula summarizes the computation (all values are average hourly wages):

[(March 1989 AHE, OT)/(March 1989 AHE, PT)] × (January 1991 AHE, PT)=(estimated January 1991 AHE, OT).

Similarly, multiplying the ratio of 1989 average hourly speech language pathology wages to 1989 average hourly respiratory therapy wages by the 1991 average hourly respiratory therapy wages yielded estimated 1991 average hourly speech language pathology wages. Again, the following formula summarizes the computation (all values are average hourly wages):

[(March 1989 AHE, SLP)/(March 1989 AHE, RT)] × (January 1991 AHE, RT)=estimated January 1991 AHE, SLP.

The American Health Care Association data provided facility-weighted mean wage rates for SNFs. The Association has estimated that 5 percent of the SNF wage rates represented supervisors and additional wages paid in lieu of fringe benefits. We used that estimate to reduce the Association survey wage data to a nonsupervisory, no additional salary in lieu of benefits basis.

We converted annual data in the American Rehabilitation Association and University of Texas surveys to hourly wages using a divisor of 2080 hours, which represents a standard work year.

The Maryland Health Services Cost Review Commission census data provided wage data, paid hours, and numbers of personnel for each hospital. We eliminated data for employees who worked less than 35 hours or more than 40 hours a week to restrict the computation to full-time employees only. We then determined the average hourly wage for each hospital by dividing aggregate wages by the number of paid hours. Finally, we computed the average hourly wages across all hospitals, weighted by the number of employees in each hospital.

NASL data were first divided by 52 to arrive at weekly salary, then divided by the number of hours worked per week which were also given in the survey, to obtain hourly wage rates. As in the case of the Maryland census data, we eliminated data for employees who worked less than 35 hours, or more than 40 hours, a week to restrict the computation to full-time employees only.

We trended all data forward to the fourth quarter of 1995, the base period for the NASL survey. For data from the University of Texas, the American Rehabilitation Association, the American Health Care Association, and the Maryland Commission census (all sources with 1994 or 1995 bases), we trended these data using average hourly earnings for hospital workers published in the BLS Current Employment Statistics' Survey, Standard Industrial Code 806 (Hospitals). To update the BLS survey data from 1991, we derived rates of increase for the period from January 1991 through January 1994 (the period which predates the other data sources, which were surveyed in 1994–1996) based 50 percent on American Hospital Association Panel wage data and 50 percent on the average hourly earnings for hospital workers published in the BLS Current Employment Statistics Survey, Standard Industrial Code 806 (Hospitals).

For the period from January 1994 through October 1995, we used only the BLS Current Employment Statistics Survey as the basis for the rate of increase in the BLS survey data (as we did for the other data sources, which date from that period). The American Hospital Association data had a higher rate of increase during the 1991–1993 period than the BLS data, resulting in cumulating 1995 therapist wage levels that reflect current market conditions in 1995.

After all data were trended to fourth quarter 1995, we determined the salary equivalency guideline amounts for April 1997 in five steps. Those five steps were: (1) Determine average wages by therapy type, separately for hospitals and nursing homes; (2) blend the hospital and nursing home average wages by therapy type, to yield average wages by therapy type for the four occupational markets; (3) approximate the 75th percentile of wages by therapy type; (4) calculate salary equivalency guideline levels for fourth quarter 1995, by adding amounts for fringe benefits, rent, etc.; and (5) update these guideline amounts to April 1997, the proposed effective date.

In the first step, we determined the mean wage levels, by therapy type, for hospitals in each of the available data sources. (Data sources used for hospitals were: BLS, Industry Wage Survey: Hospitals, March 1989 and Occupational Wage Survey: Hospitals, January 199l; University of Texas National Hospital Survey 1994 National Survey of Hospital and Medical School Salaries; American Rehabilitation Association's surveys of freestanding hospitals and of rehabilitation units, 1995 Salary Survey; Maryland Health Services Cost Review Commission's census of hospitals; American Health Care Association hospital report's data profile, 1994 AHCA Survey; and NASL 1995 survey of hospitals.) We similarly determined the mean wage levels, by therapy type, for nursing homes in each of the available data sources. (Data sources used for SNFs were: 1995 NASL survey of SNFs; American Health Care Association survey of SNFs, 1995 AHCA Survey; and the 1996 survey of SNFs by Mutual of Omaha.) We then averaged the mean wage levels from the available data sources by therapy type, separately for hospitals and nursing homes.

In the second step, we blended the hospital and nursing home average wage levels by therapy, to yield average wage levels by therapist type across the four occupational markets. We employed a blending process used in the previous salary equivalency guidelines notice (48 FR 44922, September 30, 1983), to weight the occupational averages by relative employment levels in hospitals and nursing homes, respectively. To establish appropriate weights, we used employment of therapists in nursing homes (SIC 805) and in hospitals (SIC 806), as found in the BLS Occupational Employment Statistics Survey. (The most recent available survey of employment in nursing homes is for 1993, while the most recent survey data of employment in hospitals is for 1995.) We applied these weights to the mean hospital and SNF wage rates by the four therapist types, as determined in the first step. The BLS Occupational Employment Statistics Survey shows that the hospital industry is a major employer of therapists of all types, while SNFs employ fewer salaried therapists. The weights for hospitals and nursing homes, respectively, are: For physical therapy, 85 percent and 15 percent; for occupational therapy, 85 percent and 15 percent; for speech language pathology, 82 percent and 18

percent; and for respiratory therapy, 99 percent and 1 percent.

In the third step we approximated the 75th percentile of the blended wage rates for each therapy occupation. It was necessary to approximate the 75th percentile because, unlike our previous computations of the guidelines, in this proposal we could not determine percentile values directly from each of the sources. We have observed in the BLS data and a regression analysis we performed on NASL data that the 75th percentile was approximately 110 percent of the mean. We, therefore, increased each of the four blended wage averages by 10 percent to approximate the 75th percentile of wages in each discipline across the occupational market.

Salary equivalency guidelines are based on the therapists' time in the facility. Adjustments to average hourly earnings data were necessary to include a reasonable allowance for vacation, sick leave, and administrative time. In order to convert the average hourly earnings from an hours paid basis to an hours worked basis, we applied a factor of 2080/1808 to the average hourly earnings determined thus far, which is the same methodology used in the previous notice. The 1808 figure was computed based on 2080 hours (40 hours/week × 52 weeks; a standard work year) less 15 vacation days, 10 sick leave days and 9 holidays equal to 34 days, or 272 hours. Data on leave benefits come from the BLS Employee Benefits Survey. (U.S. Department of Labor, Bureau of Labor Statistics: Employee Benefits in Small Private Establishments, 1992, Bulletin 2441, U.S. Government Printing Office, May 1994, pp. 10–20.)

In the fourth step we added fringe benefit and expense factors to the prevailing salary rates determined for each therapy type. The fringe benefit and expense factors are intended to recognize fringe benefits that are received by an employee therapist, as well as overhead expenses that a therapist or therapist organization might incur in furnishing services under arrangements. These factors are expressed as percentages of the prevailing hourly rate and are applied to every hour of service furnished at the provider site. Fringe benefits may include vacation and sick pay, insurance premiums, pension payments, allowance for job-related training, meals, severance pay, bonuses, etc.

We computed fringe benefits as a percent of total compensation using fiscal year 1994 Medicare cost reports for hospitals under the prospective payment system. We used the Medicare cost reports for prospective payment system hospitals to obtain fringe benefit information because these data are carefully scrutinized; they are used to adjust the labor portion of hospital payments under the prospective payment system. We believe these data are the best proxy for therapist fringe benefit information, which is not available for SNFs. Also, the BLS Employment Cost Index for March 1994 showed that fringe benefits for professional and technical workers in hospitals and nursing homes were similar. The fringe benefit component is about 14 percent of the total salary equivalency amount.

The expense component takes into account expenses a therapist or therapist organization might have, such as maintaining an office, purchasing insurance, etc. We based the expense component of the guidelines on an estimate of the costs of maintaining a therapy services office. The general methodology for computing the expense component is similar to that used in the 1983 notice (48 FR 44922, September 30, 1983) but the factors have been revised. This component has rental and non-rental portions.

To determine the rental portion of the expense component, we used the 1991 rental income data (updated to fourth quarter 1995 using Consumer Price Index (CPI) rental data) compiled by the Building Owners and Managers Association International (BOMA) and published in the 1992 BOMA Experience Exchange Report for Downtown and Suburban Office Buildings. (Building Owners and Managers Association International: 1992 BOMA Experience Exchange Report, Washington, DC, 1992, p. 27.) BOMA reported a national rent average, excluding utility cost, of $16.87 per square foot per year. We applied an occupancy factor of .971 to take into account the space used for rental building hallways, elevators, etc., that are included in the BOMA rent figure but that are not part of the area rented for an office. We then added the BOMA utilities cost of $1.92 per square foot. We determined total rental cost assuming a rental area of 250 square feet, the same rental area used in prior schedules of guidelines. Total 1991 rental cost was divided by 1808 (the hours factor applied to average hourly earnings) to compute rental cost per hour worked in 1991.

The expense component includes costs of maintaining an office, such as wages and salaries of administrative and clerical help, insurance, telephones, etc. We believe that Medicare should only pay for services at their reasonable cost. We estimated this component, including rent, to be reasonable at 30 percent of total expenses in 1991. We based our 30 percent estimate of total expenses on informal discussion with the rehabilitation industry. We request comments on whether this is a reasonable estimate. This component had previously been lower because it was based on a single person maintaining an office out of a home as opposed to the costs of maintaining a business. The 1991 rent per square foot amount and the other expenses amount were constant across the four therapy types, although the weights of these factors vary by therapy type (the weight for rent is lowest for physical therapy and highest for respiratory therapy).

The dollar amount for 1991 rent per hour was trended to fourth quarter 1995, using the proxy selected for rent, the CPI-U for Housing, published by BLS. The 1991 dollar amounts for the remainder of the other expenses factor were trended to October 1995, using their selected proxies. This was done for each of the four therapy types. The expense factor, including rent, is about 28 percent of the total salary equivalency amount.

Using the 1994 Medicare cost reports allows us to recognize that the relative values of certain factors, such as fringe benefits, have increased more than the relative values of other factors such as rent or wages and salaries. For instance, if the January 1991 values of the proxies for office rent and clerical worker fringe benefits are assumed to be equal to 1.0, then the fourth quarter 1995 values of these two proxies are 1.131 for rent and 1.249 for clerical worker fringe benefits. The values of these proxies have increased by different percentages.

We summed the fourth quarter 1995 dollar values of the ''blended'' wages, fringe benefits, rent, and the remainder of the other expenses factors to obtain salary equivalency guideline amounts for fourth quarter 1995. We updated the resultant fourth quarter 1995 salary equivalency guideline amounts to April 1997, using a DRI/McGraw-Hill 1996:3 forecast. The April 1997 national guidelines below are based on the amounts determined above:

Physical Therapy	$48.78
Occupational Therapy	46.27
Speech Language Pathology	44.51
Respiratory Therapy	38.51

In previous schedules, statewide therapy guideline amounts were calculated from the wage data for 22 Metropolitan Statistical Areas (MSAs) provided by the BLS survey. We averaged prevailing hourly rates for the surveyed MSAs within each State to

determine that State's therapy rate. We also grouped contiguous states into regions and used an average of the surveyed MSA wage rates from the region in order to determine the rate for States with no MSAs in the BLS survey. As we acknowledged in the notice of the last schedule (48 FR 44923), this method has two major shortcomings. First, where BLS conducted more than one survey in a given State, such as New York, providers located in the surveyed MSAs were subject to the State rate even though actual salary data were available for those MSAs. Secondly, direct application of individual MSA prevailing rates (or an average of MSA rates) to establish guidelines is relatively insensitive to geographic variations in wage rates.

Commenters on the existing guidelines have suggested that the guidelines should both account more fully for local cost variation, and more accurately reflect the different therapy service costs in urban and rural regions. In addition, commenters have cautioned us to avoid any methodology which would create unreasonable differences between adjoining geographical regions. In developing these proposed guidelines, we have reconsidered how to account for local cost variations in the light of those comments. Two other long-term care Medicare benefit programs, SNF care and home health care, use the prospective payment system hospital wage index to adjust for local area variations in labor-related costs. We have decided to employ a modified version of the prospective payment system hospital wage index as the best available method for taking local cost variation into account. Specifically, we propose to employ the pre-reclassified hospital wage index in order to establish the therapy guideline amounts for urban areas. (We use the pre-reclassified wage index because reclassifications apply to hospitals under the prospective payment system only.) For the rural areas of each State, we propose to use a weighted average of the wage index values for the urban areas of the State. This modified geographic adjustment index accounts for two salient features of the geographical variation in therapy costs. First, within MSAs there is an association between therapist hourly salary and fringe benefit rates and overall hospital hourly salary and fringe benefit rates, because nursing facilities compete in the same labor market areas as hospitals and other health care providers such as home health agencies. In addition, the therapy market for rural (non-MSA) areas tends to reflect the prevailing compensation conditions of the urban areas in the region.

In order to determine the geographic adjustment for the rural areas, it is first necessary to determine a weighted average of the wage index values for the urban areas. We determined the weighted average of the geographic adjustment index values for the MSAs in each State by the following method. We began with the pre-reclassified hospital wage index, based on the fiscal year 1993 Hospital Cost Report Information System (HCRIS) data set of hospitals under the prospective payment system, for each MSA. (This is the same data used as the basis for the hospital wage index effective for hospitals on October 1, 1996 (that is, fiscal year 1997)). For each MSA, we then obtained the number of total adjusted hours worked in prospective payment system hospitals from the fiscal 1993 HCRIS data set. We applied two edits to this data. We excluded all hospital cost reports that showed adjusted hourly compensation outside of three standard deviations of the mean of the distribution in order to eliminate erroneous reports. We also excluded all cost reports from rural areas. A total of 2,837 hospitals under the prospective payment system satisfied these edits. After obtaining the number of hours worked in each MSA, we added hours from MSAs in each State to determine the total number of hours worked in the State. For MSAs that cover more than one State, we used only the hours from hospitals inside a State boundary for determining the total hours worked in the State. Once we determined the total hours worked in the State, the ratio of hours worked in an MSA to total state hours provided the weight for each MSA. We then multiplied each MSA's pre-reclassified hospital wage index by the weight for the MSA, and added the results to produce the geographic adjustment index for the non-MSA (rural) areas of the State.

