dimethyl ammonium α-N-methyl carboxylate, octadecyl methacrylate, ethyl methacrylate, cyclohexyl methacrylate, N-vinyl-2-pyrrolidone copolymer as an antistatic agent in polyolefin films.

The environmental impact analysis report and other relevant material have been reviewed, and it has been determined that the proposed use of the additive will not have a significant environmental impact. Copies of the environmental impact analysis report may be seen in the office of the Hearing Clerk (HFA–305), Food and Drug Administration, Rm. 4–65, 5600 Fishers Lane, Rockville, MD 20857, between the hours of 9 a.m. and 4 p.m., Monday through Friday.

Dated: February 7, 1980.

Sanford A. Miller,

Director, Bureau of Foods.

[FR Doc. 80–4882 Filed 2–14–80; 8:45 am]

BILLING CODE 4110–03–M

Norden Laboratories; Phenylbutazone Crumblet Tablets; Withdrawal of Approval of NADA

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The agency withdraws approval of a new animal drug application (NADA) providing for use of phenylbutazone crumblet tablets containing 1 gram of phenylbutazone per tablet for horses for treating anti-inflammatory conditions of the musculo-skeletal system. The sponsor, Norden Laboratories, requested the withdrawal of approval.

EFFECTIVE DATE: February 25, 1980.

FOR FURTHER INFORMATION CONTACT: Leonard D. Krinsky, Bureau of Veterinary Medicine (HFV–216), Food and Drug Administration, Department of Health, Education, and Welfare, 5600 Fishers Lane, Rockville, MD 20857, 301–443–4093.

SUPPLEMENTARY INFORMATION: Norden Laboratories, Inc., Lincoln, NE 68501, is the sponsor of NADA 102–823, which provides for use of phenylbutazone tablets for treating horses for inflammatory conditions associated with the musculo-skeletal system. This application was originally approved August 19, 1977. In submitting a report on August 3, 1979, the sponsor requested that approval of the NADA be withdrawn because the product has never been manufactured or marketed.

Therefore, under the Federal Food, Drug, and Cosmetic Act (sec. 512(e), 82 Stat. 345–347 (21 U.S.C. 360b(e))), under authority delegated to the Commissioner of Food and Drugs (21 CFR 5.1) and redelegated to the Director, Bureau of Veterinary Medicine (21 CFR 5.84), and in accordance with § 514.115 *Withdrawal of approval of applications* (21 CFR 514.115), notice is given that approval of NADA 102–823 and all supplements for Norden Laboratories' phenylbutazone crumblet tablets is hereby withdrawn, effective February 25, 1980.

In a separate document published elsewhere in this issue of the **Federal Register** § 520.1720a is amended to delete that portion of the regulations which reflects approval of this NADA.

Dated: February 8, 1980.

Lester M. Crawford,

Director, Bureau of Veterinary Medicine.

[FR Doc. 80–4880 Filed 2–14–80; 8:45 am]

BILLING CODE 4110–03–M

Public Advisory Committees; Request for Nominations for Voting Members

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) requests nominations for voting members to serve on the Vaccines and Related Biological Products Advisory Committee in the Bureau of Biologics. A notice of establishment of this committee appears elsewhere in this issue.

DATE: Nominations should be received by March 17, 1980.

ADDRESS: All nominations for membership must be sent to: Jack Gertzog, Bureau of Biologics (HFB–5), Food and Drug Administration, Department of Health, Education, and Welfare, 8800 Rockville Pike, Bethesda, MD 20205.

FOR FURTHER INFORMATION CONTACT: Jack Gertzog, at the address given above (301–443–5455).

SUPPLEMENTARY INFORMATION: FDA requests nominations for voting members on the Vaccines and Related Biological Products Advisory Committee. The function of the committee is to review and evaluate available data on the safety, effectiveness, and appropriate use of vaccines and other immunological products intended for use in the diagnosis, prevention, or treatment of human diseases; to advise the Commissioner of Food and Drugs of its findings regarding the safety and effectiveness of the products; and to advise on clinical and laboratory studies involving such products, on the promulgation of monographs establishing conditions under which these particular products are generally recognized as safe and effective and not misbranded, and on the quality and relevance of FDA's research program which provides scientific support for the regulatory program concerning these agents.

Persons nominated for membership shall have adequately diversified experience appropriate to the work of the committee in such fields as immunology, virology, bacteriology, epidemiology, allergy, preventive medicine, infectious diseases, pediatrics, microbiology, and biochemistry, or other appropriate areas of expertise. The specialized training and experience necessary to qualify the nominee as an expert suitable for appointment is subject to review, but may include experience in medical practice, teaching, and/or research relevant to the field of activity of the committee. The term of office is 4 years, except that initial appointments will be staggered to provide for an orderly rotation of membership.

Any interested person may nominate one or more qualified persons for membership on the advisory committee. Nominations shall state that the nominee is aware of the nomination, is willing to serve as a member of the advisory committee, and appears to have no conflict of interest that would preclude committee membership. Potential candidates will be asked by FDA to provide detailed information concerning such matters as financial holdings, consultancies, and research grants or contracts in order to permit evaluation of possible sources of conflict of interest.

FDA has a special interest in assuring that women, minority groups, and the physically handicapped are adequately represented on advisory committees and therefore extends particular encouragement to nominations for appropriately qualified female, minority, and physically handicapped candidates.

The notice is issued under the Federal Advisory Committee Act (Pub. L. 92–463, 86 Stat. 770–776 (5 U.S.C. App. I)) and 21 CFR Part 14, relating to advisory committees.

Dated: February 7, 1980.

William F. Randolph,

Acting Associate Commissioner for Regulatory Affairs.

[FR Doc. 80–4881 Filed 2–14–80; 8:45 am]

BILLING CODE 4110–03–M

Orticalm (Reserpine) Premix; Withdrawal of Approval

AGENCY: Food and Drug Administration.

ACTION: Notice.

