Food and Drug Administration

[Docket No. 95M–0240]

Wesley-Jessen; Premarket Approval of Wesley-Jessen® COE–405 Disinfection Tablet

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is announcing its approval of the application by Wesley-Jessen, Des Plaines, IL, for premarket approval, under the Federal Food, Drug, and Cosmetic Act (the act), of the Wesley-Jessen® COE–405 Disinfection Tablet. FDA's Center for Devices and Radiological Health (CDRH) notified the applicant, by letter on June 7, 1995, of the approval of the application.

DATES: Petitions for administrative review by October 6, 1995.

ADDRESSES: Written requests for copies of the summary of safety and effectiveness data and petitions for administrative review to the Dockets Management Branch (HFA–305), Food and Drug Administration, rm. 1–23, 12420 Parklawn Dr., Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: David M. Whipple, Center for Devices and Radiological Health (HFZ–460), Food and Drug Administration, 9200 Corporate Blvd., Rockville, MD 20850, 301–594–1744.

SUPPLEMENTARY INFORMATION: On February 13, 1991, Wesley-Jessen, Des Plaines, IL 60018, submitted to CDRH an application for premarket approval of Wesley-Jessen® COE–405 Disinfection Tablet. When the Wesley-Jessen® COE–405 Disinfection Tablet is dissolved in a sterile contact lens saline solution, the solution is indicated for use in the chemical (not heat) disinfection of soft (hydrophilic) contact lenses.

In accordance with the provisions of section 515(c)(2) of the act (21 U.S.C. 360e(c)(2)) as amended by the Safe Medical Devices Act of 1990, this premarket approval application (PMA) was not referred to the Ophthalmic Devices Panel of the Medical Devices Advisory Committee, an FDA advisory committee, for review and recommendation because the information in the PMA substantially duplicates information previously reviewed by this panel.

On June 7, 1995, CDRH approved the application by a letter to the applicant from the Director of the Office of Device Evaluation, CDRH.

A summary of the safety and effectiveness data on which CDRH based its approval is on file in the Dockets Management Branch (address above) and is available from that office upon written request. Requests should be identified with the name of the device and the docket number found in brackets in the heading of this document.

Opportunity for Administrative Review

Section 515(d)(3) of the act (21 U.S.C. 360e(d)(3)) authorizes any interested person to petition, under section 515(g) of the act, for administrative review of CDRH's decision to approve this application. A petitioner may request either a formal hearing under part 12 (21 CFR part 12) of FDA's administrative practices and procedures regulations or a review of the application and CDRH's action by an independent advisory committee of experts. A petition is to be in the form of a petition for reconsideration under § 10.33(b) (21 CFR 10.33(b)). A petitioner shall identify the form of review requested (hearing or independent advisory committee) and shall submit with the petition supporting data and information showing that there is a genuine and substantial issue of material fact for resolution through administrative review. After reviewing the petition, FDA will decide whether to grant or deny the petition and will publish a notice of its decision in the **Federal Register**. If FDA grants the petition, the notice will state the issue to be reviewed, the form of review to be used, the persons who may participate in the review, the time and place where the review will occur, and other details.

Petitioners may, at any time on or before October 6, 1995, file with the Dockets Management Branch (address above) two copies of each petition and supporting data and information, identified with the name of the device and the docket number found in brackets in the heading of this document. Received petitions may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

This notice is issued under the Federal Food, Drug, and Cosmetic Act (secs. 515(d), 520(h) (21 U.S.C. 360e(d), 360j(h))) and under authority delegated to the Commissioner of Food and Drugs (21 CFR 5.10) and redelegated to the Director, Center for Devices and Radiological Health (21 CFR 5.53).

Dated: August 24, 1995.

Joseph A. Levitt,

Deputy Director for Regulations Policy, Center for Devices and Radiological Health.

[FR Doc. 95–21973 Filed 9–5–95; 8:45 am]

BILLING CODE 4160–01–F

Health Care Financing Administration

[BPO–133–PN]

Medicare Program; Data, Standards, and Methodology Used to Establish Fiscal Year 1996 Budgets for Fiscal Intermediaries and Carriers

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

ACTION: Proposed notice.

SUMMARY: This notice describes the data, standards, and methodology that would be used to establish fiscal intermediary and carrier budgets for the Federal fiscal year (FY) 1996, that begins October 1, 1995. Fiscal intermediaries and carriers are public or private entities that participate in the administration of the Medicare program by performing claims processing and benefit payment functions. This notice is published in accordance with sections 1816(c)(1) and 1842(c)(1) of the Social Security Act, which require us to publish for public comment the data, standards, and methodology we intend to use to establish budgets for Medicare fiscal intermediaries and carriers.

In addition, we respond to the single public comment we received in response to our proposed notice of October 21, 1994, and we announce the data, standards, and methodology we proposed to use to establish the Medicare fiscal intermediary and carrier budgets for FY 1995, beginning October 1, 1994, as final.

DATES: Comments will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on November 6, 1995.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: BPO–133–PN, P.O. Box 26676, Baltimore, MD 21207.

If you prefer, you may deliver your comments (1 original and 3 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. In commenting, please refer to file code BPO–133–PN. 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).

FOR FURTHER INFORMATION CONTACT: Leslie Trazzi, (410) 786–7544

SUPPLEMENTAL INFORMATION:

I. Background

Preparation of Contractor Budgets—Under sections 1816(a) and 1842(a) of the Social Security Act (the Act), public or private organizations and agencies may participate in the administration of the Medicare program under agreements or contracts entered into with the Secretary. These Medicare contractors are known as fiscal intermediaries (section 1816(a) of the Act) and carriers (section 1842(a) of the Act). Fiscal intermediaries perform bill processing and benefit payment functions for Part A of the program (Hospital Insurance), and carriers perform claim processing and benefit payment functions for Part B of the program (Supplementary Medical Insurance). When bills are submitted by providers, and claims by beneficiaries, physicians, and suppliers of services, fiscal intermediaries and carriers are responsible for—

- Determining the eligibility status of a beneficiary;
- Determining whether the services on the submitted claims or bills are covered under Medicare and, if so, the correct payment amounts; and
- Making appropriate payments to the provider, beneficiary, physician, and/or other supplier of services.

