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Report to the Ranking Minority Member, Special Committee on Aging, U.S. Senate

May 1994

MEDICARE

Shared System Conversion Led to Disruptions in Processing Maryland Claims

GAO/HEHS-94-66

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-251635

May 23, 1994

The Honorable William S. (Bill) Cohen
The Ranking Minority Member
Special Committee on Aging
United States Senate

Dear Senator Cohen:

Since 1989, the Health Care Financing Administration (HCFA) has attempted to reduce administrative costs by urging Medicare contractors to share claims processing system software or both hardware and software with other contractors. When converting to another system's software, some contractors experienced disruptions resulting in claims backlogs and erroneous and untimely payments to physicians and hospitals.

In October 1991, one Medicare contractor, Blue Cross and Blue Shield of Maryland, began using claims processing software developed and maintained by another contractor. For more than a year following the system conversion, Medicare payments to Maryland physicians were frequently late and often contained errors. You asked us to examine the claims processing and payment problems associated with this system conversion and how the Maryland contractor's conversion compared with others. To do so we interviewed representatives of HCFA, the Maryland contractor, and various physician organizations in Maryland. We also analyzed contractor performance and budget data and surveyed other contractors using shared systems. Our work was performed between November 1992 and March 1994 in accordance with generally accepted government auditing standards.

Background

HCFA contracts with 79 health insurance companies to process and pay about 700 million Medicare claims annually and provide other program services. HCFA paid these contractors about $1.7 billion in 1992 to administer the program's approximately $130 billion in outlays. In an effort to reduce administrative costs, HCFA has urged contractors to share their automated systems.[1] Contractors may share (1) system maintenance by keeping separate computer operations but using the same claims

[1]HCFA implemented the shared systems policy in January 1989 and estimated that net savings from the initiative would total $88.6 million for fiscal years 1989 to 1992. In January 1994, HCFA informed us that actual savings through fiscal 1993 were approximately $59.2 million. The number of automated systems used by Medicare contractors decreased from 58 in 1989 to 14 in 1993.

processing software (one contractor, the system maintainer, is responsible for changing and updating the software) or (2) processing by consolidating computer operations—both hardware and software—into a single system. HCFA reviews contractor proposals to enter sharing arrangements and monitors contractors' system conversions to help minimize program disruptions.

To comply with HCFA's shared system policy, Blue Cross and Blue Shield of Maryland selected a shared maintenance arrangement with General American, a Missouri Medicare contractor, for processing the Maryland contractor's 6.1 million part B claims (these are claims for physician services and various diagnostic tests). Maryland paid program benefits of $419 million at a cost of $18.2 million in fiscal 1991, the year preceding its system conversion. Over 11,000 health care providers and about 600,000 Medicare beneficiaries were affected by Maryland's switch in claims processing systems.

Claims processing problems surfaced shortly after the Maryland contractor converted to the General American system. Maryland doctors complained that their Medicare reimbursements were late, inaccurate, or not received at all. At that time, the Maryland contractor attributed the problems to anticipated short-term difficulties associated with conversion to the new claims processing system. But these problems proved to be more serious, persisting for more than a year before the carrier's performance generally improved.

Results in Brief

Poor management by Blue Cross and Blue Shield of Maryland and poor decisionmaking by HCFA contributed to the contractor's costly and turbulent shared system conversion. In particular, HCFA and the Maryland contractor allowed insufficient time for planning the effort and scheduled the conversion to take place during a period of Medicare program changes requiring major computer system modifications.

The consequences of the inadequately planned and untimely conversion were serious disruptions in Medicare claims processing and payment to thousands of physicians and a dramatic rise in erroneous payments—both of which resulted in unanticipated costs exceeding $5 million. The contractor had to pay interest to providers receiving late payments. It also paid claims that should have been paid by other insurers. In addition, a decrease in savings from cost-avoidance efforts over the 12-month period

following conversion suggests that the contractor's controls over payments were disrupted.