SUMMARY: The agency withdraws approval of a new animal drug application (NADA) sponsored by E. R. Squibb & Sons, Inc., providing for use of Orticalm (reserpine) premix used to manufacture complete feed for turkeys. E. R. Squibb & Sons, Inc., requested the withdrawal of approval.

EFFECTIVE DATE: February 25, 1980.

FOR FURTHER INFORMATION CONTACT: David N. Scarr, Bureau of Veterinary Medicine (HFV–214), Food and Drug Administration, Department of Health, Education, and Welfare, 5600 Fishers Lane, Rockville, MD 20857, 301–443–3183.

SUPPLEMENTARY INFORMATION: E. R. Squibb & Sons, Inc., P.O. Box 4000, Princeton, NJ 08540, is the sponsor of NADA 11–581 which provides for safe and effective use of a 0.08 percent reserpine premix used to manufacture complete turkey feed. The reserpine-containing feed would aid in prevention of aortic rupture or lessen the incidence of aortic rupture. The sponsor requested withdrawal of approval of the NADA by letter on July 13, 1979, because the product is no longer being manufactured or marketed.

Therefore, under the Federal Food, Drug, and Cosmetic Act (sec. 512(e), 82 Stat. 345–347 (21 U.S.C. 360b(e))) and under authority delegated to the Commissioner of Food and Drugs (21 CFR 5.1) and redelegated to the Director of the Bureau of Veterinary Medicine (21 CFR 5.84), and in accordance with § 514.115 *Withdrawal of approval of applications* (21 CFR 514.115), notice is given that approval of NADA 11–581 and all supplements thereto is hereby withdrawn; effective February 25, 1980.

A final order revoking § 556.570 *Reserpine* (21 CFR 556.570) and § 558.505 *Reserpine* (21 CFR 558.505) is issued elsewhere in this issue of the **Federal Register** to reflect withdrawal of approval of the NADA.

Dated: February 8, 1980.

Lester M. Crawford,

Director, Bureau of Veterinary Medicine.

[FR Doc. 80–4895 Filed 2–14–80; 8:45 am]

BILLING CODE 4110–03–M

Health Care Financing Administration

Medicare and Medicaid Programs; Schedule of Limits on Home Health Agency Costs per Visit

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

ACTION: Proposed notice.

SUMMARY: This Notice sets forth a proposed schedule of limits on home health agency costs that may be reimbursed under the Medicare program. Limits are established by type of service and are expressed as costs per visit. We intend for this schedule to apply for the entire cost reporting period of a provider which begins on or after July 1, 1980. It would replace the initial schedule published in the **Federal Register** on June 1, 1979 (44 FR 31814).

DATES: Comments should be received by: April 15, 1980.

ADDRESSES: Address comments in writing to: Administrator, Health Care Financing Administration, Department of Health, Education, and Welfare, P.O. Box 17073, Baltimore, MD 21235.

If you prefer, you may deliver your comments to: Room 5220 Switzer Building, 330 C Street, SW., Washington, D.C.; or to Room 789 East High Rise Building, 6401 Security Boulevard, Baltimore, Maryland.

When commenting please refer to File Code BPP–55–PN.

Agencies and organizations are requested to submit comments in duplicate. Comments will be available for public inspection, beginning approximately 2 weeks from today, in Room 5220 of the Department's offices at 330 C Street, SW., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (202–245–0365).

FOR FURTHER INFORMATION, CONTACT: Carl Slutter, 301–594–9344.

SUPPLEMENTARY INFORMATION:

Background

Section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) authorizes the Secretary to set prospective limits on allowable costs incurred by a provider of services that will be reimbursed under Meidcare, based on estimates of the costs necessary in the efficient delivery of needed health services. The limits may be applied to direct or indirect overall costs or to the costs incurred for specific items or services furnished by the provider. This provision of the statute is implemented under regulations at 42 CFR 405.460.

Under this authority, limits on home health agency per visit costs by type of service were established effective July 1, 1979. These limits contained provisions related to: (1) Classification system based on whether the HHA was located within a Standard Metropolitan Statistical Area (SMSA) or a non-SMSA; (2) limits set at the 80th percentile; and (3) an inflation factor based upon estimates by The Office of Financial and Actuarial Analysis, HCFA, of increases in the average per visit interim reimbursement and the application of a formula established by the Council on Wage and Price Stability. The limits were applied on an aggregate basis. That means that the Medicare allowable costs for all types of services are totaled and compared to an overall limit computed for each agency by multiplying the number of Medicare visits for each service furnished by the respective per visit cost limit. The revised schedule of limits proposes several changes in the methodology used in computing and applying these limits.

Summary of Proposed Changes

The proposed new schedule of limits on home health agency costs would provide for:

1. A classification system based on whether a HHA is provider-based or free-standing. (A "provider-based" HHA is one that participates in Medicare as part of a hospital, skilled nursing facility, or rehabilitation facility.) In addition, agencies would be classified according to whether the HHA is located within a Standard Metropolitan Statistical Area (SMSA) or a non-SMSA area. For the New England area, New England County Metropolitan Areas (NECMA) are used to determine urban location.

2. A market basket index developed from the price of goods and services purchased by HHAs, used to account for the impact of changing wage and price levels on HHA costs. This index would be used to adjust HHA cost data from July 1, 1980, to the beginning of the cost reporting periods to which the limits will apply.

3. A wage index, developed from hospital wages, used to adjust the wage component of the limits to reflect differing wage levels among the areas in which HHAs are located. The wages and salaries portion of the market basket index (64.99 percent) plus a factor representing the wage portion of contract services (4.79 percent) is used to determine the wage component (69.78 percent) for all group limits.

4. A cost of living adjustment for Alaska and Hawaii.

5. Application of limits to each type of service furnished by the agency (i.e., skilled nursing, physical therapy, speech pathology, occupational therapy, medical social services and home health aide).