Finally, we normalized the index values to the national average so that an area with an average geographic adjustment equal to the national average would have a geographic adjustment index of 1.0. We first computed a national area geographic adjustment index by calculating the ratio of hospital hours worked in each MSA to national hospital hours worked, multiplying this ratio by each MSA's geographic adjustment index, and adding the results. We then divided this national geographic adjustment index into the area geographic adjustment index for each region to produce the normalized therapist geographic adjustment index.

The results of these calculations are shown in Tables I and II. Table I shows the geographic adjustment index values and hourly salary equivalency amounts for each of the 318 MSAs in the 50 States and Puerto Rico. Table II lists geographic adjustment index values and hourly salary equivalency upper limits for the rural (that is, non-MSA) areas of each State and Puerto Rico.

In this proposed rule, we computed the nonurban geographic adjustment index for a State as a weighted-average index, using hospital hours for each MSA in the State as the weights. We are considering computing the nonurban geographic adjustment index by an alternative method. We are soliciting comments on alternative methods for determining the nonurban geographic adjustment index under these guidelines.

C. Specific Number of Schedules

We are proposing one schedule of guidelines for respiratory therapists, in contrast to the three schedules in the notice of September 30, 1983. This decision is based on the fact that HCFA does not differentiate in covering respiratory therapists by different levels. Therefore, to make coverage conform with payment for respiratory therapy services, we are proposing one schedule for respiratory therapists. Information from fiscal intermediaries and the American Association for Respiratory Care indicates that industry practice is to use only one schedule. Also, in the BLS 1989 Hospital Wage Industry Survey, there were four different wage classes and a summary (weighted average) wage level for respiratory therapists. Only class III and the summary level were reported for all 18 MSAs surveyed. For respiratory therapists in 1991, there were two wage classes and a summary wage level shown. Although the summary level occupational definitions were comparable from 1989 to 1991, occupational definitions for basic classes changed between surveys. The summary level was the consistent category—present for all MSAs in both surveys and encompassing all nonsupervisory levels of responsibility for both surveys. We propose to continue to have one schedule of guidelines for physical therapists. Likewise, we propose to establish one schedule of guidelines for speech language pathologists and one for occupational therapists.

The standard travel allowance is 50 percent of the salary equivalency amount. It is longstanding policy that has been used in all of the previous guideline notices. For example, the

proposed standard travel allowance amount for physical therapists in Bangor, Maine would be determined as follows:

Bangor, Maine hourly salary equivalency amount	$46.60
Standard travel allowance	×. 50

Section II.B reflects the proposed changes for computing the salary component and fringe benefit expense factors.

The salary equivalency amount is made up of a salary component and fringe benefit and expense factors, while the travel allowance, which is an additional allowance, reflects payment for the therapist's time spent in traveling to the provider site or to the patient's home. We are proposing changes in the methodology for computing the salary component and fringe benefit and expense factors. Although we are not proposing to change the current methodology with respect to the standard travel allowance in this proposed rule, we are seeking public comment on an optional travel allowance methodology for use when therapy services are furnished in areas in which geographic distance creates unique labor markets as discussed in section II.F.1 of this notice.

The schedules of guidelines that follow (Tables I and II) are based on the projected amounts, while the standard travel allowance is 50 percent of the guideline amount for each therapy type.

D. Tables of Guidelines and Geographic Adjustment Indexes

The salary equivalency guideline amounts for each therapy type are calculated in three steps: (1) Multiplication of the labor-related share (83.379 percent of the composite weight) by the geographic adjustment index and by the national salary equivalency rate for the therapist type; (2) multiplication of the non-labor related share (16.621 percent of the composite weight) by the national salary equivalency rate for the therapist type; and (3) summation of the results from steps 1 and 2. The salary equivalency guideline amounts for each therapy type computed by this method are presented in Tables I and II.

TABLE I.—GEOGRAPHIC ADJUSTMENT INDEX AND SALARY EQUIVALENCY UPPER GUIDELINE FOR URBAN AREAS

	Urban area (constituent counties or county equivalents)	Index	Physical therapy	Occupational therapy	Speech language pathology	Respiratory therapy
0040	Abilene, TX, Taylor, TX	0.8112	41.10	38.99	37.50	32.45
0060	Aguadilla, PR, Aguada, PR, Aguadilla, PR, Moca, PR [1]	0.4271	26.29	24.94	23.99	20.75
0080	Akron, OH, Portage, OH, Summit, OH	0.9931	48.50	46.00	44.25	38.29
0120	Albany, GA, Dougherty, GA, Lee, GA	0.8665	43.35	41.12	39.56	34.22
0160	Albany-Schenectady-Troy, NY, Albany, NY, Montgomery, NY, Rensselaer, NY, Saratoga, NY, Schenectady, NY, Schoharie, NY	0.8692	43.46	41.22	39.66	34.31
0200	Albuquerque, NM, Bernalillo, NM, Sandoval, NM, Valencia, NM	0.9418	46.41	44.02	42.35	36.64
0220	Alexandria, LA, Rapides, LA	0.8183	41.39	39.26	37.77	32.68
0240	Allentown-Bethlehem-Easton, PA, Carbon, PA, Lehigh, PA, Northampton, PA	1.0071	49.07	46.54	44.77	38.74
0280	Altoona, PA, Blair, PA	0.9585	47.09	44.67	42.97	37.18
0320	Amarillo, TX, Potter, TX, Randall, TX	0.8799	43.90	41.64	40.05	34.65
0380	Anchorage, AK, Anchorage, AK [1]	1.3329	64.35	61.04	58.71	50.80
0440	Ann Arbor, MI, Lenawee, MI, Livingston, MI, Washtenaw, MI	1.1754	55.91	53.04	51.02	44.14
0450	Anniston, AL, Calhoun, AL	0.8087	41.00	38.89	37.41	32.37
0460	Appleton-Oshkosh-Neenah, WI, Calumet, WI, Outagamie, WI, Winnebago, WI	0.8960	44.55	42.26	40.65	35.17
0470	Arecibo, PR, Arecibo, PR, Camuy, PR, Hatillo, PR [1]	0.4432	26.94	25.56	24.59	21.27
0480	Asheville, NC, Buncombe, NC, Madison, NC	0.9408	46.37	43.99	42.31	36.61
0500	Athens, GA, Clarke, GA, Madison, GA, Oconee, GA	0.9482	46.67	44.27	42.59	36.85
0520	Atlanta, GA, Barrow, GA, Bartow, GA, Carroll, GA, Cherokee, GA, Clayton, GA, Cobb, GA, Coweta, GA, DeKalb, GA, Douglas, GA, Fayette, GA, Forsyth, GA, Fulton, GA, Gwinnett, GA, Henry, GA, Newton, GA, Paulding, GA, Pickens, GA, Rockdale, GA, Spalding, GA, Walton, GA*	1.0112	49.24	46.70	44.93	38.87
0560	Atlantic City-Cape May, NJ, Atlantic City, NJ, Cape May, NJ	1.1165	53.52	50.76	48.83	42.25
0600	Augusta-Aiken, GA-SC, Columbia, GA, McDuffie, GA, Richmond, GA, Aiken, SC, Edgefield, SC	0.8906	44.33	42.05	40.45	35.00
0640	Austin-San Marcos, TX, Bastrop, TX, Caldwell, TX, Hays, TX, Travis, TX, Williamson, TX	0.9327	46.04	43.67	42.01	36.35
0680	Bakersfield, CA, Kern, CA	1.0270	49.88	47.31	45.51	39.38
0720	*Baltimore, MD, Anne Arundel, MD, Baltimore, MD, Baltimore City, MD, Carroll, MD, Harford, MD, Howard, MD, Queen Annes, MD	0.9876	48.28	45.79	44.05	38.11
0733	Bangor, ME, Penobscot, ME	0.9465	46.60	44.21	42.52	36.79
0743	Barnstable-Yarmouth, MA, Barnstable, MA	1.3759	64.07	60.77	58.46	50.58
0760	Baton Rouge, LA, Ascension, LA, East Baton Rouge, LA, Livingston, LA, West Baton Rouge, LA	0.85	42.68	40.48	38.94	33.69
0840	Beaumont-Port Arthur, TX, Hardin, TX, Jefferson, TX, Orange, TX	0.8644	43.26	41.04	39.48	34.16
0860	Bellingham, WA, Whatcom, WA	1.1407	54.50	51.70	49.73	43.03
0870	Benton Harbor, MI, Berrien, MI	0.8573	42.98	40.76	39.21	33.93

TABLE I.—GEOGRAPHIC ADJUSTMENT INDEX AND SALARY EQUIVALENCY UPPER GUIDELINE FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Index	Physical therapy	Occupational therapy	Speech language pathology	Respiratory therapy
0875	Bergen-Passaic, NJ, Bergen, NJ, Passaic, NJ*	1.1878	56.42	53.52	51.48	44.54
0880	Billings, MT, Yellowstone, MT	0.9158	45.36	43.02	41.39	35.81
0920	Biloxi-Gulfport-Pascagoula, MS, Hancock, MS, Harrison, MS, Jackson, MS	0.8622	43.18	40.95	39.40	34.09
0960	Binghamton, NY, Broome, NY, Tioga, NY	0.8892	44.27	42.00	40.40	34.94
1000	Birmingham, AL, Blount, AL, Jefferson, AL, St. Clair, AL, Shelby, AL	0.9108	45.15	42.83	41.20	35.65
1010	Bismarck, ND, Burleigh, ND, Morton, ND	0.7986	40.59	38.50	37.04	32.04
1020	Bloomington, IN, Monroe, IN	0.8720	43.57	41.33	39.76	34.40
1040	Bloomington-Normal, IL, McLean, IL	0.9061	44.96	42.65	41.03	35.49
1080	Boise City, ID, Ada, ID, Canyon, ID	0.9457	46.57	44.18	42.49	36.77
1123	Boston-Brockton-Nashua-MA-NH, Bristol, MA, Essex, MA, Middlesex, MA, Norfolk, MA, Plymouth, MA, Suffolk, MA, Worcester, MA, Hillsborough, NH, Merrimack, NH, Rockingham, NH, Strafford, NH*	1.1705	55.71	52.85	50.84	43.98
1125	Boulder-Longmont, CO, Boulder, CO	0.9597	47.14	44.72	43.01	37.22
1145	Brazoria, TX, Brazoria, TX	0.9274	45.83	43.47	41.82	36.18
1150	Bremerton, WA, Kitsap, WA	1.0987	52.79	50.08	48.17	41.68
1240	Brownsville-Harlingen-San Benito, TX, Cameron, TX	0.8610	43.13	40.91	39.35	34.05
1260	Bryan-College Station,TX, Brazos, TX	0.8921	44.39	42.11	40.51	35.05
1280	Buffalo-Niagara Falls, NY, Erie, NY, Niagara, NY*	0.9179	45.44	43.10	41.46	35.87
1303	Burlington, VT, Chittenden, VT, Franklin, VT, Grand Isle, VT	1.0148	49.38	46.84	45.06	38.99
1310	Caguas, PR, Caguas, PR, Cayey, PR, Cidra, PR, Gurabo, PR, San Lorenzo, PR [1]	0.4609	27.66	26.24	25.24	21.84
1320	Canton-Massillon, OH, Carroll, OH, Stark, OH	0.8716	43.56	41.32	39.74	34.39
1350	Casper, WY, Natrona, WY	0.8891	44.27	41.99	40.39	34.95
1360	Cedar Rapids, IA, Linn, IA	0.8525	42.78	40.58	39.04	33.77
1400	Champaign-Urbana, IL, Champaign, IL	0.9465	46.60	44.21	42.52	36.76
1440	Charleston-North Charleston, SC, Berkeley, SC, Charleston, SC, Dorchester, SC	0.9034	44.85	42.54	40.93	35.41
1480	Charleston, WV, Kanawha, WV, Putnam, WV	0.9601	47.16	44.73	43.03	37.23
1520	Charlotte-Gastonia-Rock Hill, NC–SC, Cabarrus, NC, Gaston, NC, Lincoln, NC, Mecklenburg, NC, Rowan, NC, Union, NC, York, SC*	0.9696	47.54	45.10	43.38	37.53
1540	Charlottesville, VA, Albemarle, VA, Charlottesville City, VA, Fluvanna, VA, Greene, VA	0.9227	45.64	43.29	41.64	36.03
1560	Chattanooga, TN-GA, Catoosa, GA, Dade, GA, Walker, GA, Hamilton, TN, Marion, TN	0.8917	44.38	42.09	40.49	35.03
1580	Cheyenne, WY, Laramie, WY	0.7739	39.58	37.55	36.12	31.25
1600	Chicago, IL, Cook, IL, DeKalb, IL, DuPage, IL, Grundy, IL, Kane, IL, Kendall, IL, Lake, IL, McHenry, IL, Will, IL*	1.0845	52.22	49.53	47.65	41.22
1620	Chico-Paradise, CA, Butte, CA	1.0499	50.81	48.20	46.36	40.11
1640	Cincinnati, OH–KY–IN, Dearborn, IN, Ohio, IN, Boone, KY, Campbell, KY, Gallatin, KY, Grant, KY, Kenton, KY, Pendleton, KY, Brown, OH, Clermont, OH, Hamilton, OH, Warren, OH*	0.9644	47.33	44.90	43.19	37.37
1660	Clarksville-Hopkinsville, TN–KY, Christian, KY, Montgomery, TN	0.7777	39.74	37.69	36.26	31.37
1680	Cleveland-Lorain-Elyria, OH, Ashtabula, OH, Cuyahoga, OH, Geauga, OH, Lake, OH, Lorain, OH, Medina, OH*	0.9964	48.63	46.13	44.38	38.39
1720	Colorado Springs, CO, El Paso, CO	0.9415	46.40	44.01	42.34	36.63
1740	Columbia, MO, Boone, MO	0.8969	44.59	42.29	40.68	35.20
1760	Columbia, SC, Lexington, SC, Richland, SC	0.9233	45.66	43.31	41.66	36.05
1800	Columbus, GA-AL Russell, AL, Chattanoochee, GA, Harris, GA, Muscogee, GA	0.7841	40.00	37.94	36.50	31.58
1840	Columbus, OH, Delaware, OH, Fairfield, OH, Franklin, OH, Licking, OH, Madison, OH, Pickaway, OH*	0.9758	47.80	45.34	43.61	37.73
1880	Corpus Christi, TX, Nueces, TX, San Patricio, TX	0.8951	44.51	42.22	40.62	35.14
1900	Cumberland, MD–WV, Allegany, MD, Mineral, WV	0.8740	43.66	41.41	39.83	34.46
1920	Dallas, TX, Collin, TX, Dallas, TX, Denton, TX, Ellis, TX, Henderson, TX, Hunt, TX, Kaufman, TX, Rockwall, TX*	0.9806	47.99	45.52	43.79	37.89
1950	Danville, VA, Danville City, VA, Pittsylvania, VA	0.8564	42.94	40.73	39.18	33.90
1960	Davenport-Rock Island-Moline, IA-IL, Scott, IA, Henry, IL, Rock Island, IL	0.8454	42.49	40.31	38.77	33.55