Among the most problematic of all Medicare shared system conversions, the Maryland contractor's conversion provides lessons for the future, especially in view of HCFA's plan to convert the 14 systems that contractors currently use to a single automated claims processing system. Poor planning, coupled with inadequate system testing, was instrumental in the new system's automated controls failing to facilitate prompt and accurate payments. In a previous report on automated system conversions, we disclosed similar findings involving disruptions in provider reimbursements and the breakdown of computerized controls over payments.[2] In the case of Blue Cross and Blue Shield of Maryland, the contractor has not realized any of the anticipated annual savings of over $600,000 in administrative costs. HCFA's experience at Maryland underscores the need to assure that planning and testing time for major system changes are adequate and not inappropriately compromised by HCFA's desire to achieve administrative savings.

Poor Management and Decisionmaking Undermined Conversion Efforts

HCFA and the Maryland contractor agreed to a 5-month time frame for implementing a new database structure, training staff, and educating the physician community.[3] This allotted time proved insufficient for several reasons. The General American system had been used solely by the Missouri contractor and neither the Maryland nor Missouri contractors had experience in a shared system arrangement.

Moreover, the period immediately following the scheduled conversion was particularly hectic because of major changes made to the Medicare program requiring additions, updates, and revisions to contractors' automated systems. For example, between October 1, 1991, and April 1, 1992, HCFA requirements included that all contractors' automated systems reflect the implementation of (1) a new provider identification system for physicians, (2) a substantially revised billing form for part B providers, (3) a new fee schedule for reimbursing physicians, and (4) changes to the

[2]Medicare: Shared Systems Policy Inadequately Planned and Implemented (GAO/IMTEC-92-41, Mar. 18, 1992).

[3]In commenting on a draft of this report, Blue Cross and Blue Shield of Maryland officials stated that the original proposal allowed 9 months for the conversion.

common working file.[4] These major program changes complicated Maryland's efforts to deal with the conversion problems and added greatly to its time constraints for implementing the new system.

Both HCFA's approval and the Maryland contractor's decision to implement the General American system in the 5-month time frame were heavily influenced by budgeting considerations. On May 3, 1991, when approving the Maryland contractor's proposal to share the General American system, HCFA informed the contractor that implementation had to be completed no later than September 30, 1991. HCFA considered it necessary to impose this deadline to permit full conversion funding from monies already available in the fiscal year 1991 budget and, thereby, avoid requesting additional funding for the conversion in HCFA's fiscal year 1992 appropriation. Carrying the conversion into fiscal year 1992 also would have required paying the contractor additional sums to implement the Medicare-wide changes scheduled for the first half of fiscal year 1992. In other words, HCFA would be funding changes to software that the contractor would shortly be abandoning.

Furthermore, the Maryland contractor made a commitment to install the General American system in fiscal year 1991 to help reduce its operating costs, following the announcement that the President's fiscal year 1992 budget proposal called for a reduction in funding levels for all Medicare contractors. The Maryland contractor's determination to enter a shared system arrangement was also influenced by HCFA's announcement in April 1990 that the agency would reduce the budgets of any contractors—like Blue Cross and Blue Shield of Maryland and General American, for example—that were not part of or committed to enter a shared system arrangement by the end of fiscal year 1990.[5] HCFA further announced that special funding for contractor-initiated projects would only be available to shared system contractors.

Although the deadline was met for installing the General American system on October 1, 1991, neither the Maryland nor the Missouri contractor had sufficient time to test the new system and correct claims payment problems. The Maryland contractor documented completing all of the

[4]The common working file (CWF) is a system that merges information from part A (claims for hospital services and care provided by skilled nursing facilities, hospices, and home health agencies) and part B systems for an entire region into a central database. CWF provides contractors with access to eligibility and entitlement data.