Fiscal intermediary and carrier performance is monitored by us at the central office staff and regional office levels. In general, the central office staff address issues that affect policies on a national level, and the regional office staff address issues dealing with regional and local policies, as well as those of an operational nature. Continuous communication between us and the fiscal intermediaries and carriers is maintained through consultation workgroups that meet on a regular basis and are comprised of representatives from the central office, regional offices, and Medicare contractors.

HCFA's central office is responsible for developing a national contractor budget for Part A and Part B of the Medicare program. The budget is formulated over an 18-month period, beginning in March of the calendar year preceding the fiscal year to which it applies. The central office receives input from the contractor community, our regional offices, the Department of Health and Human Services, and the Office of Management and Budget (OMB) before the budget is submitted to the President for approval and forwarding to the Congress. Once the national contractor budget has been approved, we issue Budget and Performance Requirements (BPRs). BPRs specify the level of effort required for contractor functions and serve as the statement of work for contractor use in preparing their individual budgets for submission to us.

The regional offices review the budgets submitted by contractors during a budget level determination process that is based on current claims processing trends, legislative mandates, administrative initiatives, current year performance standards and criteria, and the availability of funds appropriated by the Congress. Subsequently, we allocate funding within these constraints.

Requirements to Publish Contractor Budget Information—Sections 1816(c)(1) and 1842(c)(1)(A) of the Act require us to publish for public comment the data, standards, and methodology we intend to use to establish budgets for Medicare fiscal intermediaries and carriers at least 90 days before September 1. The statute further requires that we publish the final data, standards, and methodology no later than September 1. In the past, when preparing the Medicare contractor budget for each fiscal year, every attempt was made to publish the proposed and final notices as timely as possible. However, because of the time involved in developing the budget and the lengthy review and clearance process, we have been unable to publish both proposed and final notices before the beginning of the fiscal year. (See, for example, the notices for FYs 1993 and 1994 published in the **Federal Register** at 59 FR 13491 and 35933.) However, because of our continuous communications with contractors, we do not believe that the publication date of the **Federal Register** document has any negative effect on the fiscal intermediaries or carriers. The BPRs issued to all intermediaries and carriers discuss in detail the work, level of effort, and activities we expect them to perform in the coming fiscal year. Further, we provide a discussion and explanation of the bottom-line unit cost target established for each intermediary and carrier at the time the BPRs are issued.

Sections II and III of this notice contain proposed data, standards, and methodology we intend to use to establish budgets for Medicare fiscal intermediaries and carriers for FY 1996. If comments are received during the comment period, we will address those comments in a final notice and, if necessary, make revisions to the FY 1996 data, standards, and methodology. If no comments are received, the data, standards, and methodology proposed for FY 1996 will become final, effective October 1, 1995.

FY 1995 Budget Information—A proposed notice describing the data, standards, and methodology we proposed to use to establish contractor budgets for FY 1995 was published in the **Federal Register** (59 53187) on October 21, 1994. In response to our request for public comment in the proposed notice, we received one timely item of correspondence. Based on our review of the comment submitted, we are making no changes to the data, standards, and methodology we proposed to use. As noted earlier, it has been our practice to issue separate notices dealing with proposed and final budget data. Because no changes are being made to the proposed budget data included in the October 21 notice, we believe it appropriate to combine in this document the final notice announcing the contractor budget for FY 1995, and the proposed contractor budget elements for FY 1996. Therefore, through this notice, we announce that the data, standards, and methodology we proposed to use to establish the contractor budget for FY 1995 are final.

A discussion of the October 21, 1994, proposed notice and our response to the public comment received appears in section IV. of this document.

II. Overview of FY 1996 National Medicare Contractor Budget

A. Data, Standards, and Methodology

We submitted the FY 1996 national Medicare contractor budget proposal to the Congress in February 1995. The workload for the FY 1996 request is expressed in terms of work processed. For Part A, the FY 1996 estimated workload (140.6 million bills) is 8.8 percent more than the FY 1995 estimate. For Part B, the FY 1996 estimated workload (681.4 million claims) is a 3.9 percent increase over the FY 1995 estimate.

Our estimates involved the use of a regression model that uses the last 36 months of actual contractor workload data. For the FY 1996 projections, we used November 1994 data, which were the latest available to us at the time. We will continue to update the resulting projections monthly to ensure that the most timely data are available for budgeting purposes.

The FY 1996 unit costs for processing bills and claims were calculated based

on the FY 1995 level adjusted for savings achieved due to productivity, electronic media claims, and reduced funding for incremental workload. This calculation resulted in a new unit cost, which, when multiplied by the Part A or Part B workloads, determines the total amount required for bill or claim processing in FY 1996.

Feedback received from contractors and regional offices during the past several years has led us to believe that contractors can make major improvements in performance if given the authority to manage their budgets. The FY 1994 BPRs gave the regional offices the authority to set a budget and the contractors the authority to manage their budgets on a bottom-line basis. Once funding was issued, each contractor had the flexibility to optimally manage the budget consistent with the statement of work contained in the BPRs. Before FY 1993, contractors were not allowed to ''shift'' more than 5 percent of funds from one line item to another in their budget, as determined by the lesser of the two line items. That restriction was intended to allow us to maintain control over the national budget, but still give contractors some latitude with regard to reporting their costs. With the exception of the ''Payment Safeguards,'' ''Productivity Investments,'' and ''Other'' line items, contractors now have total flexibility in the use of funds. There is a 5 percent limitation on the amount of funds that may be shifted out of individual ''Payment Safeguards,'' with unlimited shifting into ''Payment Safeguards.'' Shifting into or out of ''Productivity Investments'' and ''Other'' line item funding, not governed by contract modifications, may not exceed 5 percent. Each ''Other'' line item is treated separately. The ''Productivity Investment'' line item is treated as a whole and not as separate projects. Funding that is governed by contract modifications may not be shifted to other functions or line items.

B. Medicare Contractor Functional Areas

The Medicare contractor budget consists of functional areas of responsibility that are performed by the fiscal intermediaries for Part A and the carriers for Part B. The eight functional areas of responsibility for fiscal intermediaries under Part A are—

- Bill Payment;
- Reconsideration and Hearing;
- Medicare Secondary Payer;
- Medical Review and Utilization Review;
- Provider Audit (Desk Review, Field Audit, and Provider Settlement);
- Provider Payment;
- Productivity Investments; and
- Benefits Integrity.