TABLE I.—GEOGRAPHIC ADJUSTMENT INDEX AND SALARY EQUIVALENCY UPPER GUIDELINE FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Index	Physical therapy	Occupational therapy	Speech language pathology	Respiratory therapy
2000	Dayton-Springfield, OH, Clark, OH, Greene, OH, Miami, OH, Montgomery, OH	0.9635	47.30	44.86	43.16	37.34
2020	Daytona Beach, FL, Flagler, FL, Volusia, FL	0.8941	44.47	42.18	40.58	35.11
2030	Decatur, AL, Lawrence, AL, Morgan, AL	0.8450	42.48	40.29	38.76	33.53
2040	Decatur, IL, Macon, IL	0.7910	40.28	38.21	36.75	31.80
2080	Denver, CO, Adams, CO, Arapahoe, CO, Denver, CO, Douglas, CO, Jefferson, CO*	1.0246	49.78	47.22	45.42	39.30
2120	Des Moines, IA, Dallas, IA, Polk, IA, Warren, IA	0.8885	44.25	41.97	40.37	34.93
2160	Detroit, MI, Lapeer, MI, Macomb, MI, Monroe, MI, Oakland, MI, St. Clair, MI, Wayne, MI*	1.0809	52.07	49.36	47.51	41.11
2180	Dothan, AL, Dale, AL, Houston, AL	0.7801	39.84	37.79	36.35	31.45
2190	Dover, DE, Kent, DE	0.9068	44.99	42.67	41.05	35.5
2200	Dubuque, IA, Dubuque, IA	0.8176	41.36	39.23	37.74	32.65
2240	Duluth-Superior, MN–WI, St. Louis, MN, Douglas, WI	0.9491	46.71	44.31	42.62	36.88
2281	Dutchess County, NY, Dutchess, NY	1.0673	51.52	48.87	47.01	40.67
2290	Eau Claire, WI, Chippewa, WI, Eau Claire, WI	0.8747	43.68	41.44	39.86	34.49
2320	El Paso, TX, El Paso, TX	0.9539	46.91	44.49	42.80	37.03
2330	Elkhart-Goshen, IN, Elkhart, IN	0.8871	44.19	41.91	40.32	34.88
2335	Elmira, NY, Chemung, NY	0.8484	42.61	40.42	38.88	33.64
2340	Enid, OK, Garfield, OK	0.7924	40.34	38.26	36.81	31.84
2360	Erie, PA, Erie, PA	0.9232	45.66	43.31	41.66	36.04
2400	Eugene-Springfield, OR, Lane, OR	1.1360	54.31	51.52	49.56	42.88
2440	Evansville-Henderson, IN–KY, Posey, IN, Vanderburgh, IN, Warrick, IN, Henderson, KY	0.9054	44.93	42.62	41.00	35.47
2520	Fargo-Moorhead, ND–MN, Clay, MN, Cass, ND	0.9117	45.19	42.86	41.23	35.67
2560	Fayetteville, NC, Cumberland, NC	0.9078	45.03	42.71	41.09	35.55
2580	Fayetteville-Springdale-Rogers, AR, Benton, AR, Washington, AR	0.7277	37.70	35.76	34.40	29.77
2620	Flagstaff, AZ–UT, Coconino, AZ, Kane, UT	0.9090	45.08	42.76	41.13	35.59
2640	Flint, MI, Genesee, MI	1.1337	54.22	51.43	49.47	42.80
2650	Florence, AL, Colbert, AL, Lauderdale, AL	0.8001	40.65	38.56	37.09	32.09
2655	Florence, SC, Florence, SC	0.8662	43.34	41.11	39.54	34.21
2670	Fort Collins-Loveland, CO, Larimer, CO	1.0646	51.41	48.76	46.91	40.58
2680	Ft. Lauderdale, FL, Broward, FL*	1.0632	51.35	48.71	46.86	40.54
2700	Fort Myers-Cape Coral, FL, Lee, FL	0.9104	45.14	42.81	41.18	35.63
2710	Fort Pierce-Port St. Lucie, FL, Martin, FL, St. Lucie, FL	1.0250	49.80	47.23	45.44	39.31
2720	Fort Smith, AR–OK, Crawford, AR, Sebastian, AR, Sequoyah, OK	0.7926	40.34	38.27	36.81	31.85
2750	Fort Walton Beach, FL, Okaloosa, FL	0.9265	45.79	43.43	41.78	36.15
2760	Fort Wayne, IN, Adams, IN, Allen, IN, DeKalb, IN, Huntington, IN, Wells, IN, Whitley, IN	0.8870	44.18	41.91	40.32	34.88
2800	Forth Worth-Arlington, TX Hood, TX, Johnson, TX, Parker, TX, Tarrant, TX*	1.0233	49.73	47.17	45.37	39.26
2840	Fresno, CA, Fresno, CA, Madera, CA	1.1265	53.93	51.15	49.20	42.57
2880	Gadsden, AL, Etowah, AL	0.8951	44.51	42.22	40.62	35.14
2900	Gainesville, FL, Alachua, FL	0.9509	46.78	44.38	42.69	36.93
2920	Galveston-Texas City, TX, Galveston, TX	1.1084	53.19	50.45	48.53	41.99
2960	Gary, IN Lake, IN, Porter, IN	0.9717	47.63	45.18	43.46	37.60
2975	Glens Falls, NY, Warren, NY, Washington, NY	0.8630	43.21	40.98	39.43	34.11
2980	Goldsboro, NC, Wayne, NC	0.8459	42.51	40.32	38.79	33.56
2985	Grand Forks, ND–MN, Polk, MN, Grand Forks, ND	0.9082	45.05	42.73	41.10	35.56
2995	Grand Junction, CO, Mesa, CO	0.8402	42.28	40.11	38.58	33.38
3000	Grand Rapids-Muskegon-Holland, MI, Allegan, MI, Kent, MI, Muskegon, MI, Ottawa, MI	1.0199	49.59	47.04	45.25	39.15
3040	Great Falls, MT, Cascade, MT	0.8750	43.70	41.45	39.87	34.50
3060	Greeley, CO, Weld, CO	0.9767	47.83	45.37	43.65	37.76
3080	Green Bay, WI, Brown, WI	0.9110	45.16	42.84	41.21	35.65
3120	Greensboro-Winston-Salem-High Point, NC, Alamance, NC, Davidson, NC, Davie, NC, Forsyth, NC, Guilford, NC, Randolph, NC, Stokes, NC, Yadkin, NC*	0.9388	46.29	43.91	42.24	36.54
3150	Greenville, NC, Pitt, NC	0.9150	45.32	42.99	41.36	35.78
3160	Greenville-Spartanburg-Anderson, SC, Anderson, SC, Cherokee, SC, Greenville, SC, Pickens, SC, Spartanburg, SC	0.8998	44.70	42.40	40.79	35.29
3180	Hagerstown, MD, Washington, MD	0.9248	45.72	43.37	41.72	36.10
3200	Hamilton-Middletown, OH, Butler, OH	0.9565	47.01	44.59	42.90	37.11
3240	Harrisburg-Lebanon-Carlisle, PA, Cumberland, PA, Dauphin, PA, Lebanon, PA, Perry, PA	1.0238	49.75	47.19	45.39	39.27

TABLE I.—GEOGRAPHIC ADJUSTMENT INDEX AND SALARY EQUIVALENCY UPPER GUIDELINE FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Index	Physical therapy	Occupational therapy	Speech language pathology	Respiratory therapy
3283	Hartford, CT, Hartford, CT, Litchfield, CT, Middlesex, CT, Tolland, CT*	1.2465	58.81	55.78	53.66	46.42
3285	Hattiesburg, MS, Forrest, MS, Lamar, MS	0.7309	37.84	35.89	34.52	29.87
3290	Hickory-Morganton-Lenoir, NC, Alexander, NC, Burke, NC, Caldwell, NC, Catawba, NC	0.8694	43.47	41.23	39.66	34.32
3320	Honolulu, HI, Honolulu, HI [1]	1.1552	56.92	53.99	51.93	44.93
3350	Houma, LA, Lafourche, LA, Terrebonne, LA	0.7915	40.30	38.23	36.77	31.82
3360	Houston, TX, Chambers, TX, Fort Bend, TX, Harris, TX, Liberty, TX, Montgomery, TX, Waller, TX*	1.0079	49.10	46.57	44.80	38.76
3400	Huntington-Ashland, WV–KY–OH, Boyd, KY, Carter, KY, Greenup, KY, Lawrence, OH, Cabell, WV, Wayne, WV	0.9247	45.72	43.37	41.72	36.09
3440	Huntsville, AL, Limestone, AL, Madison, AL	0.8271	41.75	39.60	38.09	32.96
3480	Indianapolis, IN, Boone, IN, Hamilton, IN, Hancock, IN, Hendricks, IN, Johnson, IN, Madison, IN, Marion, IN, Morgan, IN, Shelby, IN*	0.9981	48.70	46.20	44.44	38.45
3500	Iowa City, IA, Johnson, IA	0.9435	46.48	44.09	42.41	36.70
3520	Jackson, MI, Jackson, MI	0.9117	45.19	42.86	41.23	35.67
3560	Jackson, MS, Hinds, MS, Madison, MS, Rankin, MS	0.7946	40.43	38.35	36.89	31.91
3580	Jackson, TN, Madison, TN	0.8354	42.09	39.92	38.40	33.33
3600	Jacksonville, FL, Clay, FL, Duval, FL, Nassau, FL, St. Johns, FL	0.9158	45.36	43.02	41.39	35.81
3605	Jacksonville, NC, Onslow, NC	0.7111	37.03	35.12	33.79	29.23
3610	Jamestown, NY, Chautaqua, NY	0.7731	39.55	37.52	36.09	31.22
3620	Janesville-Beloit, WI, Rock, WI	0.8713	43.55	41.30	39.73	34.38
3640	Jersey City, NJ, Hudson, NJ	1.1472	54.77	51.95	49.97	43.24
3660	Johnson City-Kingsport-Bristol, TN–VA, Carter, TN, Hawkins, TN, Sullivan, TN, Unicoi, TN, Washington, TN, Bristol City, VA, Scott, VA, Washington, VA	0.8954	44.53	42.23	40.63	35.15
3680	Johnstown, PA, Cambria, PA, Somerset, PA	0.8464	42.53	40.34	38.81	33.58
3700	Jonesboro, AR	0.7277	37.70	35.76	34.40	29.77
3710	Joplin, MO, Jasper, MO, Newton, MO	0.7698	39.42	37.39	35.97	31.12
3720	Kalamazoo-Battlecreek, MI, Calhoun, MI, Kalamazoo, MI, Van Buren, MI	1.0625	51.32	48.68	46.83	40.52
3740	Kankakee, IL, Kankakee, IL	0.9187	45.47	43.13	41.49	35.90
3760	Kansas City, KS–MO, Johnson, KS, Leavenworth, KS, Miami, KS, Wyandotte, KS, Cass, MO, Clay, MO, Clinton, MO, Jackson, MO, Lafayette, MO, Platte, MO, Ray, MO*	0.9553	46.96	44.55	42.85	37.07
3800	Kenosha, WI, Kenosha, WI	0.9217	45.60	43.25	41.60	36.00
3810	Killeen-Temple, TX, Bell, TX, Coryell, TX	1.0474	50.71	48.10	46.27	40.03
3840	Knoxville, TN, Anderson, TN, Blount, TN, Knox, TN, Loudon, TN, Sevier, TN, Union, TN	0.8569	42.96	40.75	39.20	33.92
3850	Kokomo, IN, Howard, IN, Tipton, IN	0.8658	43.32	41.09	39.53	34.20
3870	La Crosse, WI–MN, Houston, MN, La Crosse, WI	0.8686	43.44	41.20	39.63	34.29
3880	Lafayette, LA, Acadia, LA, Lafayette, LA, St. Landry, LA, St. Martin, LA	0.8228	41.57	39.43	37.93	32.82
3920	Lafayette, IN, Clinton, IN, Tippecanoe, IN	0.8851	44.11	41.84	40.25	34.82
3960	Lake Charles, LA, Calcasieu, LA	0.8098	41.04	38.93	37.45	32.40
3980	Lakeland-Winter Haven, FL, Polk, FL	0.8843	44.07	41.81	40.22	34.80
4000	Lancaster, PA, Lancaster, PA	0.9659	47.39	44.95	43.24	37.42
4040	Lansing-East Lansing, MI, Clinton, MI, Eaton, MI, Ingham, MI	1.0089	49.14	46.61	44.84	38.80
4080	Laredo, TX, Webb, TX	0.7129	37.10	35.19	33.86	29.29
4100	Las Cruces, NM, Dona Ana, NM	0.8564	42.94	40.73	39.18	33.90
4120	Las Vegas, NV–AZ, Mohave, AZ, Clark, NV, Nye, NV*	1.0956	52.67	49.96	48.06	41.58
4150	Lawrence, KS, Douglas, KS	0.8665	43.35	41.12	39.56	34.22
4200	Lawton, OK, Comanche, OK	0.8431	42.40	40.22	38.69	33.47
4243	Lewiston-Auburn, ME, Androscoggin, ME	0.9484	46.68	44.28	42.60	36.85
4280	Lexington, KY, Bourbon, KY, Clark, KY, Fayette, KY, Jessamine, KY, Madison, KY, Scott, KY, Woodford, KY	0.8359	42.11	39.94	38.42	33.24
4320	Lima, OH, Allen, OH, Auglaize, OH	0.8801	43.90	41.64	40.06	34.66
4360	Lincoln, NE, Lancaster, NE	0.9234	45.66	43.31	41.67	36.05
4400	Little Rock-North Little Rock, AR, Faulkner, AR, Lonoke, AR, Pulaski, AR, Saline, AR	0.8665	43.35	41.12	39.56	34.22
4420	Longview-Marshall, TX, Gregg, TX, Harrison, TX, Upshur, TX	0.8713	43.55	41.30	39.73	34.38
4480	Los Angeles-Long Beach, CA, Los Angeles, CA*	1.2441	58.71	55.69	53.57	46.35