[5]More recently, in January 1994, HCFA awarded a contract to design and develop a uniform, government owned claims processing system that combines Medicare parts A and B. We recently issued a report discussing HCFA's plans for the new "Medicare Transaction System." See Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS-94-31, Jan. 25, 1994).

steps necessary to prepare for the system conversion, including testing, but contractor officials acknowledged that preparation should have been more thorough. For example, the contractor used mock data instead of actual claims during the testing period and did not check electronic media claims through all the processing phases. As a result, certain problems with the General American system's processing of the Maryland contractor's claims were not detected until the system was placed in full production. Contractor officials stated that testing could have been more effective if more time had been available before the system's implementation.

Training was also limited during the implementation period. Although the contractor reported to HCFA that staff were provided training for using the General American system before the October 1 transition date, HCFA later found that no formal training was provided at that time to system operations and programming staff. In fact, in-depth training for the General American system was not provided until about 6 months after implementation, and several problems with operating the system were directly related to the staff's lack of familiarity with the system.

Conversion Problems Disrupted Claims Payment and Safeguard Controls

The Maryland contractor's performance in administering the Medicare program declined significantly after the system conversion. In the span of a year (1991-92), HCFA's composite rating of the Maryland contractor's claims processing and payment performance (on a 100-percent scale) dropped from among the best scores (95 percent) to the worst (65 percent) in the program. Conversion-related problems resulted in the contractor exceeding its Medicare budget and in losses of Medicare funds.

HCFA uses several performance measures to rate contractors' effectiveness and efficiency in processing and paying Medicare claims. Table 1 shows, for selected measures, the decline in the Maryland contractor's performance after conversion. In fiscal year 1992, the contractor made timely payments on only 72 percent of claims for participating physicians—23 points below the standard. At the same time, the volume of backlogged claims reached over 200,000, almost twice the contractor's normal pending claims inventory. According to contractor officials, the contractor spent $3 million more than its Medicare budget for overtime and subcontracting to handle the claims backlog. (The contractor hired two other Medicare contractors and an independent contractor to process

its claims, shifted its own staff from other areas, including claims review, to process claims, and required staff to do extensive overtime.)[6]

Table 1: Maryland's Performance Before and After October 1, 1991, Conversion to a Shared System

Indicators	FY 1991 (before 10/1/91)	FY 1992 (after 10/1/91)	Percent difference
Performance rating	95%	65%	-31.6
Clean claims[a] processed	5,105,611	6,587,182	29.0
Pending claims[b]	90,046	244,006	171.0
Claims requiring interest payment	72,289	1,258,507	1,640.9
Interest paid	$19,928	$478,023	2,298.8
Timeliness (Par)[c]	97.2%	71.5%	-26.4
Timeliness (Nonpar)[d]	99.4%	77.1%	-22.4

[a]Claims that do not require investigation or development outside of the Medicare contractor's operation before payment.

[b]Claims received but not processed by the contractor. The number reflects the balance at the end of the fiscal year.

[c]Participating physicians; 1991-92 standard: 95 percent of clean claims must be paid in 17 days.

[d]Nonparticipating physicians; 1991-92 standard: 95 percent of clean claims must be paid in 24 days.

As the volume of payment delays mounted, so did adverse consequences, such as the rise in interest payment penalties. In fiscal year 1992, the contractor paid physicians nearly $500,000 in interest to compensate for late payments on over 1 million claims.

In addition, the contractor had difficulties handling the unusually large number of telephone inquiries from providers and beneficiaries who questioned inaccurate payments, nonreceipt of payments, and errors in billing notices explaining Medicare benefits. Contractors must provide responsive telephone service that allows providers and beneficiaries to receive timely information regarding claims payment and account accuracy. Telephone inquiries are also important to the program because they sometimes result in leads for fraud and abuse investigations.

[6]HCFA declined to reimburse the contractor for the entire $3 million, asserting that the overrun resulted from the contractor's mismanagement of the system conversion.