The nine functional areas of responsibility for carriers under Part B are—

- Claim Payment;
- Review and Hearing;
- Beneficiary or Physician Inquiry;
- Provider (physician/supplier) Education and Training;
- Medicare Review and Utilization Review;
- Medicare Secondary Payer;
- Participating Physicians;
- Productivity Investments; and
- Benefits Integrity.

The Hospital Insurance and Supplementary Medical Insurance Trust Funds and appropriations provide funding for these functions. Discussions concerning the data, standards, and methodology for these functional areas are in section III of this notice. In the following national budget summary, we combine the discussion of functional areas that are common to fiscal intermediaries and carriers. However, we list specific data for Part A or Part B under each heading. In developing the budget, we provide workload estimates for all functional areas that are predominantly workload driven. We do not provide workload estimates for those functional areas that are not predominantly workload driven or for an uncertain workload until final negotiations with the Medicare contractors are complete.

1. Bill and Claim Payment (Parts A and B)

We currently estimate the Part A processed workload to be 140.6 million bills in FY 1996. The Part B processed workload is currently projected at 681.4 million claims.

2. Reconsideration (Part A), Review (Part B), and Hearing (Parts A and B)

Beneficiaries, providers, physicians, and other suppliers are entitled by law to appeal, through reconsiderations, formal reviews, or hearings, as appropriate, the various payment determinations made by Medicare contractors. We project that Part B reviews and hearings workloads for FY 1996 will not exceed FY 1995 levels, while workload for Part A reconsiderations and hearings will have a moderate increase. We expect contractors to control and respond to requests for appeal and to control receipt of Administrative Law Judge hearing requests.

We continue to maintain efficiencies achieved in prior years through the use of shorter decision letters and the experimental use of the telephone to conduct reviews and reconsiderations.

3. Medicare Secondary Payer (Parts A and B)

The Medicare secondary payer function is the first of four initiatives (Medicare secondary payer, medical review and utilization review, benefits integrity, and provider audit) we developed as ''payment safeguards'' for the Medicare program. Our continuing Medicare secondary payer program is designed to identify situations in which other insurers are the primary payers, to pay all claims correctly the first time, and to recover Medicare dollars in instances in which mistaken conditional payments have occurred.

We aggressively pursue the identification of secondary payer situations through the collection and matching of beneficiary-specific health care data through the Internal Revenue Service/Social Security Administration/ HCFA (IRS/SSA/HCFA) data match authorized by section 1862(b)(5) of the Act. The FY 1996 budget includes funding to process the workloads based on the IRS/SSA/HCFA data match project. We allocate the funds based on the number of report identification numbers we expect a contractor to process.

In addition to the IRS/SSA/HCFA data match, we continue to pursue other data matches with State Motor Vehicle Administrations, Workers' Compensation, Medicaid Agencies, and the Departments of Defense, Labor, and Veterans Affairs. Further, our use of the initial enrollment questionnaire is an important part of our commitment to capturing vital health care coverage data on beneficiaries and their spouses at the time of Medicare enrollment and before any claims are filed.

4. Medical Review and Utilization Review (Parts A and B)

In addition to processing and paying claims from providers of services and Medicare beneficiaries, contractors perform medical and utilization reviews of claims to determine whether services are covered under the program and are medically necessary. The distribution of Medicare contractor funding is based on each contractor's proportion of the workload and individual contractor medical review/utilization review projects.

Specifically, our contractors are required to work with the medical community to develop clear medical review policies and communicate those policies to the providers of services. Moreover, we also emphasize the need for systematic and ongoing analysis of

claims data to focus prepayment and postpayment medical review. To meet this requirement, intermediaries and carriers currently analyze local and national data to identify practice patterns, trends, and aberrancies that may reflect areas of potential abuse, inappropriate care, and overutilization. This data-driven approach allows us to target and direct our efforts to our greatest risk of inappropriate program payment.

Part A medical reviews by fiscal intermediaries focus on preventing inappropriate billing through provider education and on targeting reviews of providers who fail to change inappropriate behavior. Through analysis of national and local data, areas of abuse and overutilization are identified and payment is denied for services that are not covered under the Medicare program. Reviews are targeted where they will be most effective in protecting the program.

Part B medical reviews by carriers identify areas of abuse and overutilization and focus on preventing Medicare payment for medically unnecessary or noncovered services. Carriers use computerized methods of analyzing utilization, epidemiologic, and demographic data to detect trends in physician and other supplier activities and the delivery of health care. This is accomplished through prepayment and postpayment analysis of Medicare Part B claims.

In FY 1996, we will continue to support the medical review activities of the four Durable Medical Equipment Regional Carriers (DMERCs). The DMERCs will conduct prepayment and postpayment review of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims to identify areas of potential abuse and overutilization and prevent payment for noncovered items and services.

The DMERCs will identify aberrancies from an analysis of national and local databases. The DMERCs will initiate corrective action for overpayment recoupment, target supplier claims for services most frequently billed, and continue to revise regional medical review policies and screens for referral to the Office of the Inspector General (OIG). This targeting principle will assist in developing regional medical review policies to address identified problem areas or trends in new technologies. In addition to educating suppliers, DMERCs need to educate the referring/ordering physicians responsible for prescribing DMEPOS items and include them in the medical policy development process.

5. Provider Audit (Part A only)

The audit of provider cost reports is our primary instrument to help ensure the integrity of Part A Medicare payments. Funding priorities are directed toward the use of limited desk reviews where low cost/low utilization providers are involved and toward the use of onsite focused reviews to expand the overall examination of high cost/ high payment issues. Program savings remain relatively flat, while the FY 1996 funding level remains constant.

In FY 1996, budget estimates allow for a relatively consistent level of reviews and audits for all types of providers, although an increasing number of providers require both desk review and settlement. Full desk reviews and field audits are directed toward high cost/ high utilization providers and past poor performers. Contractors will retain a knowledgeable audit staff and provide training in accordance with government auditing standards.

Contractors will also respond to provider appeals by conducting intermediary hearings and by filing position papers and attending hearings at the Provider Reimbursement Review Board (PRRB). Contractors will also reopen and revise prior period settlements based on provider requests, as well as PRRB and HCFA directives and resolve problems identified on provider cost reports.