TABLE I.—GEOGRAPHIC ADJUSTMENT INDEX AND SALARY EQUIVALENCY UPPER GUIDELINE FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Index	Physical therapy	Occupational therapy	Speech language pathology	Respiratory therapy
4520	Louisville, KY–IN, Clark, IN, Floyd, IN, Harrison, IN, Scott, IN, Bullitt, KY, Jefferson, KY, Oldham, KY	0.9522	46.84	44.43	42.74	36.98
4600	Lubbock, TX, Lubbock, TX	0.8577	42.99	40.78	39.23	33.94
4640	Lynchburg, VA, Amherst, VA, Bedford, VA, Bedford City, VA, Campbell, VA, Lynchburg City, VA	0.8116	41.12	39.00	37.52	32.46
4680	Macon, GA, Bibb, GA, Houston, GA, Jones, GA, Peach, GA, Twiggs, GA	0.8894	44.28	42.00	40.41	34.96
4720	Madison, WI, Dane, WI	1.0100	49.19	46.66	44.88	38.83
4800	Mansfield, OH, Crawford, OH, Richland, OH	0.8591	43.05	40.83	39.28	33.99
4840	Mayaguez, PR, Anasco, PR, Cabo Rojo, PR, Hormigueros, PR, Mayaguez, PR, Sabana Grande, PR, San German, PR[1]	0.4248	26.20	24.85	23.90	20.68
4880	McAllen-Edinburg-Mission, TX, Hidalgo, TX	0.8552	42.89	40.68	39.14	33.86
4890	Medford-Ashland, OR, Jackson, OR	1.0148	49.38	46.84	45.06	38.99
4900	Melbourne-Titusville-Palm Bay, FL, Brevard FL	0.9140	45.28	42.95	41.32	35.75
4920	Memphis, TN–AR–MS, Crittenden, AR, DeSoto, MS, Fayette, TN, Shelby, TN, Tipton, TN*	0.8231	41.59	39.45	37.94	32.83
4940	Merced, CA, Merced, CA	1.0744	51.81	49.14	47.27	40.90
5000	Miami, FL, Dade, FL*	1.0017	48.85	46.34	44.57	38.56
5015	Middlesex-Somerset-Hunterdon, NJ, Hunterdon, NJ, Middlesex, NJ, Somerset, NJ*	1.0969	52.72	50.01	48.11	41.62
5080	Milwaukee-Waukesha, WI, Milwaukee, WI, Ozaukee, WI, Washington, WI, Waukesha, WI*	0.9721	47.65	45.19	43.47	37.61
5120	Minneapolis-St. Paul, MN–WI, Anoka, MN, Carver, MN, Chisago, MN, Dakota, MN, Hennepin, MN, Isanti, MN, Ramsey, MN, Scott, MN, Sherburne, MN, Washington, MN, Wright, MN, Pierce, WI, St. Croix, WI*	1.0862	52.29	49.60	47.71	41.28
5160	Mobile, AL, Baldwin, AL, Mobile, AL	0.8044	40.82	38.72	37.25	32.23
5170	Modesto, CA, Stanislaus, CA	1.0684	51.56	48.91	47.05	40.73
5190	Monmouth-Ocean, NJ, Monmouth, NJ, Ocean, NJ*	1.0919	52.52	49.82	47.92	41.46
5200	Monroe, LA, Ouachita, LA	0.8276	41.77	39.62	38.11	32.97
5240	Montgomery, AL, Autauga, AL, Elmore, AL, Montgomery, AL	0.7938	40.39	38.31	36.86	31.89
5280	Muncie, IN, Delaware, IN	0.9791	47.93	45.46	43.73	37.84
5330	Myrtle Beach, SC, Horry, SC	0.7852	40.04	37.98	36.54	31.61
5345	Naples, FL, Collier, FL	1.0280	49.92	47.35	45.55	39.41
5360	Nashville, TN, Cheatham, TN, Davidson, TN, Dickson, TN, Robertson, TN, Rutherford TN, Sumner, TN, Williamson, TN, Wilson, TN*	0.9153	45.34	43.00	41.37	35.79
5380	Nassau-Suffolk, NY, Nassau, NY, Suffolk, NY*	1.3654	63.64	60.37	58.07	50.24
5483	New Haven-Bridgeport-Stamford-Danbury-Waterbury, CT Fairfield, CT New Haven, CT*	1.2805	60.19	57.09	54.92	47.52
5523	New London-Norwich, CT, New London, CT	1.2359	58.37	55.37	53.26	46.08
5560	New Orleans, LA, Jefferson, LA, Orleans, LA, Plaquemines, LA, St. Bernard, LA, St. Charles, LA, St. James, LA, St. John The Baptist, LA, St. Tammany, LA*	0.9368	46.21	43.83	42.16	36.48
5600	New York, NY, Bronx, NY, Kings, NY, New York, NY, Putnam, NY, Queens, NY, Richmond, NY, Rockland, NY, Westchester, NY*	1.4266	66.13	62.73	60.34	52.21
5640	Newark, NJ, Essex, NJ, Morris, NJ, Sussex, NJ, Union, NJ, Warren, NJ*	1.1855	56.32	53.43	51.39	44.47
5660	Newburgh, NY–PA, Orange, NY, Pike, PA	1.0889	52.40	49.70	47.81	41.36
5720	Norfolk-Virginia Beach-Newport News, VA–NC, Currituck, NC, Chesapeake City, VA, Gloucester, VA, Hampton City, VA, Isle of Wight, VA, James City, VA, Mathews, VA, Newport News City, VA, Norfolk City, VA, Poquoson City, VA, Portsmouth City, VA, Suffolk City, VA, Virginia Beach City, VA, Williamsburg City, VA, York, VA*	0.8414	42.33	40.15	38.62	33.42
5775	Oakland, CA, Alameda, CA, Contra Costa, CA*	1.5110	69.56	65.98	63.47	54.92
5790	Ocala, FL, Marion, FL	0.9177	45.43	43.09	41.46	35.87
5800	Odessa-Midland, TX, Ector, TX, Midland, TX	0.8549	42.88	40.67	38.13	33.85
5880	Oklahoma City, OK, Canadian, OK, Cleveland, OK, Logan, OK, McClain, OK, Oklahoma, OK, Pottawatomie, OK*	0.8437	42.42	40.24	38.71	33.49
5910	Olympia, WA, Thurston, WA	1.0774	51.93	49.26	47.38	41.00
5920	Omaha, NE–IA, Pottawattamie, IA, Cass, NE, Douglas, NE, Sarpy, NE, Washington, NE	0.9555	46.97	44.55	42.86	37.08

TABLE I.—GEOGRAPHIC ADJUSTMENT INDEX AND SALARY EQUIVALENCY UPPER GUIDELINE FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Index	Physical therapy	Occupational therapy	Speech language pathology	Respiratory therapy
5945	Orange County, CA, Orange, CA*	1.2061	57.16	54.22	52.16	45.13
5960	Orlando, FL, Lake, FL, Orange, FL, Osceola, FL, Seminole, FL*	0.9545	46.93	44.51	42.82	37.05
5990	Owensboro, KY, Daviess, KY	0.7635	39.16	37.15	35.73	30.92
6015	Panama City, FL, Bay, FL	0.8125	41.15	39.04	37.55	32.49
6020	Parkersburg-Marietta, WV–OH, Washington, OH, Wood, WV	0.7939	40.40	38.32	36.86	31.89
6080	Pensacola, FL, Escambia, FL, Santa Rosa, FL	0.8267	41.73	39.58	38.08	32.95
6120	Peoria-Pekin, IL, Peoria, IL, Tazewell, IL, Woodford, IL	0.8975	44.61	42.32	40.71	35.22
6160	Philadelphia, PA–NJ, Burlington, NJ, Camden, NJ, Gloucester, NJ, Salem, NJ, Bucks, PA, Chester, PA, Delaware, PA, Montgomery, PA, Philadelphia, PA*	1.1326	54.17	51.39	49.43	42.77
6200	Phoenix-Mesa, AZ, Maricopa, AZ, Pinal, AZ*	0.9888	48.32	45.84	44.09	38.15
6240	Pine Bluff, AR, Jefferson, AR	0.7948	40.43	38.35	36.89	31.92
6280	Pittsburgh, PA, Allegheny, PA, Beaver, PA, Butler, PA, Fayette, PA, Washington, PA, Westmoreland, PA*	0.9778	47.88	45.41	43.69	37.80
6323	Pittsfield, MA, Berkshire, MA	1.0636	51.37	48.72	46.87	40.55
6340	Pocatello, ID, Bannock, ID	0.8854	44.12	41.85	40.26	34.83
6360	Ponce, PR, Guayanilla, PR, Juana Diaz, PR, Penuelas, PR, Ponce, PR, Villalba, PR, Yauco, PR [1]	0.4722	28.12	26.68	25.66	22.20
6403	Portland, ME, Cumberland, ME, Sagadahoc, ME, York, ME	0.9695	47.54	45.09	43.38	37.53
6440	Portland-Vancouver, OR–WA, Clackamas, OR, Columbia, OR, Multnomah, OR, Washington, OR, Yamhill, OR, Clark, WA*	1.1324	54.17	51.38	49.42	42.76
6483	Providence-Warwick, RI, Bristol, RI, Kent, RI, Newport, RI, Providence, RI, Washington, RI	1.1180	53.58	50.82	48.89	42.30
6520	Provo-Orem, UT, Utah, UT	1.0196	49.58	47.03	45.24	39.14
6560	Pueblo, CO, Pueblo, CO	0.8350	42.07	39.90	38.39	33.21
6580	Punta Gorda, FL, Charlotte, FL	0.8419	42.35	40.17	38.64	33.43
6600	Racine, WI Racine, WI	0.8905	44.33	42.05	40.45	34.99
6640	Raleigh-Durham-Chapel Hill, NC, Chatham, NC, Durham, NC, Franklin, NC, Johnston, NC, Orange, NC, Wake, NC	0.9805	47.99	45.52	43.79	37.88
6660	Rapid City, SD, Pennington, SD	0.8522	42.77	40.57	39.02	33.76
6680	Reading, PA, Berks, PA	0.9520	46.83	44.42	42.73	36.97
6690	Redding, CA, Shasta, CA	1.1697	55.68	52.82	50.81	43.96
6720	Reno, NV, Washoe, NV	1.1105	53.27	50.53	48.61	42.06
6740	Richland-Kennewick-Pasco, WA, Benton, WA, Franklin, WA	1.0049	48.98	46.46	44.69	38.67
6760	Richmond-Petersburg, VA, Charles City County, VA, Chesterfield, VA, Colonial Heights City, VA, Dinwiddie, VA, Goochland, VA, Hanover, VA, Henrico, VA, Hopewell City, VA, New Kent, VA, Petersburg City, VA, Powhatan, VA, Prince George, VA, Richmond City, VA	0.9267	45.80	43.44	41.79	36.16
6780	Riverside-San Bernardino, CA, Riverside, CA, San Bernardino, CA*	1.1468	54.75	51.93	49.96	43.22
6800	Roanoke, VA, Botetourt, VA, Roanoke, VA, Roanoke City, VA, Salem City, VA	0.8771	43.78	41.53	39.95	34.56
6820	Rochester, MN, Olmsted, MN	1.0511	50.86	48.24	46.09	39.88
6840	Rochester, NY, Genesee, NY, Livingston, NY, Monroe, NY, Ontario, NY, Orleans, NY, Wayne, NY*	0.9725	47.66	45.21	43.49	37.63
6880	Rockford, IL, Boone, IL, Ogle, IL, Winnebago, IL	0.9065	44.98	42.66	41.04	35.51
6895	Rocky Mount, NC, Edgecombe, NC, Nash, NC	0.9026	44.82	42.51	40.90	35.38
6920	Sacramento, CA, El Dorado, CA, Placer, CA, Sacramento, CA*	1.2449	58.74	55.72	53.60	46.37
6960	Saginaw-Bay City-Midland, MI, Bay, MI, Midland, MI, Saginaw, MI	0.9688	47.51	45.07	43.35	37.51
6980	St. Cloud, MN, Benton, MN, Stearns, MN	0.9532	46.88	44.46	42.77	37.01
7000	St. Joseph, MO, Andrews, MO, Buchanan, MO	0.8619	43.16	40.94	39.38	34.08
7040	St. Louis, MO–IL, Clinton, IL, Jersey, IL, Madison, IL, Monroe, IL, St. Clair, IL, Franklin, MO, Jefferson, MO, Lincoln, MO, St. Charles, MO, St. Louis, MO, St. Louis City, MO, Warren, MO*	0.9093	45.09	42.77	41.14	35.60
7080	Salem, OR, Marion, OR, Polk, OR	0.9805	47.99	45.52	43.79	37.88
7120	Salinas, CA, Monterey, CA	1.3912	64.69	61.36	59.03	51.07
7160	Salt Lake City-Ogden, UT, Davis, UT, Salt Lake, UT, Weber, UT*	0.9754	47.78	45.32	43.60	37.72