Finally, the contractor's mishandling of computerized controls during the system conversion period resulted in additional losses. The biggest measurable loss occurred when the contractor bypassed the new system's automated controls that flag claims that should be paid by the beneficiaries' other insurers. These controls and the review of claims that they trigger are known collectively as the Medicare Secondary Payer (MSP) program. The Maryland contractor overpaid almost $3 million in claims as a result of improperly handling General American system's computerized MSP edits. At the end of the contractor's collection efforts in March 1993, about $1.6 million of the $3 million in mistaken payments remained uncollected. The contractor was also unable to meet its $12.6 million MSP savings goal for fiscal year 1992, achieving only 48 percent of this goal (about $6 million).

The Maryland contractor also experienced significant declines in its reported savings from reviewing claims, but the extent to which system conversion problems were responsible remains unclear. In fiscal year 1991, for example, the contractor reported saving $51 million in its reviews of claims to determine whether services billed to Medicare were necessary and constituted an appropriate level of care. In 1992 the savings figure dropped to $24 million. However, the concurrence of major program and operational changes with conversion to a shared system makes it difficult to determine the exclusive role of the shared system conversion in the decline of savings. New coding of medical procedures made certain computer controls obsolete, layoffs and temporary reassignments of staff cut into claims review efforts, and HCFA issued new requirements reducing the proportion of the claims work load contractors must review.[7]

Compared with other contractors' system conversions, the Maryland contractor's was one of the worst since HCFA implemented its shared systems policy. We found that contractors identified by HCFA as having more successful conversions tended to resume normal operations within 2 to 6 months and completed their system conversions within their budgets. These contractors generally selected systems that were already shared by others.

Over the past year, the Maryland contractor has implemented several corrective measures, including modifications to automated processing controls, the addition of staff to handle provider and beneficiary inquiries, and changes in senior management. Its performance ratings have

[7]In a separate letter (GAO/HEHS-94-93R, Feb. 28, 1994) we asked the HCFA administrator to determine whether the contractor's reported savings numbers are accurate and, if so, what accounts for the drop in savings.

improved in most areas previously rated as deficient. For example, key performance measures, such as the number of pending claims and payment timeliness, have returned to the levels achieved before the conversion. Moreover, between 1992 and 1993, the Maryland contractor increased its overall performance rating from 65 percent to 91 percent. Despite this considerable improvement in its 1993 performance rating, the Maryland contractor failed several activities during the year—including timely installing of fee schedules and accurately responding to correspondence—and ranked 40th of 43 Medicare part B contractors.[8] Additionally, although HCFA and the Maryland contractor had anticipated system operating costs would be reduced by about $600,000 annually from this system conversion, in October 1993, the contractor reported no material savings were achieved.

Experience of Maryland Contractor Provides Lessons for Future Conversions

HCFA's shared system initiative has been part of a series of strategies to consolidate the claims processing function and standardize claims processing automation. Under a recent effort, HCFA plans to acquire a new system that will consolidate the claims processing done by the 14 systems that contractors now share into a single automated system. HCFA expects to improve not only claims processing efficiency programwide but also the effectiveness of other Medicare operations, including the availability and use of data for program management purposes. The implementation of this system will entail the largest system conversion that HCFA has ever undertaken. The Maryland contractor's conversion experience, one of the program's most problematic, underscores the need for HCFA to adequately plan and test each system conversion phase.

In a 1992 report on the shared system initiative, we recommended that HCFA provide continual direction of conversion activities to minimize disruption.[9] In addition, while supporting the use of current technology to improve claims processing efficiency, we cautioned that HCFA's focus on administrative savings with inadequate consideration for other effects—such as the effect on program safeguards—could result in wasting millions of Medicare dollars. The Maryland contractor's conversion shows the pitfall of HCFA's haste to save administrative dollars. With thorough planning and testing, HCFA and its contractors can minimize the adverse effects of system conversion problems.

[8]A performance rate of 100 percent in 1993 indicated that a contractor met HCFA's basic requirements to administer the Medicare program.

[9]Medicare: Shared Systems Policy Inadequately Planned and Implemented (GAO/IMTEC-92-41, Mar. 18, 1992).