6. Provider Payment (Part A only)

In FY 1996, Medicare contractors will provide payment services to approximately 31,500 health care providers. These payment services include establishing and adjusting interim rates, recouping provider overpayments, and providing consultative services to providers for maintaining and adjusting their accounting systems to ensure accurate data for preparing Part A bills and cost reports.

We will distribute funds in proportion to workload by provider type.

7. Productivity Investments (Parts A and B)

We refer to the costs of implementing legislation and new initiatives that are designed to improve the effectiveness of Medicare program administration as productivity investments. Productivity investments generally provide start-up funds for new or revised contractor activities. Once these projects are operational, their funding becomes part of the contractor's ongoing costs. The criteria for selecting productivity investments vary. For example, the statute or regulations require some productivity investments. We also fund projects that will improve administrative cost efficiency, such as administrative simplification.

There is no single distribution methodology for the allocation of productivity investment funds. After we determine the national cost of a productivity investment, we distribute funds among the contractors. These funds are based on the contractors' cost estimates or through formulas that we derive based on project specifications. Other productivity investment initiatives require equal effort by all contractors regardless of size and, therefore, funds are distributed equally among contractors. Finally, some productivity investments, such as administrative simplification and the Medicare Transaction System, are given only to contractors that are involved in the specific projects.

8. Beneficiary or Physician Inquiry (Part B only)

The Medicare contractors are the direct link between beneficiaries, providers, physicians and other suppliers, and the Medicare program. It is the responsibility of HCFA and the contractors to provide the most effective and efficient service to beneficiaries, providers, physicians, and other suppliers, and to continue to expand their awareness and understanding of the Medicare program.

We are currently revising all benefit notices into a single, easy to read summary format. Carriers will begin using the new notice format in FY 1996. Beneficiary and provider feedback is used to modify the format, as necessary, to ensure maximum beneficiary comprehension. We and our contractors will conduct extensive outreach to ensure a smooth transition to the new format.

Our Carrier Customer Service Plan initiative is expanded to include—

- Tone/clarity self-assessment;
- Initiatives to improve service to blind, deaf, and disabled beneficiaries;
- An automated inquiries analysis program;
- Improvements to the internal review process;
- Partnerships with local beneficiary counseling and assistance organizations;
- The expansion of beneficiary advisory committees; and
- Initiatives designed to improve service to Spanish speaking individuals.

Also, carriers use Audio Response Units as the initial contact for providers, and a beneficiary Audio Response Unit script is offered to all carriers. In FY 1996, carriers will expand the use of Audio Response Units. The Audio

Response Units will provide improved service, accuracy, and consistency through the use of expanded standardized scripts and equipment enhancements.

In FY 1996, carriers will receive an estimated 40.1 million inquiries by telephone, in writing, or through direct contact, an increase of 1 percent over the current FY 1995 projection of 39.6 million inquiries.

9. Participating Physicians/Suppliers (Part B only)

Participating physicians and suppliers are those who agree to accept assignment on all Medicare claims in return for certain incentives or benefits. All physicians are given an opportunity to enroll or disenroll in the program annually.

Carriers must perform several activities including: (1) Conducting annual participation enrollment; (2) Distributing the Medicare Participating Physician/Supplier Directories; (3) Upgrading and maintaining direct electronic media claim lines for participants; and (4) Monitoring and enforcing the program requirements for participants and nonparticipants, which includes the comprehensive limiting charge compliance program.

10. Physician/Supplier Education and Training (Part B only)

Increasing numbers of physicians, nonphysician practitioners, and other suppliers who furnish health care services rely on information gained through communications with carriers about Medicare program provisions. To respond to this need, we have fostered interaction between suppliers of health care services and carriers to promote efficient, economic claims activities. For example, these activities include: (1) Communicating with suppliers of health care services; (2) Educating suppliers to eliminate the submission of erroneous or underdocumented claims; (3) Distributing newsletters to all suppliers of services detailing changes in coverage, payment, or billing policy; and (4) Educating carrier staff members, on a regularly scheduled basis, to ensure compliance with legislative and policy changes affecting the coding and submission of claims.

11. Benefits Integrity (Parts A and B)

We will continue to deter and detect Medicare fraud and abuse activities through concerted efforts with the OIG, the Federal Bureau of Investigation, Medicaid Fraud Control Units, the Department of Justice, and other HCFA partners. As in FY 1995, we will continue to improve the quality of referrals to the OIG by increasing our fraud detection capabilities through expanded data analysis and improvements in fraud detection by the carriers and intermediaries.

In addition, the National Claims History Database continues to be available to focus postpayment review on practitioners and suppliers that appear to be billing fraudulently or that are misrepresenting to Medicare the services or items they are furnishing.

In FY 1996, Medicare carriers will focus their detection activities on medical laboratory, radiology, anesthesia, physician services, and ambulance claims. Also, in FY 1996, Medicare carriers will upgrade their fraud detection capabilities by making better use of available databases and expanded relationships with other fraud detection organizations.

12. Printing Claim Forms (Parts A and B)

Although this activity is not among the nine Part A and eight Part B contractor functional areas, it is a part of the national Medicare contractor budget. In the interest of maintaining standard formats and quality of Medicare entitlement and report forms, we supply beneficiary enrollment and provider cost reporting forms. The use of these forms is essential for beneficiary notification and for effective and efficient contractor operations. We will print 50 million copies of these forms for FY 1996.

C. Contractor Unit Cost Calculations

A key step in the contractor budget process is the development of contractor unit costs for processing Part A bills and Part B claims. These bottom-line unit costs encompass all budget line items except ''Provider Audit,'' ''Provider Reimbursement,'' ''Productivity Investments,'' and, ''Other.''

As first implemented in FY 1992, the complexity index was designed to improve efficiency and reduce contractor-by-contractor cost inequities and was based on the application of the Industrial Engineering study commissioned by us. The Industrial Engineering study provided us with an actual weighted unit cost for each claim type; that is, inpatient or outpatient, and method of submission of a bill or a claim. After adjustment for changes in program emphasis, these unit costs were applied to each contractor's individual workload mix to develop a weighted unit cost that reflects the complexity of its workload mix. We published an explanation of the complexity index in a **Federal Register** notice published on January 2, 1992 (57 FR 57). After adjusting for various savings and increases associated with initiatives, we then arrayed the contractors' unit costs and identified the high cost contractors.