TABLE I.—GEOGRAPHIC ADJUSTMENT INDEX AND SALARY EQUIVALENCY UPPER GUIDELINE FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Index	Physical therapy	Occupational therapy	Speech language pathology	Respiratory therapy
7200	San Angelo, TX, Tom Green, TX	0.7637	39.17	37.15	35.74	30.92
7240	San Antonio, TX, Bexar, TX, Comal, TX, Guadalupe, TX, Wilson, TX*	0.8456	42.50	40.31	38.78	33.55
7320	San Diego, CA, San Diego, CA*	1.2230	57.85	54.87	52.79	45.67
7360	San Francisco, CA, Marin, CA, San Francisco, CA, San Mateo, CA*	1.4373	66.57	63.14	60.74	52.55
7400	San Jose, CA, Santa Clara, CA*	1.4634	67.63	64.15	61.71	53.39
7440	San Juan-Bayamon, PR, Aguas Buenas, PR, Barceloneta, PR, Bayamon, PR, Canovanas, PR, Carolina, PR, Catano, PR, Ceiba, PR, Comerio, PR, Corozal, PR, Dorado, PR, Fajardo, PR, Florida, PR, Guaynabo, PR, Humacao, PR, Juncos, PR, Los Piedras, PR, Loiza, PR, Luguillo, PR, Manati, PR, Morovis, PR, Naguabo, PR, Naranjito, PR, Rio Grande, PR, San Juan, PR, Toa Alta, PR, Toa Baja, PR, Trujillo Alto, PR, Vega Alta, PR, Vega Baja, PR, Yabucoa, PR[1]*	0.4542	27.39	25.98	24.99	21.62
7460	San Luis Obispo-Atascadero-Paso Robles, CA, San Luis Obispo, CA	1.1653	55.50	52.65	50.64	43.82
7480	Santa Barbara-Santa Maria-Lompoc, CA, Santa Barbara, CA	1.1331	54.19	51.40	49.45	42.78
7485	Santa Cruz-Watsonville, CA, Santa Cruz, CA	1.3627	63.53	60.26	57.97	50.16
7490	Santa Fe, NM, Los Alamos, NM, Santa Fe, NM	1.0909	52.48	49.78	47.88	41.43
7500	Santa Rosa, CA, Sonoma, CA	1.2586	59.30	56.25	54.11	46.81
7510	Sarasota-Bradenton, FL, Manatee, FL, Sarasota, FL	0.9866	48.24	45.75	44.01	38.08
7520	Savannah, GA, Bryan, GA, Chatham, GA, Effingham, GA	0.9725	47.66	45.21	43.49	37.63
7560	Scranton-Wilkes-Barre-Hazleton, PA, Columbia, PA, Lackawanna, PA, Luzerne, PA, Wyoming, PA	0.8821	43.98	41.72	40.13	34.72
7600	Seattle-Bellevue-Everett, WA, Island, WA, King, WA, Snohomish, WA*	1.1474	54.78	51.96	49.98	43.24
7610	Sharon, PA, Mercer, PA	0.8955	44.53	42.24	40.63	35.15
7620	Sheboygan, WI, Sheboygan, WI	0.7825	39.93	37.88	36.44	31.53
7640	Sherman-Denison, TX, Grayson, TX	0.8682	43.42	41.19	39.62	34.28
7680	Shreveport-Bossier City, LA, Bossier, LA, Caddo, LA, Webster, LA	0.9433	46.47	44.08	42.41	36.69
7720	Sioux City, IA–NE, Woodbury, IA, Dakota, NE	0.8379	42.19	40.02	38.49	33.31
7760	Sioux Falls, SD, Lincoln, SD, Minnehaha, SD	0.8688	43.44	41.21	39.64	34.30
7800	South Bend, IN, St. Joseph, IN	1.0013	48.83	46.32	44.56	38.55
7840	Spokane, WA, Spokane, WA	1.0607	51.25	48.61	46.76	40.46
7880	Springfield, IL, Menard, IL, Sangamon, IL	0.8740	43.66	41.41	39.83	34.46
7920	Springfield, MO, Christian, MO, Greene, MO, Webster, MO	0.7885	40.18	38.11	36.66	31.72
8003	Springfield, MA, Hampden, MA, Hampshire, MA	1.0670	51.51	48.85	47.00	40.66
8050	State College, PA, Centre, PA	0.9614	47.21	44.78	43.08	37.27
8080	Steubenville-Weirton, OH–WV, Jefferson, OH, Brooke, WV, Hancock, WV	0.8331	41.99	39.83	38.32	33.15
8120	Stockton-Lodi, CA, San Joaquin, CA	1.1420	54.56	51.75	49.78	43.07
8140	Sumter, SC, Sumter, SC	0.7760	39.67	37.63	36.20	31.32
8160	Syracuse, NY, Cayuga, NY, Madison, NY, Onondaga, NY, Oswego, NY	0.9469	46.62	44.22	42.54	36.81
8200	Tacoma, WA, Pierce, WA	1.0946	52.63	49.92	48.02	41.55
8240	Tallahassee, FL, Gadsden, FL, Leon, FL	0.8379	42.19	40.02	38.49	33.31
8280	Tampa-St. Petersburg-Clearwater, FL, Hernando, FL, Hillsborough, FL, Pasco, FL, Pinellas, FL*	0.9323	46.03	43.66	42.00	36.34
8320	Terre Haute, IN, Clay, IN, Vermillion, IN, Vigo, IN	0.8659	43.33	41.10	39.53	34.20
8360	Texarkana, AR-Texarkana, TX, Miller, AR, Bowie, TX	0.8570	42.96	40.75	39.20	33.92
8400	Toledo, OH, Fulton, OH, Lucas, OH, Wood, OH	1.0443	50.58	47.98	46.15	39.93
8440	Topeka, KS, Shawnee, KS	1.0166	49.46	46.91	45.13	39.04
8480	Trenton, NJ, Mercer, NJ	1.0633	51.35	48.71	46.86	40.54
8520	Tucson, AZ, Pima, AZ	0.9140	45.28	42.95	41.32	35.75
8560	Tulsa, OK, Creek, OK, Osage, OK, Rogers, OK, Tulsa, OK, Wagoner, OK	0.8159	41.29	39.17	37.68	32.60
8600	Tuscaloosa, AL, Tuscaloosa, AL	0.7846	40.02	37.96	36.52	31.59
8640	Tyler, TX, Smith, TX	1.0075	49.09	46.56	44.79	38.75
8680	Utica-Rome, NY, Herkimer, NY, Oneida, NY	0.8480	42.60	40.41	38.87	33.63
8720	Vallejo-Fairfield-Napa, CA, Napa, CA, Solano, CA	1.4057	65.28	61.92	59.57	51.54
8735	Ventura, CA, Ventura, CA	1.1545	55.06	52.23	50.24	43.47
8750	Victoria, TX, Victoria, TX	0.8459	42.51	40.32	38.79	33.56

TABLE I.—GEOGRAPHIC ADJUSTMENT INDEX AND SALARY EQUIVALENCY UPPER GUIDELINE FOR URBAN AREAS—Continued

	Urban area (constituent counties or county equivalents)	Index	Physical therapy	Occupational therapy	Speech language pathology	Respiratory therapy
8760	Vineland-Millville-Bridgeton, NJ, Cumberland, NJ	1.0072	49.06	46.55	44.78	38.74
8780	Visalia-Tulare-Porterville, CA, Tulare, CA	1.0231	49.72	47.16	45.37	39.25
8800	Waco, TX, McLennan, TX	0.7834	39.97	37.91	36.47	31.56
8840	Washington, DC–MD–VA–WV, District of Columbia, DC, Calvert, MD, Charles, MD, Frederick, MD, Montgomery, MD, Prince Georges, MD, Alexandria City, VA, Arlington, VA, Clarke, VA, Culpeper, VA, Fairfax, VA, Fairfax City, VA, Falls Church City, VA, Fauquier, VA, Fredericksburg City, VA, King George, VA, Loudoun, VA, Manassas City, VA, Manassas Park City, VA, Prince William, VA, Spotsylvania, VA, Stafford, VA, Warren, VA, Berkeley, WV, Jefferson, WV*	1.0909	52.48	49.78	47.88	41.43
8920	Waterloo-Cedar Falls, IA, Black Hawk, IA	0.8774	43.79	41.54	39.96	34.57
8940	Wausau, WI, Marathon, WI	1.0405	50.43	47.83	46.01	39.81
8960	West Palm Beach-Boca Raton, FL, Palm Beach, FL	1.0283	49.93	47.36	45.56	39.42
9000	Wheeling, OH–WV, Belmont, OH, Marshall, WV, Ohio, WV	0.7623	39.11	37.10	35.69	30.88
9040	Wichita, KS, Butler, KS, Harvey, KS, Sedgwick, KS	0.9443	46.51	44.12	42.44	36.72
9080	Wichita Falls, TX, Archer, TX, Wichita, TX	0.8105	41.07	38.96	37.48	32.43
9140	Williamsport, PA, Lycoming, PA	0.8534	42.82	40.61	39.07	33.80
9160	Wilmington-Newark, DE–MD, New Castle, DE, Cecil, MD	1.1405	54.49	51.69	49.72	43.02
9200	Wilmington, NC, New Hanover, NC, Brunswick, NC	0.9118	45.19	42.87	41.24	35.68
9260	Yakima, WA, Yakima, WA	1.0105	49.21	46.68	44.90	38.85
9270	Yolo, CA Yolo, CA	1.1535	55.02	52.19	50.21	43.44
9280	York, PA, York, PA	0.9176	45.43	43.09	41.45	35.86
9320	Youngstown-Warren, OH, Columbiana, OH, Mahoning, OH, Trumbull, OH	0.9819	48.04	45.57	43.84	37.93
9340	Yuba City, CA, Sutter, CA Yuba, CA	1.0496	50.80	48.18	46.35	40.10
9360	Yuma, AZ, Yuma, AZ	0.9572	47.04	44.62	42.92	37.14

[1] Nonlabor portion increased in the following areas based on cost of living surveys conducted by the U.S. Office of Personnel Management:

Location	Adjustment factor
Alaska	1.250
Hawaii	1.225
Puerto Rico	1.100

*Large Urban Area.

TABLE II.—GEOGRAPHIC ADJUSTMENT INDEX AND SALARY EQUIVALENCY GUIDELINE AMOUNTS FOR NONURBAN AREAS

Nonurban area	Wage index	Physical therapy	Occupational therapy	Speech language therapy	Respiratory therapy
Alabama	0.8477	42.59	40.39	38.86	33.62
Alaska [1]	1.3329	64.35	61.04	58.71	50.80
Arizona	0.9718	47.63	45.18	43.46	37.60
Arkansas	0.8270	41.74	39.60	38.09	32.96
California	1.2551	59.16	56.11	53.98	46.70
Colorado	0.9895	48.35	45.86	44.12	38.17
Connecticut	1.2644	59.53	56.47	54.32	47.00
Delaware	1.1100	53.25	50.51	48.59	42.04
Florida	0.9589	47.11	44.68	42.98	37.19
Georgia	0.9596	47.14	44.71	43.01	37.21
Hawaii [1]	1.1552	56.92	53.99	51.93	44.93
Idaho	0.9457	46.57	44.18	42.49	36.77
Illinois	1.0368	50.28	47.69	45.88	39.69
Indiana	0.9570	47.03	44.61	42.91	37.13
Iowa	0.8889	44.26	41.98	40.39	34.94
Kansas	0.9553	46.96	44.55	42.85	37.07
Kentucky	0.9022	44.80	42.50	40.88	35.37
Louisiana	0.8884	44.24	41.96	40.37	34.93
Maine	0.9607	47.18	44.75	43.05	37.25
Maryland	1.0011	48.82	46.31	44.55	38.55
Massachusetts	1.1619	55.36	52.52	50.52	43.71
Michigan	1.0717	51.70	49.04	47.17	40.81

TABLE II.—GEOGRAPHIC ADJUSTMENT INDEX AND SALARY EQUIVALENCY GUIDELINE AMOUNTS FOR NONURBAN AREAS—Continued

Nonurban area	Wage index	Physical therapy	Occupational therapy	Speech language therapy	Respiratory therapy
Minnesota	1.0586	51.16	48.53	46.68	40.39
Mississippi	0.8033	40.78	38.68	37.21	32.19
Missouri	0.8996	44.70	42.40	40.78	35.29
Montana	0.8980	44.63	42.33	40.72	35.23
Nebraska	0.9479	46.66	44.26	42.58	36.84
Nevada	1.1012	52.90	50.17	48.27	41.76
New Hampshire	1.1705	55.71	52.85	50.84	43.98
New Jersey [2]	.....	.....	.....	.....	.....
New Mexico	0.9501	46.75	44.34	42.66	36.91
New York	1.2428	58.66	55.64	53.52	46.31
North Carolina	0.9456	46.57	44.17	42.49	36.76
North Dakota	0.8717	43.56	41.32	39.75	34.39
Ohio	0.9764	47.82	45.36	43.63	37.75
Oklahoma	0.8320	41.95	39.79	38.28	33.12
Oregon	1.1085	53.19	50.46	48.54	41.99
Pennsylvania	1.0269	49.87	47.31	45.51	39.37
Puerto Rico [1]	0.4539	27.38	25.97	24.98	21.62
Rhode Island [2]	.....	.....	.....	.....	.....
South Carolina	0.8964	44.57	42.27	40.67	35.18
South Dakota	0.8638	43.24	41.02	39.46	34.14
Tennessee	0.8711	43.54	41.30	39.73	34.37
Texas	0.9492	46.71	44.31	42.62	36.88
Utah	0.9824	48.06	45.59	43.86	37.94
Vermont	1.0148	49.38	46.84	45.06	38.99
Virginia	0.9249	45.73	43.37	41.72	36.10
Washington	1.1105	53.27	50.53	48.61	42.06
West Virginia	0.9145	45.30	42.97	41.34	35.76
Wisconsin	0.9480	46.67	44.26	42.58	36.84
Wyoming	0.8386	42.22	40.04	38.52	33.33

[1] Nonlabor portion increased in the following areas based on cost of living surveys conducted by the U.S. Office of Personnel Management:

Location	Adjustment factor
Alaska	1.250
Hawaii	1.225
Puerto Rico	1.100

[2] All counties within the State are classified urban.

E. Salary Equivalency Amount Updates

The adjusted hourly salary equivalency amounts were developed using fourth quarter 1995 wage level data, 1994 fringe benefit data as a share of wage levels, and fourth quarter 1995 dollar amounts for rent and other expenses (updated from January 1991 to the fourth quarter of 1995 using their price proxies). In order to account for input price inflation between the base period (fourth quarter 1995), the illustrative implementation period of April 1997, and subsequent updated periods, HCFA developed therapy-specific input price indexes, using as weights the fourth quarter 1995 relative importance factors of the salary equivalency market baskets guideline. The therapy-specific input price indexes are fixed-weight, or Laspeyres type, input price indexes that were constructed in two steps. First, a base period (fourth quarter 1995) was selected and the proportion of total costs accounted for by designated cost categories was estimated. In the second step, a rate of price increase for each cost category was multiplied by the expenditure's relative importance for that category. (Section II.B of this preamble discusses the methodology used to develop the base-period weights (fourth quarter 1995) for each therapy-specific input price index.) The sum of these products for all cost categories yielded the percentage change in the input price index.