Discussion of Proposed Limits and Changes

We propose to establish these revised limits for home health agency costs per visit by type of service and apply them

to the following services—skilled nursing care, physical therapy, occupational therapy, speech pathology, medical social services, and intermittent services of home health aides.

The limits also include the cost of medical supplies routinely furnished in conjunction with patient care. However, the costs of medical appliances and supplies that are not routinely furnished in conjunction with patient care visits and which are direct identifiable services to an individual patient are excluded from the per visit limit amounts. The reasonable costs of these items will be reimbursed without regard to the schedule of limits.

Before the limits are applied at cost settlement, the provider's actual costs will be reduced by the amount of individual items of cost (e.g., administrative compensation, contract services) that are found to be excessive under Medicare principles of provider reimbursement, and of reimbursable costs that are not included in the limitation amount (e.g., medical appliances).

1. Use of Separate Limits for Provider-Based and Free-Standing HHAs

The initial schedule of limits on home health agency costs made no distinction between provider-based and free-standing agencies. Under this system, the percentage of provider-based agencies exceeding the cost limit was far greater than the percentage of provider-based agencies represented in the data base. Since the initial schedule of limits was published, we have further examined the reasons for the higher costs associated with some provider-based HHAs. We have also received input from providers and home health organizations citing cost differences between provider-based and free-standing agencies. Although some of these commenters claim that the provider-based HHA serves a more seriously ill patient and therefore provides a more intensive level of care, we have not received compelling evidence of this. However, we have more closely examined the effects of Medicare cost reporting requirements nationally on costs per visit for provider-based HHAs. We analyzed the relationship between the indirect overhead costs allocated from the hospital to the home health care department and the direct visit costs incurred by the agency. (See 42 CFR 405.453 for explanation of allocation of overhead costs.) We found that as a rule a substantial proportion of the home health care department's total costs per visit (nationally about 26 percent of total cost) can be traced to the method of allocating overhead expenses to the home health cost center required by the Medicare cost reporting instructions. For this reason, we believe separate limits are justifiable to take into account the cost differential resulting from the cost reporting requirements that are beyond the control of the provider-based HHA.

Although separately classifying the provider-based agencies diminishes the impact on the provider-based classification, it does not significantly alter the impact of the freestanding agencies as the provider-based group comprises only 14 percent of the data base for the entire universe of HHAs. We will continue to evaluate all possible reasons for the higher costs in many provider-based facilities and alternative ways in which comparisons can be made among various types of home health providers.

Approximately 38 percent of provider-based HHAs are located in rural areas. Of this group, however, not all offer every home health service. Consequently, we do not have sufficient data on which to set valid basic limit amounts for Speech Pathology, Occupational Therapy, and Medical Social Service disciplines of the provider-based non-SMSA agencies. For these groupings, we propose using the basic limits computed for the free-standing non-SMSA agencies. On the basis of the data available, we believe the costs of the free-standing non-SMSA agencies most closely approximate the cost of the provider-based non-SMSA agencies.

2. Use of a Wage Index in Calculating Cost Per Visit Limits

Our analysis of area economic factors in conjunction with the initial schedule of limits included per capita income and service industry wage levels. Since that schedule was published, HCFA has developed an index based upon hospital wage data supplied by the Bureau of Labor Statistics (BLS). This data is compiled by BLS from the "hospital group" reporting category of the ES–202 Reporting Services for Unemployment Insurance. Using this data we have found a statistically significant correlation between hospital wage levels and HHA costs. Because there is no data available for which to develop a specific HHA wage index, and because the types of personnel employed by a HHA are comparable to that of hospitals, we believe the hospital wage index is currently the best proxy for area differences in HHA wages. In addition, competition between HHAs and hospitals for personnel should necessitate similar salary levels within the same labor market.

The hospital wage index, based on data for the year 1977, was developed by computing the national SMSA (or NECMA) average wage for the hospital group and dividing this average into the average hospital wage for each SMSA (NECMA). The result is expressed as an index number, which is used to adjust the wage portion of the group limit. For non-SMSA areas, the index was developed by computing the national non-SMSA average wage for the hospital group and dividing this average into the average hospital wage for all non-SMSA counties in a State. The index then applies to all non-SMSA counties in the State. If an index based on more current data is developed prior to publication of a final notice, we will incorporate the updated wage index at the time of final publication. The wage percentage used to adjust the per visit limit is 69.78 percent. In determining this wage factor for HHAs, we added an estimated wage percentage of contract service costs (4.79 percent) to the wages and salary weight shown in the market basket (64.99 percent). Home health agencies frequently contract for direct patient care services. As a result the contract service component is expected to contain an element of salary expense. This added factor is based on an assumption, in the absence of any evidence to the contrary, that the salary portion of contract services has the same weight as the wage portion in direct employment. The wage index for both SMSA and non-SMSA areas is set forth in Table IV.

3. Use of a Market Basket Index

In the initial schedule of home health limits, the inflation adjustment factors were obtained from actuarial projections of the change in HHA interim reimbursement rates. We believe a more accurate measure of increased costs would be based on the cost of purchased goods and services necessary to provide home health care. Therefore, HCFA has developed a "market basket" price index, similar to that used to adjust inpatient hospital routine operating costs, but derived from and weighted by expenditures that are specifically associated with home health agency costs.

Nine categories of costs specifically related to home health agencies were identified on the basis of data on the expenditures of home health agencies. Each item was weighted according to its estimated proportion to total costs. The percentage distribution of total operating costs was obtained from an analysis of Medicare cost reports and other available health industry surveys. Column 2 of the "market basket" index

table lists the weight for each category. In columns 3 and 4 of the "market basket" index, we have identified the price variables used to determine historical rates of increase for the various cost categories and the source of the forecast for 1980–1982. The price variables for contract services are based on an assumption that the distribution of expenditures within contract services is similar to noncontract service costs. The price increase factors for contract services were, therefore, derived from price and weight factors for all other categories.