Comments and Our Evaluation

In its overall comments to our draft report, HCFA stated that it is committed to learning from past mistakes and applying this knowledge to future initiatives. The agency emphasized, for example, that it has planned to do extensive testing and validation before implementing Medicare's proposed new claims processing system.

HCFA expressed concern that we did not present a balanced picture of the underlying causes for the Maryland contractor's problems implementing its new claims processing system. Specifically, HCFA believed that we tended to understate the contractor's role in causing the problems. While we included some additional information to better characterize the contractor's role, we believe that we have not overstated HCFA's responsibility to ensure that the contractor performed adequately. We agree, however, with HCFA's observation that despite the Maryland contractor's general improvement in performance since the transition period, the contractor's current performance in some areas remains unacceptable. We revised the text of this report to more fully reflect the contractor's current performance.

HCFA also believes that our draft report did not adequately (1) compare the Maryland contractor's transition with similar efforts of other contractors and (2) discuss recent transition successes. Our analyses of other contractors' transition period performances indicate that the Maryland contractor's effort was among the most problematic and this is what we reported. We also cite a prior GAO study involving several contractor system transitions (GAO/IMTEC-92-41, Mar. 18, 1992) that found problems similar to those experienced by the Maryland contractor. Though not of the magnitude of the Maryland contractor's problems, the study identified disruptions in provider reimbursements and breakdowns in computerized controls over payment. We added results of a survey we administered to contractors that HCFA identified as having successful transitions. It should be noted, however, that we did not verify the responses we received.

In commenting on the draft, Blue Cross and Blue Shield of Maryland cited its improved performance ratings since the system conversion. Moreover, the contractor agreed that improved planning and testing are needed in future transitions. (HCFA's and Blue Cross and Blue Shield of Maryland's written comments appear in apps. I and II.)

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of HCFA, officials of Blue Cross and Blue Shield of Maryland, and interested congressional committees. We will also make copies available to others on request. Please call me on (202) 512-7119 if you or your staff have any questions about this report. The major contributors to this report are listed in appendix III.

Sincerely yours,

Leslie G. Aronovitz
Associate Director,
Health Financing and Policy Issues

Contents

Abbreviations

CWS	Common Working File
HCFA	Health Care Financing Administration
MSP	Medicare secondary payer

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

APR 1 1994

TO: Sarah Jaggar, Director
Health Financing and Policy Issues, GAO

FROM: Administrator
Health Care Financing Administration

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicare: Shared System Conversion Led to Disruptions in Processing Maryland Claims" -- INFORMATION

We have reviewed the GAO draft report which discusses problems a Medicare contractor, Maryland Blue Shield (MDBS), experienced in converting to a shared Part B claims processing system.

The Health Care Financing Administration (HCFA) is committed to learning from past mistakes as well as successes, and to applying this knowledge to future initiatives. However, we are concerned that this report does not mention other contractor conversions, nor does it develop a comparison of MDBS' conversion to that of other contractors, as the cover letter from Senator Cohen requests.

GAO is correct in stating that the MDBS transition will serve as a lesson learned by HCFA as it prepares to implement the Medicare Transaction System (MTS). We do not dispute the fact that there were problems concerning MDBS. However, HCFA has had many successful contractor replacement and systems transitions both before and after the MDBS transition. Over the past 10 years, HCFA has handled at least 20 Medicare contractor replacements, 5 contractor mergers, and over 80 contractor software systems changes, facilities management arrangements, and shared processing installations. The overwhelming majority of these transitions have been accomplished on schedule and without major systems or processing problems. Attachment 1 lists just a few examples of these transitions. Our successful track record is evidence that HCFA and the contractor community can successfully plan and carry out a transition without disruption to the Medicare program or the beneficiary and provider community.

Conversion to the MTS is indeed a major challenge for HCFA, and we are aware of the need for qualitative testing and validation of the software. Our plans call for an extensive series of tests

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to include actual claims received, and we plan to include many users in the testing and validation, including providers and beneficiaries. Please be assured that HCFA will not convert to the MTS until it is fully tested and validated.