We believe that the use of the complexity index has enabled us to successfully achieve the goals of improving efficiency in contractor operations and reducing contractor-by-contractor cost inequities. Since we have achieved these goals, and believe that costs can be controlled, we will base each contractor's FY 1996 unit cost on the FY 1995 level, adjusted for inflation and for savings achieved as a result of increased productivity, and on reduced funding for incremental workload.

D. Overall Budget Considerations

We note that limitations on the FY 1996 budget could require across-the-board cost cutting measures. In that case, each regional office will determine the amount of budget reduction for its contractors.

III. FY 1996 National Medicare Contractor Budget: Data, Standards, and Methodology

Since the submission of the President's FY 1996 Medicare contractor budget request to the Congress in February 1995, we have developed and issued BPRs to the contractors. These requirements outline the statement of work and level of effort that fiscal intermediaries and carriers are expected to perform during the upcoming fiscal year in each of the functional areas for which they are responsible.

Our schedule is that draft BPRs are released to the regional offices in April, and the final BPRs are released in June 1995. At the time of release, each fiscal intermediary and carrier is given the individual requirements to be used in preparing their FY 1996 budget request. The regional offices will send any additional information that is pertinent to the fiscal intermediaries and carriers within their region. Fiscal intermediaries and carriers must submit their budget requests to us no later than 6 weeks after the issuance of the BPRs.

After the fiscal intermediaries and carriers review the BPRs, they prepare their budget requests. The central office and regional office staff review the fiscal intermediary and carrier budget requests as they are submitted. The regional office staff negotiates a final and mutually-acceptable budget, within the limits of the funding available to us, with each fiscal intermediary and carrier. The central office prepares a financial operating plan for each regional office that provides total regional funding authority for each

functional area. The regional offices, in turn, prepare a Notice of Budget Approval for each fiscal intermediary and carrier that provides a full year budget plan subject to quarterly cash draw limitations.

A. Standards

The basic statement of work, along with new and special activities that fiscal intermediaries and carriers are expected to perform, is described in the BPR package. Fiscal intermediaries and carriers are expected to perform the work as described in the BPR package and in accordance with the standards included in the Contractor Performance Evaluation for FY 1996. For consideration in developing their initial budget requests, a copy of the draft Contractor Performance Evaluation standards will be sent to contractors. Final FY 1996 Contractor Performance Evaluation standards will be published in the **Federal Register**.

B. Data

The following data contain various workload volumes, functional costs, and manpower information that are used in developing the individual fiscal intermediary and carrier budgets for FY 1996:

- Forms HCFA–1523/1524 (a multipurpose form that serves as the Budget Request, Notice of Budget Approval, and Interim Expenditure Report).
- Forms HCFA–1523A/1524A (Schedule of Productivity Investments and Other).
- Forms HCFA–1523B/1524B (Schedule of Credits, Electronic Data Processing, and Overhead).
- Forms HCFA–1523C/1524C (Schedule of Appeals).
- Forms HCFA–1523D/1524D (Schedule of Medicare Secondary Payer Costs).
- Forms HCFA–1523E/1524E (Schedule of Medical Review Costs).
- Forms HCFA–1523G/1524G (Schedule of Fraud and Abuse).
- Form HCFA–1525A/1525A (Contractor Audit Settlement Report).
- Schedules A, B, & C.
- Provider Payment Profile.
- Schedule of Providers Serviced.
- Medicare Secondary Payer Savings Report.
- Medical Review/Utilization Review Savings Report.
- Form HCFA–2580 (Cost Classification Report).
- Forms HCFA–1565/1566 (Carrier Performance Report/Intermediary Monthly Workload Report).
- OMB's economic assumptions of 3.2 Percent.
- Savings from prior productivity investments.
- New legislation costs.
- Regional Office recommendations.
- Contract provisions.

C. Methodology

The Medicare contractor budget is organized around the previously listed functional areas that are performed by the fiscal intermediaries for Part A and the carriers for Part B. In 1992, we developed a bottom-line unit cost for each individual contractor. The following narrative describes the methodology used to calculate individual line-item costs. This methodology will be considered as general reference for contractors as they develop their FY 1996 budgets and also provides additional explanation in determining how certain costs and savings were determined. The regional offices will negotiate with the fiscal intermediaries and carriers to resolve any differences within the limits of the funding available to us.

1. Bill and Claim Payment

A statistical forecasting model determines the individual fiscal intermediary and carrier workload levels for FY 1996. Using the same data, we are also projecting the number of bills or claims a fiscal intermediary and carrier may expect to have pending at the end of FY 1995. We will then combine the FY 1996 receipt estimate with the anticipated end of FY 1995 pending level, and subtract the estimated FY 1996 pending for each fiscal intermediary and carrier to establish a processed workload; that is, Estimated FY 1996 receipts + Estimated end of FY 1995 pending − Estimated end of FY 1996 pending = Estimated FY 1996 Processed Workload.

In order to price individual contractor bill and claim workload, we develop a unit cost that is the cost of processing a single bill or claim. The individual fiscal intermediary and carrier unit costs for FY 1996 are calculated from the unit costs in the FY 1995 Notice of Budget Approvals. Savings achieved from operating efficiencies also are part of the formula employed in computing FY 1996 target unit costs.

2. Reconsiderations (Part A), Reviews (Part B), and Hearings (Parts A and B)

We will allocate funding based on the dollar amount spent (line 2 of Forms HCFA–1523/1524) in the prior years, adjusted for inflation and changes in volume. Specifically, we will adjust the previous year's costs for reconsiderations and hearings by the estimated percentage change in workload.

We estimate the individual fiscal intermediary and carrier budget allocations for reconsiderations, reviews, and hearings by multiplying forecast workloads by the adjusted unit costs.

3. Beneficiary and Provider Inquiries (Part B only)

To establish a budgeted amount for beneficiary and provider inquiries, we increase the prior year's cost by the projected workload change. We also consider special conditions unique to specific carriers in negotiating the budget. We will use the data to develop a budgeted cost for beneficiary and provider inquiries by multiplying forecasted processed volume by the unit cost.