Five indexes (base = fourth quarter 1995) were developed initially: One each representing physical therapy, occupational therapy, speech language pathology, respiratory therapy, and a weighted composite index of all four therapy types. The individual therapy indexes were built into the composite index based upon the relative proportion of total therapy services. All input price indexes have the same cost categories and price proxies. However the base period weights vary because of slight differences in the cost structures associated with providing each type of therapy. Table III presents the therapy-specific base period weights as well as the price proxies proposed to represent inflation for each cost category.

TABLE III.—THERAPY SPECIFIC ADJUSTED HOURLY SALARY EQUIVALENCY INPUT PRICE INDEXES (BASE PERIOD: FOURTH QUARTER 1995=100.000)

	Base period weights by therapy type(1)					Proposed price proxies
	Physical therapy	Occupational therapy	Speech language pathology	Respiratory therapy	Composite therapy index	
Total	100.000	100.000	100.000	100.000	100.000	
A. Therapist Compensation	73.720	72.304	71.208	66.733	71.900	
Wages	59.326	58.186	57.304	53.703	57.860	50% ECI Civilian Hospital Workers/50% ECI Private Professional & Technical Workers Wages.
Benefits	14.395	14.118	13.904	13.030	14.039	50% ECI Civilian Hospital Workers/50% ECI Private Professional & Technical Workers Benefits.
B. Overhead	26.273	27.696	28.792	33.275	28.099	
Other Compensation	10.733	11.314	11.762	13.593	11.478	
Other Wages	8.779	9.255	9.621	11.119	9.389	
Clerical Wages	4.422	4.661	4.846	5.600	4.729	ECI Wages Private Administrative Support Including Clerical.(2)
Managerial Wages	4.357	4.593	4.775	5.519	4.660	ECI Wages Private Executive, Administrative, & Managerial.(2)
Other Benefits	1.953	2.059	2.141	2.474	2.089	
Clerical Benefits	0.987	1.041	1.082	1.251	1.056	ECI Benefits Private Administrative Support Including Clerical.(2)
Managerial Benefits	0.966	1.018	1.059	1.223	1.033	ECI Benefits Private Executive, Administrative, & Managerial.(2)
Office Costs	6.482	6.834	7.104	8.210	6.933	CPI–U Housing.
Other Costs	9.058	9.549	9.927	11.472	9.688	CPI–U All Items Less Food & Energy.
Composite Index Share (3)	0.313	0.412	0.153	0.122	1.000	

(1) Base year weights were developed for each type of therapy offered under arrangement. These weights are multiplied by price index levels to measure composite price change over time.
(2) ECI=Employment Cost Index. ECIs are fixed-weighted indexes which track labor cost free from the influence of employment shifts among occupations and industries.
(3) The composite index share represents the proportion that each therapy index type represents of the composite index. These shares were derived from estimates of the 1995 shares of therapy services offered under arrangement by therapy type.

Despite the differences in the fourth quarter 1995 base-year weights for the four therapists' input price indexes, there were virtually no differences in the rates of increase for these indexes. Therefore, we propose to use the composite index to adjust the hourly salary equivalency amounts for inflation. Using the composite index is advantageous because of its administrative simplicity and demonstrated validity. Because the five indexes produce rates of increase that are essentially the same, the gain in administrative ease does not come at the expense of the validity of the inflation adjustment being used. Table IV, which presents the calendar year rates of increase in the four therapist indexes and the composite index, demonstrates their similarity.

TABLE IV.—THERAPY INPUT PRICE INDEXES FOR FORECASTING THE INCREASE IN THE COST OF THERAPY SERVICES, CALENDAR YEARS 1991–1999

Calendar year	Physical therapist index	Occupational therapist index	Speech language pathologist index	Respiratory therapist index	Composite therapist index [1]
Historical					
1991	4.8	4.8	4.8	4.8	4.8
1992	4.0	4.0	4.0	4.0	4.0
1993	3.5	3.5	3.5	3.5	3.5
1994	3.0	3.0	3.1	3.0	3.1
1995	2.6	2.6	2.6	2.6	2.6
Forecast [2]					
1996	3.1	3.1	3.1	3.1	3.1
1997	3.2	3.2	3.2	3.2	3.2
1998	3.2	3.2	3.2	3.2	3.2
1999	3.3	3.3	3.3	3.3	3.3

Released by: HCFA, OACT, Office of National Health Statistics.
[1] The outlays for services rendered in 1995 were used to develop the outlay-weighted composite therapy index.
[2] Source: DRI/McGraw-Hill HHC 3rd QTR 1996;@USSIM/TRENDL25YR0896@CISSIM/CONTROL963.

Table IV shows calendar year rates of inflation for historical years 1991 through 1995 and forecasted years 1996 through 1999. Salary equivalency amount adjustments will be made on a monthly basis using the factors in Table V.

TABLE V: ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT MONTHLY INFLATION FACTORS USING OUTLAY WEIGHTED COMPOSITE INDEX

[An example of how to use the inflation factors follows this table.]

Salary equivalency period		Period inflation factors
Month	Year	
1 April	1997	1.00000
2 May	1997	1.00272
3 June	1997	1.00546
4 July	1997	1.00819
5 August	1997	1.01094
6 September	1997	1.01369
7 October	1997	1.01646
8 November	1997	1.01922
9 December	1997	1.02200
10 January	1998	1.02478
11 February	1998	1.02758
12 March	1998	1.03037
13 April	1998	1.03318
14 May	1998	1.03600
15 June	1998	1.03882
16 July	1998	1.04165
17 August	1998	1.04449
18 September	1998	1.04733
19 October	1998	1.05018
20 November	1998	1.05304
21 December	1998	1.05591
22 January	1999	1.05879
23 February	1999	1.06167
24 March	1999	1.06456
25 April	1999	1.06746
26 May	1999	1.07037
27 June	1999	1.07329
28 July	1999	1.07621
29 August	1999	1.07914
30 September	1999	1.08208
31 October	1999	1.08503
32 November	1999	1.08799
33 December	1999	1.09095
34 January	2000	1.09392
35 February	2000	1.09690
36 March	2000	1.09989

Source: DRI/McGraw-Hill HHC 3rd QTR 1996; @USSIM/TRENDL25YR0896

For example, the proposed national salary equivalency guideline amount for physical therapists for cost reporting periods beginning April 1997 is $48.78. The salary equivalency guideline amount for cost reporting periods beginning in May 1997 would be determined as follows:

April 1997 national physical therapy salary equivalency amount $48.78
May 1997 monthly inflation factor 1.00272
May 1997 national salary equivalency amount $48.91

We have developed monthly adjustment factors for May 1997 through March 2000. If we do not publish new schedules of guidelines for cost reporting periods beginning on or after April 1, 2000, or do not announce other changes in the schedules, the schedules would remain in effect, increased by the appropriate adjustment factor (0.00272 monthly, compounded) [1], until new guideline schedules are issued. This is equivalent to a compounded annual rate of increase of 3.3 percent. The 3.3 percent rate of increase in the proposed guidelines is based upon the forecast rate of increase in the composite therapists input price index that HCFA's Office of the Actuary developed. For the period between 1997 and 1999, the price proxies in the therapists input price index were forecast in DRI/McGraw-Hill's 1996 third quarter forecast.

The 3.3 percent forecast rate of increase is based upon the average annual rate of increase for the period between 1997 and 1999. The 3.3 and 7.2 percent rates of increase are applied to their respective salary equivalency guidelines in different ways. The 3.3 percent is applied to the guidelines we are now proposing in a multiplicative fashion. That is, the salary equivalency guideline amount for each month is multiplied by one plus the 12th root of the 3.3 percent average annual rate of increase for each month moved away from the guideline base period. Conversely, the 7.2 percent rate of increase was applied by adding 0.6 percent of the October 1982 base value to the adjustment factor for each month after the guideline base period. The effect of using the additive adjustment factor rather than the multiplicative factor is that the additive factor gets progressively smaller in percentage terms each year.

Choosing appropriate wage and price proxies for each expense category necessarily involved making tradeoffs and exercising judgment. HCFA used four, sometimes conflicting, criteria to evaluate the strengths and weaknesses of each proxy in the therapy-specific input price indexes: relevance, reliability, timeliness, and time-series length. A relevant price variable should appropriately represent price changes for specific goods or services within the expense category. Relevance may encompass judgments about relative efficiency in the market generating the price and wage increases and may include normative factors relating to fairness and national policy objectives.

[1] The monthly rate of inflation is 0.00272. It is necessary to create the multiplicative factor that produces the next monthly level. Each month's factor (Table V) is 1.00272 times the previous month's factor.

The second criterion, reliability, concerns sampling variability. If the proxy wage-price variable has a high sampling variability or inexplicable erratic patterns over time, its value is greatly diminished since it is unlikely to accurately reflect price changes in the associated expenditure category. In some cases, low sampling variability can conflict with relevance, since the more specifically the price variable is defined in terms of service, commodity, or geographic area, the higher the potential sampling variability. An example of such a conflict is the tradeoff that must be made when considering two proxies, one of which is the product of a rigorously designed survey methodology for a somewhat broader occupational or industry grouping, while the other more closely surveys the targeted industry or occupation, but from a nonscientifically designed, nonrepresentative sample. Timeliness of actual published data is the third criterion. For this reason, monthly and quarterly data take priority over annual data. The fourth criterion is the length of time the time-series data have been available. A well-established time series is needed to provide a valid base from which to forecast future price changes in the series.

The price proxies for the therapy-specific input price indexes are based on BLS data and are one of the two following types:

- Employment Cost Indexes (ECIs), which measure the rate of change in employee wage rates and employer costs for employee benefits per hour worked. These indexes are fixed-weight indexes that strictly measure the change in wage rates and employee benefits per hour. They are not affected by shifts in employment mix.

- Consumer Price Indexes (CPIs), which measure change in the prices of final goods and services purchased by the typical consumer. They are fixed-weight price measures.

These price proxies ''best balance'' the criteria of relevance, reliability, timeliness, and time-series length. For reasons that are discussed later, the main issue in selecting price proxies for the Therapists Input Price Index is relevance.

In selecting price proxies for updating payment rates for various provider types (hospitals, offices of physicians, SNFs, home health agencies, etc.), HCFA considers using internal price proxies (that is, health-sector-specific data), external price proxies (that is, exclusively based upon economy-wide

price proxies), or a blend of internal and external price proxies based upon the competitive structure of the market and Medicare reasonable cost principles.[2]

It is generally accepted that prices for most nonlabor inputs are not directly influenced or biased by health-sector-specific market forces. As a result, we propose to use economy-wide price proxies for approximate price changes for the nonlabor inputs. However, workers in the four therapist occupations and industries are potentially affected by market imperfections associated with both supply and demand. Imperfections in these labor markets include third party payment, based at least in part on actual labor costs rather than on costs in efficiently operating competitive labor markets. Limitations on entry and restrictions on job content also potentially influence compensation levels and rates of increase relative to workers with similar education, skills, and work effort, but in different occupations and industries. Therefore, compensation of these workers should not be considered totally free from market imperfections and health industry influence. To the extent that supply and demand imperfections exist, using health-sector-specific compensation proxies could manifest these imperfections and, therefore, would not be the most socially or economically desirable public policy. The Prospective Payment Assessment Commission (ProPAC) has affirmed the blending of internal and external compensation indexes for the prospective payment system. The Physician Payment Review Commission also has recognized that it is appropriate to use external compensation proxies for certain health sector specific occupations such as physicians.

At the same time, it is important to recognize some of the unique features of the four therapist labor markets that suggested that health-sector-specific proxies may also have relevance. HCFA has chosen to balance these internal and external forces by using an equal blend of sector-specific compensation proxies (ECI Civilian Hospital Workers) and economy-wide compensation price proxies (ECI Private Professional and Technical Workers) for measuring therapist compensation price growth.[3] The proxies that are discussed in this section have been chosen to most closely estimate the changes that will occur in the different costs that are part of a salary equivalency guideline. We have already estimated the level of base period costs for the fourth quarter of 1995 that a provider would pay. The rehabilitation therapist input price index (IPI) proxies escalate the base level 1995 fourth quarter costs to the present (using actual price and wage change data) and into the future (with forecasted data). Thus, a March 1998 guideline reflects what we believe the cost to an efficient provider to employ a therapist will be in March 1998. The rehabilitation therapist input price index using these price proxies, weighted by the shares of costs of the expense categories they represent, is used to forecast the escalation of these costs over time. The principles being adopted here are the same as those in HCFA's use of a 50/50 blend of internal and external price proxies elsewhere in Medicare regulatory policy to adjust the professional and technical labor compensation component of the prospective payment system hospital input price index (IPI).[4] In other words, under the prospective payment system hospital IPI (market basket), compensation for physical therapists, occupational therapists, speech language pathologists, and respiratory therapists is updated using the same price proxies and blend as are proposed for these same therapists under arrangements. Consistent with its application in the hospital IPI, HCFA's proposed therapy-specific input price indexes apply the blend to professional and technical occupations only. However, for clerical and managerial workers, who are employed in significant proportions in nonhealth sectors of the overall economy, HCFA's therapy-specific input price indexes use economy-wide compensation proxies to measure price change just as is done in the prospective payment system hospital IPI for clerical and managerial workers.

F. Other Proposed Changes in Policies

1. Optional Travel Allowance

We particularly invite comments from the public on a proposal to extend to other providers the optional travel allowance for therapy furnished under arrangement by an outside contractor that is currently available to HHAs. The optional travel allowance could be used when therapy services are furnished in areas in which geographic distance creates unique labor markets. The actual number of travel hours could be used in lieu of the standard travel allowance. This would be used at the option of the provider, who would maintain time records of visits. Only the actual time spent in travel to reach the visit site would be included in the actual travel time. Payment for the actual travel hours would be based on the adjusted hourly salary equivalency amount for the area, and this amount would not be affected by the additional allowance for administrative-supervisory duties or by any other additional allowances described in section 1412 of the Provider Reimbursement Manual.

2. Data Sources for Future Salary Equivalency Guidelines

We have learned from the BLS that its 1991 ''Occupational Wage Survey: Hospitals, January 1991'' is the last edition of the series that it will produce. Prior BLS occupational wage surveys have been used to establish salary equivalency guidelines for physical therapy and respiratory therapy services furnished under arrangements, and we are proposing to include as two of our data sources the 1989 and 1991 surveys trended forward. We developed our proposed guideline amounts using many survey sources, we invite comments on alternative data sources and methodologies for future updates.