Because of the difficulty in projecting increases which relate to current inflationary trends, we are proposing to allow for a retrospective adjustment to the cost limits. We will adjust the projected rate of increase in the market basket to actual where our estimate is more than ¼ of 1 percentage point below the actual rate of increase. This estimate, we feel, is the smallest amount that can be quantified at this point.

Home Health Agency Input "Price" Index: Cost Categories, Weights, Forecasters and "Price" Variable Used

Cost category	Relative weight 1978	Forecaster	"Price" variable used
Wages and salaries	$64.99		A. *Historical*—Payroll expenses per full-time equivalent worker employed by community hospitals. Source: American Hospital Association Panel Survey.
		DRI–CFS	B. *Projections*—Average hourly earnings of production and nonsupervisory workers on private nonagricultural payrolls, service industry. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Employment and Earnings*, Table C–2.
Employee benefits	8.61		A. *Historical*—Employee benefits per full-time equivalent worker employed by community hospitals. Source: Americal Hospital Association, National Hospital Panel Survey.
		DRI–MM	B. *Projection*—Supplements to wages and salaries per worker in nonagricultural establishments. Source: For supplements to wages and salaries—U.S. Dept. of Commerce, Bureau of Economic Analysis, *Survey of Current Business*, (monthly) Table 7 (1.13) July issue has detailed components. For total employment—U.S. Dept. of Labor, Bureau of Labor Statistics, *Employment and Earnings*, Table B–4.
Transportation	4.73	DRI–CFS	Transportation component of the consumer price index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 2.
Office costs	2.78	DRI–MM	Services component of consumer price index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 2.
Rent	1.30		Residential rent component of Consumer Price Index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review* + Table 23.
		DRI–MM, HCFA–DHEW.	B. *Projection*—Historical relationship of rental component of consumer price index, all urban, for 1977 and 1978 to all item consumer price index, all urban, projected to subsequent years.
Nonrental space occupancy costs	1.16	DRI–MM	Composite fuel and other utilities index. Source: DHEW–HCFA, Community Hospital Input Price Index.
Medical nursing supplies and rental equipment.	2.69		A. *Historical*—1978: Medical equipment and supplies component of the consumer price index. Prior to 1978: commodities component of consumer price index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table.
		DRI–CFS	B. *Projection*—Medical commodities component of the consumer price index, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
Miscellaneous	6.95	DRI–MM	Consumer price index for all items, all urban. Source: U.S. Dept. of Labor, Bureau of Labor Statistics, *Monthly Labor Review*, Table 23.
Contract services	6.87	DHEW–HCFA	Weighted mean of price variables for items 1 through 8 above.
Total	100.00		

Sources: DRI–MM refers to Data Resources, Inc., Macro Model; 29 Hartwell Ave., Lexington, Massachusetts 02173, Control 042379, DRI–CFS refers to Data Resources, Inc., Cost Forecasting Service, 1750 K St., N.W., Washington, D.C. 20006, CFS–792.

4. Limits set at the 80th Percentile

We are proposing to maintain the basic service limit at the 80th percentile of each group. Each HHA's individual limits would be increased or decreased by the application of the wage index as described in the methodology section of this notice. We examined the possibility of using a percentage of the mean as the basis for establishing the limit, but did not find this an appropriate measure for HHA limits set by type of service. Not all agencies provide every type of service nor is the distribution of agencies comparable across services. In examining the cost distributions we found that the mean was sensitive to distortion and would not be representative of expected cost.

5. Limits Applied to Each Service

In the initial schedule of HHA limits, we explained that we would apply limits to the costs of each service provided by a HHA when all HHAs are computing their costs under a single method of cost-finding and cost-apportionment. Until that time, the limits apply to the total costs for all covered services provided by the HHA.

A proposed regulation establishing a single method of cost finding is being promulgated coincidentally with these revised cost limits. Therefore, we are proposing to apply each per visit limit to

the costs of individual services, effective with cost reporting period beginning on or after July 1, 1980. We believe the refinements made to the classification system, as well as the single cost reporting methodology, eliminates the need for the aggregate application, used in the current methodology.

6. Reclassification, Exemptions and Exceptions

The provisions of 42 CFR 405.460 provide that classification adjustments, exemptions and exceptions may be made to the application of cost limits where certain conditions are met. This section of the regulations was most recently amended on June 1, 1979. An explanation of the current provisions as set forth at 44 FR 51802. New provisions pertaining to HHAS are:

(a) A provider must submit a request for reclassification within 180 days of the date of its intermediary's notice of program reimbursement (A provider could, of course, make a request as soon as a schedule of cost limits is published, or at any time during its cost reporting year affected by the cost limits, if it knew how it would be affected by the cost limits.);

(b) An exception may be granted to a provider for additional costs that result from the provision of medical education programs;

(c) An exception may be granted to a newly established HHA which has operated as the type of provider for which it was certified for Medicare under previous ownership for less than 3 full years;

(d) If a provider's cost limit is based in part on an average proportion of labor cost that is adjusted for area differences in wage levels, a new exception provides an adjustment to the limit if a provider can demonstrate that its actual labor percentage varies more than 10 percent from the percentage used in promulgating the limits.

Application of Limits to State Medicaid Rates

Methods of reimbursement for home health agencies under Medicaid are determined by the individual State agencies. Although many States reimburse on a cost related basis, others use a fee schedule, flat rate or payment based on a percentage of charges. Often the Medicaid payment rate is less than Medicare reasonable cost. There is no existing regulatory requirement that Medicare cost limits be applied to payment rates for HHA services under Medicaid. HHA cost limits will only apply to Medicaid payments in those cases where the State chooses to incorporate the limits into its State plan for payment for home health services.