4. Provider Payment (Part A only)

In determining individual fiscal intermediary budgets for reimbursement activities, we took into consideration the FY 1995 budgeted figures, the projected funding for FY 1996, and the projected workload based on the workload reported on the Schedule of Providers Serviced. The Schedule of Providers Serviced is a listing of all the facilities serviced by the fiscal intermediary. The Schedule of Providers Serviced is submitted with each initial budget request so that a part of the analysis is the comparison of the composition of the provider community serviced by the fiscal intermediary and any change reported between fiscal years.

5. Provider Audit (Part A only)

For FY 1996, the provider audit function is divided into three major activities: field audits, desk reviews, and settlements. The Contractor Auditing and Settlement Report (Form HCFA–1525/1525A) provides a breakout of audit activities and costs by type of provider and documents the savings incurred as a result of audit activity. Using this as a base, we develop the desk review costs by projecting the number of providers serviced by the unit cost per desk review (developed for the latest Contractor Auditing and Settlement Report for FY 1994) to determine the cost of handling the FY 1996 workload at the FY 1994 unit cost. We base the settlement costs on the workload projected in the fiscal intermediary's budget request, multiplied by the unit cost for settlements found in the most recent Contractor Auditing and Settlement Report for FY 1994.

The first priority of all audit efforts is the completion of any special activities required by legislation. The second priority is that all cost reports be reviewed and, to the extent possible, settled.

6. Medicare Secondary Payer

We will review the estimated workload data, reported backlog data, and any other items, for example, proposed Medicare secondary payer systems enhancements, to determine Medicare secondary payer funding allocations. Each contractor's case mix will be analyzed to adjust for specialized workloads such as home health claims or durable medical equipment (DME). In FY 1996, we will allocate the budget based on the above considerations, adjustments created by shifts in the DME workload from all carriers to the four specialty carriers, and other shifts in workload that may require adjustments.

7. Medical Review/Utilization Review

The individual fiscal intermediary and carrier medical review/utilization review budgets for FY 1996 will be calculated in three segments: (1) Prepayment medical review; (2) Postpayment medical review activities; and (3) Data analysis and screen development. The BPR describes the activities and workload requirements that the fiscal intermediaries and carriers are expected to meet. As part of the BPRs, we will ask the fiscal intermediaries and carriers to estimate the level of funding that will be necessary to meet such requirements. We will allocate prepayment and postpayment medical review funding to contractors based upon the workload that a fiscal intermediary or carrier projects for FY 1996.

8. Participating Physicians/Suppliers (Part B only)

In determining the individual carrier funding levels for the participating physician/supplier program for FY 1996, we considered the following factors:

- The number of physicians/suppliers in the carrier's service area.
- The carrier's current participation rate.
- The carrier's recent performance in increasing its participation rate.
- The statement of work to be performed as outlined in the BPRs.
- FY 1995 cost experience.

Since participating physicians/suppliers are eligible for toll-free telephone lines for electronic billing, allowance will be made for these expenses. Carriers with lower participation rates will receive greater funding for the limiting charge violation monitoring. We have discontinued carrier monitoring of the elective surgery disclosure requirement. We now require carriers to investigate beneficiary complaints on a case-by-case basis.

We allocate carrier monitoring funds based on the national percentage of nonparticipating physicians/suppliers. All carriers will receive the same funding amount for reporting participation statistics.

9. Productivity Investments

We refer to the costs of implementing legislation and new initiatives that are designed to improve the effectiveness of Medicare program administration as productivity investments. Several allocation methodologies will be employed in calculating the productivity investment budgets for individual fiscal intermediaries and carriers. For those projects involving only single contractors or small groups of contractors, we will allocate funds based upon the specifications of the particular project. For those projects involving all fiscal intermediaries or carriers, if the costs are driven by bill or claim volume, we will distribute the funding based upon our workload projections for each contractor. Finally, for those projects involving all fiscal intermediaries or carriers that require equal effort, regardless of the contractor's size, we derive a standard allocation to be given to all contractors.

10. Physician/Supplier Education and Training (Part B only)

Distribution of funds made available to HCFA for physician/supplier education and training is based upon the ratio of physicians and suppliers in each carrier's service area to the national total of physicians and suppliers.

11. Benefits Integrity

In allocating the FY 1996 benefits integrity budget to individual fiscal intermediaries and carriers, we will consider the following:

- The prior year's effectiveness in initiating fraud referrals to the OIG.
- Initiating overpayment recoveries when appropriate.
- Prioritizing workload to concentrate on high dollar and multi-state fraud.
- The extracted workload and cost data from the Schedule of Fraud and Abuse (Forms HCFA–1523G/1524G).
- The Medicare Fraud Unit Workload Report.
- The fraud unit's level of sophistication to determine benefits integrity funding allocations.
- The completion of any special activity required by legislation which will be an overriding priority.
- The networking costs, which will be determined by the personnel cost to support the Medicare Fraud and Abuse Information Coordinator, travel costs, and the other expenses needed to conduct networking for the area assigned.

IV. Data, Standards, and Methodology Used to Establish the Medicare Contractor Budgets for FY 1995

The October 21, 1994, notice described the budget development process in general and gave an overview of how we intended to use the contractor budget data, standards, and methodology to establish the FY 1995 budgets.

Based on our review of the comments submitted, we are making no changes to the proposed data, standards, and methodology as published on October 21, 1994. Therefore, we announce provisions of the proposed notice as final.

Provisions of the Proposed Notice

We indicated in the proposed notice that the contractor budget would be structured to coincide with the eight functional areas of responsibilities performed by fiscal intermediaries for Part A and nine functional areas of responsibilities performed by carriers for Part B of the Medicare program. We proposed that final funding for the contractor functions would be allocated in accordance with the current claims processing trends, legislative mandates, administrative initiatives, current year performance standards and criteria, and the availability of funds appropriated by the Congress. While the contractors were preparing their budget requests, we developed preliminary budget allocations for the 17 functional areas that were based on historical patterns, workload growth, inflation assumptions, statistical forecasting reports, and any other available information.