3. Application of Guidelines

We are proposing to revise § 413.106(c) to add a new paragraph (c)(6) that would provide that the salary equivalency guidelines will apply in situations where compensation to a therapist employed by the provider is based, at least in part, on a fee-for-service or on a percentage of income (or commission). The entire compensation would be subject to the guidelines in cases where the nature of the arrangements are most like an under ''arrangement'' situation, although technically the provider may treat the therapists as employees. The guidelines would be applied in this situation so that an employment relationship is not being used to circumvent the guidelines.

Since June 1977, there has been longstanding governing policy at section 1403 of the Provider Reimbursement Manual, Guideline Application, regarding this issue for making payments to providers. That instruction states, ''In situations where compensation, at least in part, is based on a fee-for-service or on a percentage of income (or commission), these arrangements will be considered

[2] See, for example, Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1997 Rates; Final rule. 61 FR 46192, August 30, 1996.

[3] The ECI for Civilian Hospital Workers provides data on hospital workers in the total private economy and the public sector, excluding the Federal Government. Because this price series represents hospitals, it is health sector-specific.

[4] See, for example, Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1997 Rates; Final rule. 61 FR 46192, August 30, 1996.

nonsalary arrangements, and the entire compensation will be subject to the guidelines in this chapter.'' This instruction clearly requires the intermediary to apply the salary equivalency guidelines in cases where the provider is paying the physicial therapists on a fee-for-service basis. This instruction considered the nature of those arrangements and that they are most like an under ''arrangement'' situation, although technically they are employees. Therefore, the instructions further the statutory purpose as reflected in the legislative history of the salary equivalency guidelines. This instruction addresses the fact that HCFA recognizes that certain employment relationships would effectively circumvent the guidelines and provided for these circumstances in section 1403 of the Provider Reimbursement Manual.

4. Limiting Contracted Services To 40 Hours

While we were evaluating the data we used in developing the guideline amounts, we became aware of a tendency for contracted therapy hours in some cases to exceed 40 hours per therapist a week, the amount of hours a full-time employee would generally work. While the Medicare program does not dictate the mode of delivery of therapy services, we do believe that under section 1861(v)(1)(A) of the Act, in making payments for services on a reasonable cost basis, costs incurred that are associated with providing therapy services that exceed the hours of a full-time employee are unnecessary in the efficient delivery of needed health services. It is our understanding that providers obtain services on a contractual basis because the facility does not require the services of a full-time employee and, therefore, it is more efficient to contract for therapy services rather than hire a full-time employee who may spend many hours not delivering services. Therefore, we propose to eliminate the expense factor where the hours of therapy services exceed 40 hours. Because the expense factor is associated with costs of maintaining an outside contractor's office, we believe where 40 or more hours of service are provided per therapist, the contracted services are being delivered in the same manner as a full-time salaried employee. We invite comments on this proposal.

5. Outcomes Based Systems

We have received several comments requesting that the guidelines not restrict differential therapy services (for example, ''full-service'' programs offering supervision, outcomes measurement, and therapy department support). Those comments have suggested that for example, where providers incur additional costs for outcomes measurement systems where Medicare beneficiaries benefit and thus, the provider incurs less routine costs, the provider should be allowed to claim those additional costs related to the outcomes measurement system. We are aware of no outcomes measurement for therapy services that would permit the adoption of the proposal for differentiated services. However, we invite comments on the development of an outcomes based system.

6. Exception for Binding Contract

Existing regulations at 42 CFR 413.106(f)(1) provide for an exception to the salary equivalency guidelines for a provider that has entered into a written binding contract with a therapist or contracting organization prior to the date the initial guidelines are published. Before the exception is granted, the provider was required to submit the contract to its intermediary, subject to review and approval by the HCFA regional office. The exception may be granted for the contract period, but no longer than 1 year from the date the guidelines for the particular therapy are published. During the period in which a binding contract exception is in effect, the cost of the services is evaluated under the prudent buyer concept. (Section 1414.1 of the Provider Reimbursement Manual contains instructions on this exception.)

We are proposing to eliminate this exception. We believe that providers should have been prudent purchasers of therapy services prior to the establishment of guidelines for speech language pathology and occupational therapy services and, therefore, should not be disadvantaged if contracted speech-language pathology and occupational therapy services are subject to the proposed guideline amounts. We also wish to point out that there has never been an exception for providers who enter into a contingency contract with a therapist or contracting organization and we are not now providing such an exception. In a contingency contract, the provider and contractor agree that, if Medicare does not reimburse the provider for the rate that the contract is set at, the provider and contractor agree that the provider will not be liable for the difference.

7. Exceptions Process for Unique Circumstances or Special Labor Market Conditions

Section 413.106 provides that a provider may request an exception to the established hourly salary equivalency amount for unique circumstances or special labor market conditions. The provider must submit evidence or information to the intermediary, in accordance with instructions issued in § 1414.2 of the Provider Reimbursement Manual, so that the intermediary can make a determination on the request. We invite specific comments on the substantiating documentation requirements and the process used to determine whether a provider would be granted an exception for unique circumstances or special labor market conditions.

8. Time Period for Submission of Exception Requests

We are proposing to revise the time period for a provider to submit a request for an exception to the salary equivalency guidelines for unique circumstances or special labor market conditions, to within 150 days after the close of its cost reporting period. Under existing policy, a provider's request for an exception, together with substantiating documentation, must be submitted to the intermediary no later than 90 days after the close of its cost reporting period. In response to provider claims that 90 days is not long enough for providers to submit cost reports and, as mentioned earlier, we have published final regulations to change the due date for submission of cost reports (60 FR 33137). If the circumstances giving rise to the exception remain unchanged from a prior cost reporting period, however, the provider need only submit evidence to the intermediary 150 days after the close of its cost reporting period to establish that fact.

III. Regulatory Impact

A. Background

For proposed rules such as this, we generally prepare a regulatory flexibility analysis that is consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612), unless we certify that a proposed rule would not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, States and individuals are not considered small entities. All therapists, however, are treated as small entities.

Also, section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. For purposes

of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 50 beds. We are not preparing a rural hospital impact statement because we have determined, and we certify, that this proposed rule would not have a significant economic impact on the operations of a substantial number of small rural hospitals.

This proposed rule would (1) Revise the methodology for determining salary equivalency guidelines for physical therapy and respiratory therapy services furnished under arrangement; (2) apply the revised methodology for payment of physical therapy and respiratory therapy services to speech language pathology and occupational therapy services; and (3) establish revised schedules of salary equivalency guidelines for physical and respiratory therapy services and initial schedules of salary equivalency guidelines for speech language pathology and occupational therapy services. The proposed guidelines would be used by Medicare fiscal intermediaries to determine the maximum allowable payment for therapy services furnished under arrangements.

As we indicated earlier, the salary equivalency guidelines for physical and respiratory therapy services furnished under arrangements were last revised in 1983, with provisions for yearly adjustments for inflation. In addition, although the law gives us explicit authority to establish salary equivalency guidelines for speech language pathology and occupational therapy services furnished under arrangements, we have never previously done so. We have, instead, paid for these services using reasonable cost methodologies. We now believe that, if we continue to use these methods to pay for speech language pathology and occupational therapy services furnished under arrangements, we would be paying for costs that are in excess of what Congress intended under section 1861(v)(5) of the Act.

Although we expect that the establishment of these proposed revised guidelines would be beneficial to the Medicare program as well as to Medicare beneficiaries, we recognize that a large number of small entities, such as suppliers of rehabilitation therapy services, would be affected by these proposed revised guidelines, and a substantial number of these entities may be required to make changes in their operations. This analysis, in combination with the remainder of this preamble, is consistent with the standards for analysis set forth by the RFA.

B. Anticipated Effects

1. Effects on the Medicare Trust Funds

The proposed guidelines are based upon a provider's reasonable cost for an employee therapist furnishing therapy services. This cost includes the prevailing salary levels for therapists, prevailing market area fringe benefits, as well as a share of the other expenses that could be attributed to an employee therapist. The estimated savings to the Medicare Trust Funds result from the differences in the proposed guidelines relative to current rates of payment after behavioral offsets for increased add-ons, volume, intensity, mix of services and other revenue enhancement behaviors have occurred.

Although we were confronted with limited available data on the effect of the proposed guidelines on the Medicare Trust Funds, we developed an estimate of that effect. A detailed paper on the methodology of the impact analysis is available to interested parties upon request. We had limited data sources with which to develop hourly salary rates and other expense factors and to develop a projection of the effect of the proposed guidelines on the Medicare Trust Funds for proposed versus current levels. We are limited because the Medicare cost reports and claims data do not furnish us with data on hourly rates paid to therapists and other relevant expense and net revenue data. So, we based the hourly salary rates and the effect of the proposed guidelines on the Medicare Trust Funds on the best data available to us from HCFA sources and the therapy industry. The hourly salary rates were based on a blend of hospital and SNF survey data sources and the impact analysis was based on billing data from HCFA's Decision Support Access Facility (DSAF) files and SNF cost report data from the Hospital Cost Reporting Information System file as well as industry sources. We invite comments on other data sources that may be used.

Based upon various data sources for 1993, 1994, and 1995 we formed a base line for purposes of projecting volume of services in future years for each of the four therapy types. For each therapy type, we then found the difference between the current rate and the proposed rate, multiplied that difference by the projected volume in order to estimate the savings or additional outlays that this proposed rule would have.

When trend factors from the DRI/McGraw Hill third quarter 1996 forecast of the HCFA rehabilitation therapist input price index are used, we estimate the proposed guidelines for April 1997 will increase the current national or aggregate guidelines per hour for physical therapy by 30.5 percent and the national or aggregate guidelines for respiratory therapy by 8.1 percent. At the same time, the proposed guidelines for occupational therapy and speech-language pathology will decrease estimated current aggregate rates by 42.7 percent and 28.1 percent, respectively.

Our projected savings per year are based on the difference between current and proposed total costs after a standard behavioral adjustment is applied for lower proposed prices relative to current payments under current payment rules.

We followed the Office of the Actuary (OACT) standard practice of allowing an offset of 35–50 percent for behavioral changes when we estimated the proposed savings resulting from lowered prices. In recent years suppliers of therapy services have bundled physical therapy, occupational therapy, and speech language pathology (but not respiratory therapy) when they have contracted to furnish therapy services to SNFs. The 35 percent behavioral offset allows for changes in behavior that generate increased revenue to the suppliers at the lower average price for the bundle of services. The behavioral offset was not applied to respiratory therapy services because proposed prices are higher than current regulation prices and the respiratory therapy industry contracts separately with the SNF industry. We chose the lower end of the range because services are provided in the facility based on time in facility, not fee for service, thus there are substantially fewer opportunities for revenue enhancing behavior. Suppliers are estimated to compensate for about one third of the reduction in prices by a combination of increased add-ons, volume, intensity, change in mix, and a shift in the site of service or a change in options for reimbursement. Suppliers might shift from being suppliers where payment is controlled by salary equivalency guidelines to being providers where payment is on a reasonable cost basis not subject to guidelines (unless as providers they also contract for therapy services); or they may increase the volume of services in physical therapy where guideline amounts are higher; or they may use less experienced and therefore lower salaried therapists. Other revenue enhancement practices may emerge which cannot be fully anticipated. Using this offset, the 4½ year impact of the proposed guidelines for 1997

through 2001 for therapy services under arrangements is estimated to be a savings of $1,250 million for Medicare Part A and $410 million for Medicare Part B.

When the 4½ year impact analysis methodology and the expected percentage increase in Medicare enrollees per year (from 2002 to 2006) are used to estimate the increased volume of rehabilitation therapy services for 2002 to 2006, the impact on outlays over 9½ years is a savings of $2,920 million for Medicare Part A and $980 million for Medicare Part B.

For a 9½ year impact, the expected percentage increase in Medicare enrollees for 2002–2006 was used in part to compute estimated volume of services. The results were then multiplied by the estimated current and proposed guidelines, which had been estimated by extending the current guidelines by their inflation methods and the proposed guidelines by their proposed inflation method. Estimated outlays for each year under current and proposed guideline amounts were calculated. Again a 35-percent behavioral offset was applied to the aggregate savings for physical therapy, occupational therapy, and speech language pathology services, and the resultant outlay savings calculated. The results using the proposed guideline amounts were additional estimated savings. When combined with the 4½ year total impact shown above, the estimated 9½ year savings total is $2,920 million for Medicare Part A and $980 million for Medicare Part B.

Our projected outlays under current guidelines, under the proposed guidelines, and the difference between the two sets for fiscal year 1997 through fiscal year 2001 are as follows:

SALARY EQUIVALENCY: OUTLAYS AND SAVINGS ESTIMATES—PARTS A AND B

Federal fiscal year	Estimated outlays			Estimated savings after offset (in millions, rounded)	Coinsurance (in millions, rounded)
	Under current regulations before offset (in millions)	Under proposed regulations			
		Before offset (in millions)	After offset of 35 percent (in millions)		
1997	$1,790	$1,530	$1,630	$140	$20
1998	3,900	3,310	3,530	340	30
1999	4,230	3,560	3,810	380	40
2000	4,420	3,730	3,990	390	40
2001	4,620	3,900	4,170	410	40
2002	4,830	4,080	4,360	430	40
2003	5,040	4,270	4,560	440	40
2004	5,260	4,480	4,770	450	40
2005	5,490	4,690	4,990	460	40
2006	5,740	4,930	5,240	460	40
Totals	45,320	38,480	41,050	3900	370

The budget outlays and savings include coinsurance and are before the Part B premium offset.
This applies the 35 percent offset to physical therapy, occupational therapy, and speech-language pathology only and no offset to respiratory therapy.
Estimates are based on an illustrative effective date of April 1, 1997.

SALARY EQUIVALENCY: OUTLAYS AND SAVINGS ESTIMATES [1]—PART A

Federal fiscal year	Estimated outlays			Estimated savings (in millions, rounded)
	Under current regulations before offset (in millions)	Under proposed regulations		
		Before offset (in millions)	After offset of 35 percent (in millions) [2]	
1997	$1,370	$1,200	$1,270	$100
1998	2,990	2,590	2,740	250
1999	3,250	2,780	2,960	290
2000	3,400	2,910	3,100	300
2001	3,550	3,050	3,240	310
2002	3,710	3,190	3,390	320
2003	3,870	3,330	3,540	330
2004	4,040	3,490	3,700	340
2005	4,210	3,660	3,870	340
2006	4,410	3,850	4,070	340
Totals	34,800	30,050	31,880	2,920

[1] Estimates are based on an illustrative effective date of April 1, 1997.
[2] This applies the 35 percent offset to physical therapy, occupational therapy, and speech-language pathology only and no offset to respiratory therapy.