Methodology for Determining Proposed Cost Per Visit Limits

1. Data. The proposed limits were determined by using cost per visit data obtained from the latest Medicare cost reports for periods ending on or before September 30, 1978. The data were adjusted from the midpoint of each provider's cost reporting period to June 30, 1980. These adjustment factors were developed by HCFA from actual historical increases in home health agency reimbursement. The market basket index factors would be used to project costs from July 1, 1980, to the midpoint of the first cost reporting period to which the limits would apply. The annual percentage increases for this projection are:

Calendar year and percent increase	
1977	7.3
1978	6.9
1979	9.1
1980 (1/1/80–6/30/80)	9.0
1980 (market basket, 7/1/80–12/31/80)	9.0
1981 (market basket)	8.9
1982 (market basket)	9.5

The projected rate of increase in the market basket index would be adjusted to actual if the actual rate of increase is more than ¼ of 1 percentage point above the estimated rate. The actual rate of increase would be published in the **Federal Register** and used to adjust a home health agency's cost limit at time of final settlement.

2. Deflation by Wage Index. Each HHA's per visit costs is divided into wage and non-wage portions. The wage portion of costs is determined by using the 69.78 percent routine wage factor derived from the market basket weight (64.99%) for employee wages and salaries plus a wage percentage (4.79%) of contract services. This wage portion is then divided by the wage index applicable to the HHA's location to arrive at an adjusted wage cost. (See table IV.) This adjusted wage cost is then added to the non-wage cost to obtain the per visit cost used to calculate the basic service limit.

3. Basic Service Limit. A basic service limit equal to the 80th percentile of the array was calculated for each type of service according to the provider-based and free-standing classification and the urban or non-urban location of the group.

4. Computing the Adjusted Limit. The basic limit for each type of service is divided into its wage and non-wage components. The cost weight (69.78 percent) representing wage and salary expenditures is used to determine the wage component of the cost limit. The wage component of the basic service limit is then multiplied by the wage index. (See Table IV.) The adjusted limit which would apply to each service group would be the sum of the non-wage component of the basic limit, plus the adjusted wage component.

Example—Calculation of Adjusted Limit
Limit from Schedule—$46.67
Labor portion—$32.57
Non-labor portion—$14.10
Wage Index—1.1310564

Computation of Adjusted Limit

$32.57×1.1310564 (wage index)=$36.84—Adjusted Labor Portion
$36.84+14.10=$50.94—Adjusted per visit limit for this HHA

5. Adjustment for Reporting Year. If a HHA has a cost reporting period beginning on or after August 1, 1980, the published limit for each service would be revised upward before adjusting for wages by a factor of .7417 percent for each elapsed month between July 1, 1980, and the month in which the HHA's cost reporting period starts. (The figure .7417 is one twelfth of the calendar year projected market basket increase of 8.9 percent.) This factor is developed by dividing the projected increase in the market basket index by 12 and is used to account for inflation in costs that will occur after the date on which the limits become effective.

Example—HHA A's cost reporting period begins October 1, 1980. The basic limit for physical therapy for HHA A's group is $47.54.

Computation of Revised Group Limit

Group Per Visit Limit)—$47.54
Plus Adjustment for 3-month period
3×.7417=2.23 percent
1.0223×$47.54=$48.60

In this example, the revised basic group limit for physical therapy services applicable to HHA A for cost reporting period beginning October 1, 1980, is $48.60 per visit. This basic service limit will be divided into its labor and non-labor portions, using the percentage published in Table I and II. and the labor portion will be adjusted by use of the wage index. The sum of the adjusted labor portion and the unadjusted non-labor portion would be the home health agency's per visit cost limit for that service.

If a HHA uses a cost report period which is not 12 months in duration, a special calculation of the adjustment factor must be made. This results from the fact that projections are computed to the midpoint of a cost reporting period and the factor of .7417 is based on an

assumed 12-month reporting period. For cost reporting periods other than 12 months, the calculation must be done specifically for the midpoint of the cost reporting period. The HHA's intermediary will obtain this adjustment factor from HCFA.

Schedule of Limits

The proposed schedule of limits set forth below would apply to the 12-month cost reporting period beginning on or after July 1, 1980. The adjusted limits (using the wage index published in Table IV) would be computed by the fiscal intermediaries and each HHA would be notified of its applicable limit. A home health agency operating as a branch or subunit (not independently certified for Medicare participation) whose main office, as of the effective date of the schedule of limits, is located in a Standard Metropolitan Statistical Area (SMSA) or within a New England County Metropolitan Area (NECMA), if in New England, will be classified as metropolitan. (NECMA counties are listed in Table III.) A home health agency whose main office is not located in a SMSA (or NECMA) will be classified non-metropolitan. (See 42 CFR 405.1202 for definition of branch office.)

Table I—*Per Visit Limits for Provider-Based HHAs*

SMSA (NECMA) Location

Type of visit	Per visit limit for SMSA location	Labor portion (69.78 percent)	Nonlabor portion (30.22 percent)
Skilled nursing care	58.33	40.70	17.63
Physical therapy	51.73	36.10	15.63
Speech pathology	51.53	35.96	15.57
Occupational therapy	54.23	37.84	16.39
Medical social services	59.35	41.41	17.94
Home health aide	50.61	35.32	15.29

Non-SMSA Location

Type of visit	Per visit limit for non-SMSA location	Labor portion (69.78 percent)	Nonlabor portion (30.22 percent)
Skilled nursing care	46.83	32.68	14.15
Physical therapy	44.68	31.18	13.50
Speech pathology	[1]	[1]	[1]
Occupational therapy	[1]	[1]	[1]
Medical social services	[1]	[1]	[1]
Home health aide	42.37	29.57	12.80

[1] Insufficient data—Use basic service limits for freestanding non-SMSA agencies.