A key step in the contractor's budget process is the development of contractor unit costs for processing Part A bills and Part A claims. As in FY 1994, the FY 1995 budget process used a bottom line unit cost approach. All budget line items except Provider Audit, Productivity Investments, Other, and in FY 1995, Provider Payment, are part of the bottom line unit cost calculation. In FY 1995, the complexity index was not used as it was in prior years. We believe that the use of the complexity index

over the last 3 fiscal years has enabled us to successfully achieve the goals of improving efficiency in contractor operations and reducing contractor-by-contractor cost inequities. Since we have achieved these goals, and believe that costs can be controlled, we based each contractor's unit cost on their FY 1994 level, adjusted for savings achieved due to increased productivity, electronic media claims, and reduced funding for incremental workload. Because of reduced funding in FY 1995 inflation was not given.

The Medicare secondary payer function is the first of four initiatives we developed as ''Payment Safeguards'' for the Medicare program. The focus of the Medicare secondary payer initiative is to ensure that the Medicare program pays for covered care only to the extent required after payment by the primary insurer. We proposed that the standard for determining the amount of Medicare secondary payer funding a contractor would receive in FY 1995 would be based on workload volumes, required systems changes, and any special projects that may be assigned to contractors.

Based on actuarial analysis, we developed specific savings goals for each contractor. The goals were developed on estimates of savings to be achieved by contractors for the Medicare secondary payer categories of working aged, disabled, workers' compensation, end-stage renal disease, and liability or no-fault insurance. After assigning goals to contractors, funds were allocated based on the various Medicare secondary payer activities a contractor must perform such as processing prepayment claims, postpayment claims, inquiries, outreach, and hospital reviews.

We proposed that in FY 1995, the Initial Enrollment Questionnaire would be operational. The Initial Enrollment Questionnaire eliminates the need for first claim development on approximately 85 percent of new enrollees. This initiative improves service to beneficiaries on a national basis by providing detailed information on the Medicare secondary payer program at the time a beneficiary enrolls in Medicare.

We proposed to include funding to process the workloads based on the IRS/SSA/HCFA data match project. The funds would be allocated on the basis of the number of report identification numbers a contractor will process. We would review the estimated workload data, reported backlog data, and proposed Medicare secondary payer systems enhancements to determine Medicare secondary payer funding allocations. Each contractor's case mix would be analyzed to adjust for specialized workloads such as home health claims or DME.

In FY 1995, we proposed the budget be allocated based on adjustments created by shifts in the DME workload from all carriers to the four specialty carriers and by other shifts in workload that may require adjustments. The regional offices would negotiate with the fiscal intermediaries and carriers to resolve any differences between our allocations and their requests within the limits of the funding available to us.

Analysis of and Response to Public Comment

In response to our request for public comment in the October 21, 1994 notice, we received one timely item of correspondence from a health insurance company. Several issues that were raised by the commenter are outside the scope of the proposed notice and are not addressed in this notice. The proposed notices are intended to address only the data, standards, and methodology to be used to establish budgets for fiscal intermediaries and carriers for a particular fiscal year. Specific instructions on how to implement and monitor certain initiatives (for example, beneficiary inquiries, participating physician and benefits integrity) are presented through program memoranda, manual instructions, BPR, and other means.

Comment: The commenter was concerned that the proposed notice was published after the beginning of FY 1995. The commenter believed that untimely publication of the proposed notice denied interested parties the opportunity to comment before implementation of the budget.

Response: In the preparation of the Medicare contractor budget each fiscal year, we attempt to publish the proposed and final notices timely. However, because of the time involved in reviewing data and developing the budget and the lengthy review and clearance process, we were not able to publish the proposed and final notices before the beginning of the 1995 fiscal year. We regret that we were unable to publish the proposed notice timely, but we do not believe that our actions substantively penalized or prejudiced the fiscal intermediaries or carriers. The BPRs issued to all intermediaries and carriers discuss in detail the work, level of effort, and activities we expect them to perform in the coming fiscal year. Further, we provide a discussion and explanation of the bottom-line unit cost target established for each intermediary and carrier at the time the BPRs are issued. The intermediaries and carriers have ample time to identify and resolve any problems before they finalize their budget requests for the fiscal year.

Comment: The commenter indicated that the use of the complexity index in prior years provided a methodologically flawed basis for calculating the contractor unit costs in FY 1995.

Response: We do not agree. As stated in the proposed notice, we believe that the complexity index is useful in helping to control contractor costs by providing funding on the basis of workload complexity. The use of the complexity index over the last 3 fiscal years has enabled us to successfully achieve the goals of improving efficiency in contractor operations and reducing contractor-by-contractor cost inequities. Since we have achieved the above goals, we believe it is reasonable for FY 1995 contractor unit costs to be based on each contractor's FY 1994 level.

Comment: The commenter expressed concern about the process used to develop specific Medicare secondary payer savings goals for each contractor for FY 1995 as well as how funding was determined for each contractor for Medicare secondary payer activities. The commenter believed that Medicare secondary payer funds are allocated after assigning Medicare secondary payer savings goals.

Response: The President's budget estimate that was published in February 1994 covers the entire Medicare contractor budget. Although the budget estimate mentions Medicare secondary payer savings, it does not define specific savings per contractor. Further, we have not assigned savings goals to intermediaries and carriers since FY 1993. Therefore, Medicare secondary payer funds are not allocated after assigning Medicare secondary payer savings goals to contractors.

The factors that affect Medicare secondary payer funding for individual contractors are: the national Medicare secondary payer budget; the priority of the Medicare secondary payer activities; individual contractor Medicare secondary payer budget requests and workload estimates (a contractor's estimated Medicare secondary payer workload and budget request is compared to its previous workload and expenditures for Medicare secondary payer activities); an analysis of a contractor's Medicare secondary payer budget request and that of similar contractors with similar workloads (intermediaries and carriers are compared separately); the ability of a contractor to justify and document its request for additional funding, or for

funding we believe is out of its peer grouping; and negotiations between the regional offices and the individual contractors.

V. Response to Comments

Because of the large number of items of correspondence we normally receive on documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date specified in the DATES section of this notice, and we will respond to the comments in a subsequent published notice. To the extent that we receive comments during the comment period, we will address those comments in a final notice and, if necessary, make revisions to the proposed data, standards, and methodology for FY 1996. If no comments are received, we will simply adopt the proposed data, standards, and methodology for FY 1996 as final, effective October 1, 1995.

In accordance with the provisions of Executive Order 12866, this proposed rule was not reviewed by the Office of Management and Budget.