SALARY EQUIVALENCY: OUTLAYS AND SAVINGS ESTIMATES [1]—PART B

Federal fiscal year	Estimated outlays [2]				
	Under current regulations before offset (in millions)	Under proposed regulations		Estimated savings (in millions, rounded)	Coinsurance (in millions, rounded)
		Before offset (in millions)	After offset of 35 percent (in millions) [3]		
1997	$420	$330	$360	$40	$20
1998	910	720	790	90	30
1999	980	780	850	90	40
2000	1,020	820	890	90	40
2001	1,070	850	930	100	40
2002	1,120	890	970	110	40
2003	1,170	940	1,020	110	40
2004	1,220	990	1,070	110	40
2005	1,280	1,030	1,120	120	40
2006	1,330	1,080	1,170	120	40
Totals	10,520	8,430	9,170	980	370

[1] Estimates are based on an illustrative effective date of April 1, 1997.
[2] The budget outlays and savings include coinsurance and are before the Part B premium offset.
[3] This applies the 35 percent offset to physical therapy, occupational therapy, and speech-language pathology only and no offset to respiratory therapy.

2. Effects on Providers

We expect that the proposed salary equivalency guidelines will provide adequate payments for all classes of efficient providers. It is possible that certain inefficient therapy suppliers may be unwilling to contract with providers at the proposed salary equivalency rates, expanding the market for more efficient therapy suppliers. We also understand that certain therapy suppliers were requiring providers to purchase a bundled package of physical therapy, occupational therapy, and speech-language pathology services. By requiring this bundling of services, suppliers were able to make substantial profits because, even though there was an hourly payment limit on the physical therapy services, there were no guidelines for the speech-language pathology and occupational therapy services. Consequently, the suppliers marked up the speech-language pathology and occupational therapy services. Our proposed guidelines for speech-language pathology and occupational therapy services may eliminate suppliers profiting from excessively high prices for occupational therapy and speech language pathology. We expect that providers will continue to provide therapy services at the proposed published rates. We expect that providers will be able to furnish the same array of beneficiary services they furnish under current guidelines amounts or payment on a reasonable cost basis.

3. Effects on Beneficiaries

We believe that the impact of the proposed guidelines on Medicare beneficiaries will be minimal. Beneficiaries may be slightly affected by the proposed guidelines for physical therapy, speech language pathology, and occupational therapy services. With respect to physical therapy services, the Medicare Part B coinsurance amounts associated with these services, that must be paid by beneficiaries (20 percent of the provider's charges to the beneficiary) may increase if providers increase charges for those services. The charges may increase because physical therapy hourly amounts recognized by Medicare fiscal intermediaries to determine the maximum allowable cost of those services will increase in this proposed rule over the previous schedules of guidelines. However, the Medicare program does not dictate a provider's charge structure. We do expect charges to be reasonably related to cost. Conversely, beneficiary coinsurance would be reduced for speech language pathology and occupational therapy services because Medicare payment rates for these services would be reduced by the establishment of guidelines in this proposed notice and the provider's charges to the beneficiary may also decrease. Because respiratory therapy provided in comprehensive outpatient rehabilitation facilities under arrangements is a Part B service, Medicare Part B coinsurance amounts related to those services that must be paid by beneficiaries may increase if providers increase charges for those services. This may also occur because respiratory therapy hourly amounts recognized by Medicare fiscal intermediaries to determine the maximum allowable cost of those services will increase in this proposed notice over the previous schedules of guidelines. We believe that our proposed guideline amounts are adequate so that therapy suppliers should continue to contract with providers to furnish services to beneficiaries. Since we are now introducing proposed guideline amounts for occupational therapy and speech language pathology, if providers are passing along the therapy companies higher charges, then we would expect providers' charges may be lower for those services.

4. Effects on Therapists and Therapist Companies

The proposed salary equivalency guidelines would have varying impacts on the four categories of therapists. Speech language pathologists and occupational therapists working for contract suppliers should be minimally affected, since the suppliers typically bundle all therapy services when negotiating rates (including overhead) with providers. Physical therapists acting as suppliers or employed by supplying therapy companies may be affected positively because physical therapy hourly rates recognized by Medicare fiscal intermediaries to determine the maximum allowable cost of those services will increase in this proposed notice and, therefore, providers may contract with physical therapists at a higher amount. Also, providers may contract with therapy companies at a higher amount and they, in turn, may pay the therapists higher salaries. Similarly, respiratory therapists acting as therapy suppliers or employed by therapy suppliers may be positively affected because respiratory therapy

hourly amounts recognized by Medicare fiscal intermediaries to determine the maximum allowable cost of those services will increase in this proposed notice and, therefore, providers may contract with respiratory therapy suppliers at a higher amount. Also providers may contract with therapy companies at a higher amount and they, in turn, may pay the therapists higher salaries.

We recognize that a large percentage of providers have contracts with therapy companies that may dominate a market area. We understand that because the contracted physical therapy services have been limited by the guidelines, some of these therapy companies have been requiring providers to sign up for three therapy services, that is, physical, occupational and speech-language pathology services, but were overcharging providers for speech-language pathology and occupational therapy services. These therapy companies may incorrectly claim that the introduction of our proposed guidelines for contracted speech-language pathology and occupational therapy services may put them out of business. Our rates are designed to reflect adequate rates for all classes of efficient suppliers. Even though we do not pay contracted therapy companies directly, unless they also act as providers, and (with the exception of independent physical therapists and occupational therapists) contracted therapy services are one of the few Medicare services that have not been targeted in earlier deficit reduction laws.

Other changes in behavior might include a change in the type of therapy offered (perhaps substituting physical therapy for occupational therapy and increasing the volume of services furnished in physical therapy, which has a higher guideline amount), use by suppliers of less experienced (and therefore lower salaried) therapists, a shift by suppliers from furnishing therapy services under arrangements to furnishing therapy services under agreement, in which the therapy company bills Medicare directly as a provider under Part B. In the latter case, the providers are paid under Part B on a reasonable cost basis and are not subject to salary equivalency guidelines unless they contract for therapy services.

Inefficiently run rehabilitation therapy companies may cut expenses and become more efficient, as is happening in much of the rest of the economy. More efficient companies may expand or enter the market, picking up the therapy services volume which less efficient suppliers may leave unserved. Therapists'' productivity could increase. Overhead is a likely candidate for expense reduction. In addition, profit margins may be reduced, but still be at or above competitive rates for efficient firms. Individual therapy suppliers may already have lower overhead than corporate suppliers. Multi-therapy companies may adjust their service mix away from therapy types for which they are inefficient producers and expand the therapy types for which they are efficient producers.

Due to the proposed salary equivalency guidelines, some therapists who work for inefficient rehabilitation therapy suppliers may have compensation levels above competitive rates and may find that their yearly salary and fringe benefit increases lag those of therapists employed in other more competitive settings of the local therapist labor market. A deceleration in wage increases for workers with excessively high compensation levels will continue until wages in various settings, after compensating non-wage differences, are roughly comparable for each therapy type. Those therapists whose employers curtail furnishing services under arrangements with providers may either furnish therapy for those same employers as employees of rehabilitation agencies that will bill Medicare directly as providers, change employers to those efficiently run companies that expand their contracted therapy services, or become self-employed and contract directly with providers to furnish therapy services under arrangements. Therapists who are employed by efficient rehabilitation therapy suppliers where salaries are in line with those of other therapists (after adjustments for compensating non-wage differentials) in the local labor market should notice no substantial effect. The expected effects described above result in a better functioning, more efficient health care system.

C. Alternatives Considered

Section 1861(v)(5) of the Act requires us to determine the reasonable cost of services furnished to Medicare beneficiaries ''under an arrangement'' with a provider of services, by therapists or other health-related personnel. Other alternatives to implementing the salary equivalency program are to continue paying for therapy services furnished under arrangements using current reasonable cost methodologies or to use alternative data sources to establish the proposed salary equivalency guidelines.

We rejected the first alternative because, if we continue to pay for speech language pathology and occupational therapy services furnished under arrangements using reasonable cost methodologies, we will be paying for costs that are in excess of what Congress intended under section 1861(v)(5) of the Act, to the detriment of the Medicare Trust Funds. In the case of physical therapy and respiratory therapy services, current salary equivalency guidelines may reflect less than a provider's reasonable costs in furnishing these services.

As we indicated in our discussion of data sources we used to establish the proposed guidelines (see section II.A. of this proposed rule), we were unable to find a sole or primary source of data on hourly rates paid to therapists by providers that is timely and statistically valid. Because the BLS hospital wage industry surveys were not timely, we were unable to use that data as our sole source as in prior guideline notices. The rehabilitation therapy industry has submitted survey data to HCFA that they believe support higher guideline amounts than are proposed in this proposed rule. Although the survey data was submitted to us to determine its appropriateness for use in determining new guideline amounts as provided in 42 CFR 413.106(b)(6), it did not meet the requirements in those regulations, but we nevertheless evaluated the data. As indicated in Section II.A. of this preamble, because we were unable to find a sole or primary source that met our criteria of reliability, validity, and representativeness, we decided to blend selected hospital and SNF data sources so that the wages and salary parts of our proposed rule have been determined using a ''best estimate'' approach, giving equal weight to each data source, but preferential status to none.

D. Conclusion

Federal Medicare expenditures have grown at an extraordinary rate in recent years. A study commissioned by the National Association for Support of Long-Term Care indicates that 75 percent of all therapy services under arrangements were furnished in SNFs. We also project that the 65 and over population will nearly double by the year 2025. We believe that the salary equivalency guidelines proposed in this rule are in the public interest since they balance the needs of Medicare program beneficiaries, (taxpayers), providers of therapy services, and suppliers who furnish therapy services under arrangements. Nevertheless, we solicit public comments as well as acceptable data on the extent to which any of the affected entities would be significantly economically affected by these guidelines.

We are not preparing a rural impact analysis since we have determined, and certify, that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

In accordance with the provisions of Executive Order l2866, this proposed rule was reviewed by the Office of Management and Budget.

IV. Response to Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, we will consider all comments that we receive by the date and time specified in the ''Dates'' section of this preamble, and if we proceed with the final rule, we will respond to the comments in the preamble of the final rule.

V. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, agencies are required to provide a 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- Whether the information collection is necessary and useful to carry out the proper functions of the agency;
- The accuracy of the agency's estimate of the information collection burden;
- The quality, utility, and clarity of the information to be collected; and
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

This proposed rule contains a collection of information requirement that would be subject to OMB review and approval. Section 413.106(e) requires a provider of therapy services to supply its intermediary with documentation that supports additional costs incurred for services furnished by an outside supplier. Under § 413.106(f), before an exception to the application of the guidelines may be granted, the provider must submit appropriate evidence, in accordance with instructions issued in section 1414 of the Provider Reimbursement Manual, to its intermediary to substantiate its claim.

Public reporting burden for this collection of information is estimated to be 10 providers at 15 minutes each to prepare and submit to the intermediary documentation that supports the additional costs. We estimate that 10 providers will request an exception. It will take intermediaries 2 hours to process each request. The total public burden is 22½ hours.

This collection of information request is not effective until it has been approved by OMB. A notice will be published in the **Federal Register** when approval is obtained. Organizations and individuals desiring to submit comments on this requirement should direct them to the OMB official whose name appears in the **ADDRESSES** section of this preamble.

List of Subjects in 42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR part 413 would be amended as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; OPTIONAL PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1861(v)(1)(A), and 1871 of the Social Security Act (42 U.S.C 1302, 1395x(v)(1)(A), and 1395hh).

2. In § 413.106, paragraph (c)(5) is redesignated as paragraph (c)(6) and republished, a new paragraph (c)(5) is added, paragraph (f)(1) is removed and paragraphs (f) (2), (3), and (4) are redesignated as (f) (1), (2), and (3) and republished, to read as follows:

§ 413.106 Reasonable cost of physical and other therapy services furnished under arrangements.

* * * * *

(c) Application. * * *

(5) If therapy services are performed in situations where compensation to a therapist employed by the provider is based, at least in part, on a fee-for-service or on a percentage of income (or commission), the guidelines will apply. The entire compensation will be subject to the guidelines in cases where the nature of the arrangements is most like an under ''arrangement'' situation, although technically the provider may treat the therapists as employees. The intent of this section is to prevent an employment relationship from being used to circumvent the guidelines.

(6) These provisions are applicable to individual therapy services or disciplines by means of separate guidelines by geographical area and apply to costs incurred after issuance of the guidelines but no earlier than the beginning of the provider's cost reporting period described in paragraph (a) of this section. Until a guideline is issued for a specific therapy or discipline, costs are evaluated so that such costs do not exceed what a prudent and cost-conscious buyer would pay for the given service.

* * * * *

(f) *Exceptions:* The following exceptions may be granted but only upon the provider's demonstration that the conditions indicated are present:

(1) *Exception because of unique circumstances or special labor market conditions.* An exception may be granted under this section by the intermediary if a provider demonstrates that the costs for therapy services established by the guideline amounts are inappropriate to a particular provider because of some unique circumstances or special labor market conditions in the area. The provider's request for an exception, together with substantiating documentation, must be submitted to the intermediary each year, no later than 150 days after the close of the provider's cost reporting period. If the circumstances giving rise to the exception remain unchanged from a prior cost reporting period, however, the provider need only submit evidence of the intermediary 150 days after the close of its cost reporting period to establish that fact.

(2) *Exception for services furnished by risk-basis HMO providers.* For special rules concerning services furnished to an HMO's enrollees who are Medicare beneficiaries by a provider owned or operated by a risk-basis HMO (see § 417.201(b) of this chapter) or related to a risk-basis HMO by common ownership or control (see § 417.205(c) of this chapter).

(3) *Exception for inpatient hospital services.* Effective with cost reporting periods beginning on or after October 1, 1983, the costs of therapy services furnished under arrangements to a hospital inpatient are excepted from the guidelines issued under this section if such costs are subject to the provisions of § 413.40 or part 412 of this chapter. The intermediary will grant the exception without request from the provider.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital

Insurance Program and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 8, 1996.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: January 13, 1997.

Donna E. Shalala,

Secretary.

[FR Doc. 97–7477 Filed 3–26–97; 2:28 pm]

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