Table II—*Per Visit Limits for Free-Standing HHAs*

SMSA (NECMA) Location

	Limit for SMSA location	Labor portion (69.78 percent)	Nonlabor portion (30.22 percent)
Skilled nursing	46.67	32.57	14.10
Physical therapy	45.87	32.01	13.86
Speech pathology	47.63	33.24	14.39
Occupational therapy	48.96	34.16	14.80
Medical social services	52.52	36.65	15.87
Home health aide	34.94	24.38	10.56

Non-SMSA Location

	Non-SMSA	Labor portion (69.78 percent)	Nonlabor portion (30.22 percent)
Skilled nursing care	44.27	30.89	13.38
Physical therapy	47.54	33.17	14.37
Speech pathology	46.14	32.20	13.94
Occupational therapy	56.85	39.67	17.18
Medical social services	42.78	29.85	12.93
Home health aide	30.64	21.38	9.26

Table III NECMAs and Constitutent Counties

Boston-Lowell-Brockton-Lawrence-Haverhill

Massachusetts Portion

Essex
Middlesex
Norfolk
Plymouth
Suffolk

New Hampshire Portion

Rockingham

Bridgeport-Stamford-Norwalk-Danbury

Connecticut

Fairfield

Hartford-New Britain-Bristol

Connecticut
Hartford
Litchfield
Middlesex
Tolland

Lewiston-Auburn

Maine

Androscoggin
Manchester-Nashua

New Hampshire

Hillsborough
Merrimack

New Bedford-Fall River

Massachusetts

Bristol

New Haven-Waterbury-Meriden

Connecticut

New Haven

New London-Norwich

Connecticut
New London

Pittsfield

Massachusetts

Berkshire

Portland

Maine

Cumberland
Sagadahoc
York

Providence-Warwick-Pawtucket

Rhode Island

Bristol
Kent
Newport
Providence
Washington

Springfield-Chicopee-Holyoke

Massachusetts

Hampden
Hampshire

Worcester-Fitchburg-Leominster

Massachusetts

Worcester

Table IVA.—*Wage Index for Urban Areas*

SMSA Area	Wage index
Abilene, TX	.7817864
Akron, OH	.9009922
Albany, GA	.6888152
Albany-Schenectady-Troy, NY	.9564138
Albuquerque, NM	1.0024912
Alexandria, LA	.8846018
Allentown-Bethlehem-Easton, PA–NJ	.9676768
Altoona, PA	1.0162619
Amarillo, TX	.9160869
Anaheim-Santa Ana-Garden Grove, CA	1.0459080
Anchorage, AK	1.3802678
Anderson, IN	.8253111
Ann Arbor, MI	1.1310564
Anniston, AL	.6573296
Appleton-Oshkosh, WI	.8826942
Asheville, NC	1.0053936
Atlanta, GA	.9610632

Table IVA.—*Wage Index for Urban Areas*—Continued

SMSA Area	Wage index
Atlantic City, NJ	.8647122
Augusta, GA–SC	.9618104
Austin, TX	.8146060
Bakersfield, CA	.9299136
Baltimore, MD	1.0411706
Baton Rouge, LA	.7507689
Battle Creek, MI	1.1068553
Bay City, MI	.8832990
Beaumont-Port Arthur-Orange, TX	.7751797
Billings, MT	.7925247
Biloxi-Gulfport, MS	1.0729591
Binghamton, NY–PA	.9250013
Birmingham, AL	.8999575
Bloomington, IN	.6545872
Bloomington-Normal, IL	.8614273
Boise City, ID	.9617917
Boston-Lowell-Brockton-Lawrence-Haverhill, MA–NH	1.0383125
Bradenton, FL	.7840533
Bridgeport-Stamford-Norwalk-Danbury, CT	1.0174962
Brownsville-Harlingen-San Benito, TX	.7766896
Bryan-College Station, TX	.8780472
Buffalo, NY	.8785651
Burlington, NC	.7132341
Canton, OH	.8070206
Cedar Rapids, IA	.7870741
Champaign-Urbana-Rantoul, IL	.8275104
Charleston-North Charleston, SC	.9526042
Charleston, WV	.9867342
Charlotte-Gastonia, NC	.7968266
Chattanooga, TN–GA	.7933366
Chicago, IL	1.0802769
Cincinnati, OH–KY–IN	.9936312
Clarksville-Hopkinsville, TN–KY	.7707538
Cleveland, OH	1.0727585
Colorado Springs, CO	.8010228
Columbia, MO	1.1482990
Columbia, SC	.8929865
Columbus, GA–AL	.7559156
Columbus, OH	.9097972
Corpus Christi, TX	.7713051
Dallas-Fort Worth, TX	.8395097
Davenport-Rock Island-Moline, LA–IL	.7602528
Dayton, OH	1.0188927
Daytona Beach, FL	.9138623
Decatur, IL	.9320051
Denver-Boulder, CO	.9893444
Des Moines, IA	.9549639
Detroit, MI	1.0741969
Dubuque, IA	.7330132
Duluth-Superior, MN–WI	.7808646
Eau Claire, WI	.7479729
El Paso, TX	.8247950
Elmira, NY	.7894086
Erie, PA	.8756995
Eugene-Springfield, OR	.8370397
Evansville, IN–KY	.9039087
Fargo-Moorhead, ND–MN	.9334691
Fayetteville, NC	1.4407862
Fayetteville-Springdale, AR	.9143109
Flint, MI	1.0090565
Florence, AL	.7396290
Fort Collins, CO	.7120910
Fort Lauderdale-Hollywood, FL	1.0729465
Fort Myers-Cape Coral, FL	.8458896
Fort Smith, AR–OK	.7501032
Fort Wayne, IN	.8273668
Fresno, CA	.9922715
Gadsden, AL	.8372010
Gainesville, FL	1.0245569
Galveston-Texas City, TX	.8697117
Gary-Hammond-East Chicago, IN	1.0393875
Grand Forks, ND–MN	.7402307
Grand Rapids, MI	.8200939
Great Falls, MT	.8271435
Greeley, CO	.7550165
Green Bay, WI	.8074495
Greensboro-Winston-Salem-High Point, NC	.7804297
Greenville-Spartanburg, SC	.7774527
Hamilton-Middletown, OH	.9677146
Harrisburg, PA	.9395567
Hartford-New Britain-Bristol, CT	1.0293896
Honolulu, HI	1.0521231
Houston, TX	.9066861
Huntington-Ashland, WV–KY–OH	.8121577
Huntsville, AL	.6648394
Indianapolis, IN	.9806246
Jackson, MI	.8855644
Jackson, MS	.8413921
Jacksonville, FL	.8922471
Janesville—Beloit, WI	.7369821