Authority: Sections 1816(c)(1) and 1842(c)(1) of the Social Security Act (42 U.S.C. 1395h(c)(1) and 1395u(c)(1)).

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program.)

Dated: August 16, 1995.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

[FR Doc. 95–22029 Filed 9–5–95; 8:45 am]

BILLING CODE 4120–01–P

Office of Inspector General

Program Exclusions: July 1995

AGENCY: Office of Inspector General, HHS.

ACTION: Notice of program exclusions.

During the month of July 1995, the HHS Office of Inspector General imposed exclusions in the cases set forth below. When an exclusion is imposed, no program payment is made to anyone for any items or services (other than an emergency item or service not provided in a hospital emergency room) furnished, ordered or prescribed by an excluded party under the Medicare, Medicaid, Maternal and Child Health Services Block Grant and Block Grants to States for Social Services programs. In addition, no program payment is made to any business or facility, e.g., a hospital, that submits bills for payment for items or services provided by an excluded party. Program beneficiaries remain free to decide for themselves whether they will continue to use the services of an excluded party even though no program payments will be made for items and services provided by that excluded party. The exclusions have national effect and also apply to all other Federal non-procurement programs.

Subject, city, State	Effective date
PROGRAM-RELATED CONVICTIONS	
AHMAD, MIRZA N, DEWITT, NY	08/16/95
BAKER, DALE, DAYTON, OH	08/14/95
BEGG, CYNTHIA L, ALBANY, NY	08/16/95
BEGG, CAROL J, KINDERHOOK, NY	08/16/95
BELL, DOROTHY S, BRYAN, TX	08/14/95
BOLAN, BERT WAYNE, EL RENO, OK	08/03/95
BORREGO, ORESTES T, MIAMI, FL	08/14/95
BRIZ, PAZ, PIEDMONT, CA	08/03/95
CAMBRIA MEDICAL ASSOCIATES, PHILADELPHIA, PA	08/14/95
CASE, DAVID A, EUGENE, OR	07/18/95
CHAN, JUAN M, FREMONT, CA	08/03/95
CLARK, MAUREEN E, PHILADELPHIA, PA	08/14/95
CLARK'S FAMILY PHARMACY, PHILADELPHIA, PA	08/14/95
CLINE, DARRELL E, AUBURN, WA	08/03/95
FONSECA, MARIO, MIAMI LAKES, FL	08/14/95
GRECO, ISABEL, SANTE FE, NM	08/10/95
HAMILTON, ROSS, BRONX, NY	08/16/95
HARR, ROBERT L, FORT WORTH, TX	08/10/95
HERNANDEZ, MARILYN SUE, OKLAHOMA CITY, OK	08/10/95
HERZOG, BRUCE, ROSLYN, NY	08/16/95
HOLSTON AMBULANCE SERVICE, INC, LAKE CHARLES, LA	08/03/95
HOWARD, ROBERT L, ROSSVILLE, GA	08/14/95
HUFF, MARY ANN, GRAND PRAIRIE, TX	08/10/95
JOHN R WHITE DRUGS, INC, FAYETTEVILLE, NC	08/14/95
JOHNSON, DEBRA A, GALVESTON, TX	08/10/95
KANSAGRA, RAY, MARLTON, NJ	08/16/95
KIMBRO, WILLIAM D, SLAUGHTER, LA	08/10/95
KURTZ, JOSEPH A, PHILADELPHIA, PA	08/14/95
M.A.S. TRANSIT, INC, COLUMBIA, LA	08/10/95
MANGA, GREGORY M, YORK, PA	08/14/95
MANIK, GOLAM, FLORAL PARK, NY	08/16/95
MATHIS, JIMMY RONALD, PARKER, TX	08/10/95
MERKOW, LEONARD, PITTSBURGH, PA	08/14/95
PILARCZYK, DONNA, PAINESVILLE, OH	08/14/95
RAO, MOHAN KONAKONDRA, LONGVIEW, TX	08/10/95
SANDERS, DEBORAH, LITTLE ROCK, AR	08/03/95
SLON, TIMOTHY, AMHERST, NY	08/16/95
VAOESEA, SIAKI L, SEATTLE, WA	08/03/95
VILLARD, JOSEPH JR, ALEXANDRIA, LA	08/03/95
WALTER, DONALD M III, PALM BEACH, FL	08/14/95
WALTER, LUCILLE H, WINCHESTER, VA	08/14/95
WALTER, FRANCINE P, PALM BEACH, FL	08/14/95
PATIENT ABUSE/NEGLECT CONVICTIONS	
BORDELON, BRADLEY JAMES, MOREAUVILLE, LA	08/10/95
BROWN, MICHELLE, ADAMS, NY	08/16/95
BROWN, CYNTHIA M, PLAQUEMINE, LA	08/10/95
CARAVAGLIO, JOSEPH F, TRUMANSBURG, NY	08/16/95
CAVINESS, GEORGE E, RAMSEUR, NC	08/14/95
COPELAND, MARY LOIS, MAYFLOWER, AR	08/03/95
DAVIS, KEVIN EARL, GRANBURY, TX	08/10/95
DEAN, CHARLOTTE REBECCA, NATCHITOCHES, LA	08/10/95
FORSYTHE, RONALD J, HOT SPRINGS, AR	08/10/95
GRIFFIS, CHARLES LAMAR, OKLAHOMA CITY, OK	08/10/95
HASAN, LEA, STATEN ISLAND, NY	08/16/95
JACKSON, JASON L, COLUMBIA, LA	08/03/95
KNIGHT, CARLA JEAN, TALLULAH, LA	08/10/95
OLSEN, CHERYL ANN, OCEAN SPRINGS, MS	08/10/95
PARHAM, REGINA L, FORDYCE, AR	08/10/95
PEGUES, CLIFTON CURTIS, DUNN, NC	08/14/95
PHILLIPS, QUINITA AMELIA, LAFAYETTE, LA	08/10/95
PITCHER, DONALD, BAKERSFIELD, MO	08/03/95
SIMMONS, LARRY, NEW BERN, NC	08/14/95
SIMMONS, MICHAEL LEON, NEW BERN, NC	08/14/95
THOMAS, BERNICE, SPRING LAKE, NC	08/14/95
UZZLE, CARLTON BERNARD, GOLDSBORO, NC	08/14/95