Table IVA.—*Wage Index for Urban Areas*—Continued

SMSA Area	Wage index
Jersey City, NJ	1.0024191
Johnson City-Kingsport, TN–VA	.8520487
Johnstown, PA	.8906999
Kalamazoo-Portage, MI	.9827004
Kankakee, IL	.9173186
Kansas City, MO–KS	.8746920
Kenosha, WI	.8646885
Killen-Temple, TX	.9697617
Knoxville, TX	.7454802
Kokomo, IN	.8180744
La Crosse, WI	.7692549
Lafayette, LA	.7299344
Lafayette-West Lafayette, IN	.8036818
Lake Charles, LA	.7122432
Lakeland-Winter Haven, FL	.7291346
Lancaster, PA	.8188873
Lansing-East Lansing, MI	.9398465
Laredo, TX	.6974902
Las Vegas, NV	1.0363198
Lawrence, KS	1.1054001
Lawton, OK	.6814294
Lewiston-Auburn, ME	.7724421
Lexington-Fayette, KY	.9239338
Lima, OH	.8451905
Lincoln, NE	.9063802
Little Rock-North Little Rock, AR	.9937774
Long Branch-Asbury Park, NJ	.9575276
Longview-Marshall, TX	.7113164
Lorain-Elyria, OH	.8584578
Los Angeles-Long Beach, CA	1.1037830
Louisville, KY–IN	.9069019
Lubbock, TX	.7230551
Lynchburg, VA	.7576805
Macon, GA	.8802635
Madison, WI	.9362551
Manchester-Nashua, NH	.7704519
Mansfield, OH	.7670934
McAllen-Pharr-Edinburg, TX	.5906622
Melbourne-Titusville-Cocoa, FL	.8192981
Memphis, TN–AR–MS	.8646840
Miami, FL	1.0854220
Midland, TX	.7111879
Milwaukee, WI	.9199721
Minneapolis-St. Paul, MN–WI	.7570047
Mobile, AL	.7915066
Modesto, CA	.8302491
Monroe, LA	.7499661
Montgomery, AL	.8241726
Muncie, IN	.7878266
Muskegon-North Shores-Muskegon Heights, MI	.8856485
Nashville-Davidson, TN	.9308903
Nassau-Suffolk, NY	1.1435511
New Bedford-Fall River, MA	.8609717
New Brunswick-Perth Amboy-Sayreville, NJ	.9529374
New Haven-Waterbury-Meriden, CT	1.0431054
New London-Norwich, CT	.9580296
New Orleans, LA	.9323589
New York, NY–NJ	1.2836483
Newark, NJ	1.1530874
Newport News-Hampton, VA	.9250905
Norfolk-Virginia Beach-Portsmouth, VA–NC	.8917366
Northeast Pennsylvania	.9671651
Odessa, TX	.6942824
Oklahoma City, OK	.7853505
Omaha, NE–IA	.8506704
Orlando, FL	.7672632
Owensboro, KY	.6712032
Oxnard-Sun Valley-Ventura, CA	1.2991618
Panama City, FL	.7860455
Parkersburg-Marietta, WV–OH	.8482920
Pascagoula-Moss Point, MS	.8144002
Peterson-Clifton-Passaic, NJ	.9871591
Pensacola, FL	.8687345
Peoria, IL	.9603141
Petersburg-Colonial Heights-Hopewell, VA	.8604133
Philadelphia, PA–NJ	1.0427889
Phoenix, AZ	.9367511
Pine Bluff, AR	.6387947
Pittsburgh, PA	1.0037657
Pittsfield, MA	.9315021
Portland, ME	.8732662
Portland, OR–WA	1.0046502
Poughkeepsie, NY	1.0379910
Providence-Warwick-Pawtucket, RI	.9101288
Provo-Orem, UT	.6906648
Pueblo, CO	.9417969
Racine, WI	.8080810
Raleigh-Durham, NC	.9982751
Rapid City, SD	.9912066
Reading, PA	.8929759
Reno, NV	1.1936960

Table IVA.—*Wage Index for Urban Areas*—Continued

SMSA Area	Wage index
Richland-Kennewick-Pasco, WA	.8333314
Richmond, VA	.8557333
Riverside-San Bernardino-Ontano, CA	.9922397
Roanoke, VA	.9616381
Rochester, MN	.8039937
Rochester, NY	1.0114625
Rockford, M	.8863163
Sacramento, CA	1.0701363
Saginaw, MI	1.0305533
ST. Cloud, MN	.7889363
St. Joseph, MO	.8106216
St. Louis, MO–IL	.8353947
Salem, OR	.9671521
Salinas-Seaside-Monterey, CA	1.0521816
Salt Lake City–Ogden, UT	.8003268
San Angelo, TX	.7280581
San Antonio, TX	1.2015727
San Diego, CA	1.0423081
San Francisco-Oakland, CA	1.2261579
San Jose, CA	1.2318725
Santa Barbara-Santa Maria-Lompoc, CA	.9141919
Santa Cruz, CA	.9390376
Santa Rosa, CA	1.3319986
Sarasota, FL	.7794111
Savannah, GA	.7991026
Seattle-Everett, WA	.9114513
Sherman-Denison, TX	.6840456
Shreveport, LA	.9304503
Sioux City, IA–NE	.8158065
Sioux Falls, SD	.7752901
South Bend, IN	.8039176
Spokane, WA	.9596857
Springfield, IL	.8021688
Springfield, MO	.8428475
Springfield, OH	.8397949
Springfield-Chicopee-Holyoke, MA	.9118872
Steubenville-Weirton, OH–WV	.8687642
Stockton, CA	1.1694052
Syracuse, NY	1.0320677
Tacoma, WA	.9338239
Tallahassee, FL	.7936591
Tampa-St. Petersburg, FL	.9112976
Terre Haute, IN	.8133320
Texarkana, TX-Texarkana, AR	.9651876
Toledo, OH–MI	.9636379
Topeka, KS	1.0191180
Trenton, NJ	1.0181014
Tucson, AZ	.9615322
Tulsa, OK	.8065469
Tuscaloosa, AL	.9434434
Tyler, TX	.7888754
Utica-Rome, NY	.9483622
Vallejo-Fairfield-Napa, CA	1.3675897
Vineland-Millville-Bridgeton, NJ	.8849021
Waco, TX	1.0659982
Washington, DC–MD–VA	1.1430803
Waterloo-Cedar Falls, IA	.7296063
West Palm Beach-Boca Raton, FL	.8588761
Wheeling, WV–OH	.8278128
Wichita, KS	.9081149
Wichita Falls, TX	.7661439
Williamsport, PA	.8408558
Wilmington, DE-NJ-MD	1.0590599
Wilmington, NC	.6793208
Worcester-Fitchburg-Leominster, MA	.8941985
Yakima, WA	.7821286
York, PA	.8702993
Youngstown-Warren, OH	.9486057

Table B—*Wage Index for Rural Areas*

Alabama	1.0461294
Alaska	1.6354423
Arizona	1.1122143
Arkansas	.8273242
California	1.2993578
Colorado	1.0080249
Connecticut	1.1747087
Delaware	1.0342322
Florida	.9703395
Georgia	1.0599658
Hawaii	1.1225531
Idaho	.8969254
Illinois	.9286388
Indiana	1.0841407
Iowa	1.0275121
Kansas	.9487575
Kentucky	.8980309
Louisiana	.8812404
Maine	1.0173606
Maryland	1.0668544
Massachusetts	1.2069380
Michigan	1.1016350
Minnesota	.7643302

Table B—*Wage Index for Rural Areas*—Continued

Mississippi	.8376849
Missouri	.9206227
Montana	.9939387
Nebraska	.8271144
Nevada	1.3182003
New Hampshire	1.0166505
New Jersey	1.1075845
New Mexico	.9872106
New York	1.0818880
North Carolina	1.0102951
North Dakota	.8934854
Ohio	.9990494
Oklahoma	.8099723
Oregon	1.0864072
Pennsylvania	1.1423726
Rhode Island	1.0525859
South Carolina	.9095838
South Dakota	.7760311
Tennessee	.8322538
Texas	.9576274
Utah	.7477027
Vermont	1.0353552
Virginia	.9030129
Washington	1.0312944
West Virginia	1.0907991
Wisconsin	.8837830
Wyoming	1.0836848

(Secs. 1102, 1814(b), 1861(v)(1), 1866(a), and 1871 of the Social Security Act; (42 U.S.C. 1302, 1395f(b), 1395x(v)(1), 1395cc(a) and 1395hh))

(Catalog of Federal Domestic Assistance Program No. 13,773, Medicare—Hospital Insurance)

Dated: January 17, 1980.

Earl M. Collier,

Acting Administrator, Health Care Financing Administrator.

Approved: February 7, 1980.

Patricia Roberts Harris,

Secretary.

[FR Doc. 80-4940 Filed 2-14-80; 8:45 am]

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Office of Human Development Services

[Program Announcement No. 13628-802]

Demonstration Projects for Child Abuse and Neglect Program

AGENCY: Office of Human Development Services, Department of Health, Education, and Welfare.

SUBJECT: Announcement of Availability of Grant Funds for Demonstration Projects for the Child Abuse and Neglect Programs.

SUMMARY: The Administration for Children, Youth and Families (ACYF) announces that application are being accepted for demonstration grants for Fiscal Year 1980 under The Child Abuse Prevention and Treatment Act of 1974, as amended. Regulations governing this program are published in the *Code of Federal Regulations* in 45 CFR Part 1340.

DATES: Closing date for receipt of applications is: May 5, 1980.

Scope of This Announcement

This Program announcement is one of four for the Child Abuse and Neglect Research, Demonstration and Service-Improvement Grants Program in Fiscal Year 1980. It relates specifically to Section 5(b)(1) of the Child Abuse Prevention and Treatment Act, as amended, which requires that no less than three centers be established for the provision of treatment and personnel training and other related services related to the prevention and treatment of *child sexual abuse.*

Program Purpose

The purpose of the Child Sexual Abuse Treatment-Training Institute Demonstration program is to test effective and efficient methods for providing training on intervention and treatment skills for professionals with responsibility for working with intrafamily child sexual abuse cases in an ongoing treatment program setting.

Program Objectives

Applications are solicited for projects which reflect the following program objectives:

4. To design and test within a treatment program context an inservice training program for transferring clinical skills and knowledge about the treatment of intrafamily child sexual abuse;

2. To continue the development of treatment models and methods which are aimed at: protecting victims from further maltreatment; providing humane, therapeutic intervention and treatment for all members of the family, including the perpetrator; and strengthening the family unit when that goal is in the best interests of the child and other family members.

3. To define and test the most effective, replicable training techniques for dealing with the treatment of child sexual abuse;

To design and test effective training techniques for imparting the program development skills necessary to assist trainees in developing specialized treatment programs within the agencies from which they are drawn;

5. To define what combination of staff/clients/trainees are most conducive to successful clinical training on child sexual abuse;

6. To determine what types of training/treatment models are most effective in terms of: numbers of persons served, quality of training experience, cost, length of time necessary to impart skills, and replicability of program models.

Eligible Applicants

Only public or nonprofit private agencies and organizations *with already existing treatment programs for*