We would note also that HCFA had reservations about MDBS entering into a shared systems arrangement with General American because, as GAO points out, both contractors had no experience with a shared systems arrangement. However, MDBS assured HCFA that MDBS and General American could successfully carry out the conversion without problems.

In addition, General American has a proprietary system (i.e., it is not owned by the Government). MDBS chose General American's system; HCFA did not choose the system for MDBS. Many of the problems MDBS encountered could have been avoided had they selected a system that was more compatible with their claims processing operation, and a maintainer that had experience installing a system at other sites.

HCFA is committed to ensuring that payment safeguard activities are themselves safeguarded during transitions. Past and continued performance problems on the part of MDBS, as outlined in attachment 2, fully demonstrate that the transition was not the sole cause for the problems outlined in the report.

Thank you for giving us the opportunity to review and comment on this report. Should you have any questions or require any additional information, kindly contact Ron Miller of the Executive Secretariat at (410) 966-5237.

Bruce C. Vladeck

Attachments

Attachment 1

Successful Transitions

- On January 1, 1994, HCFA successfully transferred the State of Washington Medicare Part B workload from King County Medical Blue Shield to Aetna Life Insurance Company.
- The two previous contractor replacements were equally successful. They were:
  - Blue Cross of Missouri left the Medicare program on October 1, 1992. The contractor replacement transition involved the coordination of two regions and was complicated by provider nomination procedures which resulted in the workload being transferred to 3 incoming intermediaries;
  - Kansas City Blue Shield left the Medicare program on October 1, 1991. Kansas Blue Shield took over the service area without incident or disruption to the provider community.
- Major software systems installations in the past several years have involved large volume contractors and have been successfully implemented with little or no interruption to beneficiaries or providers. They were:
  - Blue Shield of Texas--30 million claims, implemented over a 9-month period from April 1992-December 1992;
  - TransAmerica--25 million claims, implemented over a 12-month period from July 1991-June 1992; and
  - Aetna--40 million claims implemented over a 15-month period from December 1991-March 1993. The Aetna transition was especially complex since it involved the stagger implementation at five field offices across the country.

Attachment 2

Performance at Maryland Blue Shield

- MDBS has continued to receive marginal scores in the Contractor Performance Evaluation Program well after the transition.

FY 1993 Performance:

- MDBS failed 4 activities in its corrective action plan:
  - Timely installation of fee schedules;
  - Achievement of electronic media claims (EMC) goal;
  - Correspondence accuracy;
  - Timely and accurate Priority I critical tasks.

First quarter of FY 1994:

- MDBS ended quarter with an EMC rate well below the national average (57.9 percent versus national average of 68.7 percent).

- Continuing to demonstrate marginal performance, MDBS erroneously paid over $130,000 in interest charges for over 91,000 claims. The error was due to data entry problems, having nothing to do with the system.

- MDBS has performed badly in the Medicare secondary payer (MSP) area since before the transition, and continued poor performance in MSP has proven the systems conversion cannot be cited as a cause for poor performance.

As GAO demonstrates in its report dated January, 1991, titled Medicare: Millions Not Being Sought in Potential Recoveries by Maryland Contractor, MDBS' MSP performance was poor before the system change.

In addition,

- The systems conversion took place in October 1991. MDBS' MSP savings dropped for FY 1992. The contractor only achieved 49.61 percent of the assigned goal. However, the contractor's performance did not improve significantly in FY 1993. At fiscal year end, MDBS had obtained only 64.02 percent of its assigned goal. After almost 2 years, the systems conversion cannot be cited as a cause for poor performance.

- In FY 1993, MDBS obtained only 64 percent of its MSP goal. Through January 1994, it has achieved only about 19 percent of its goal (contractors should be at 33 percent of goal this time of year).

- Through January 1994, MDBS has achieved only 18.72 percent of its assigned goal. Contractors should be at approximately 33 percent of their goal at this point in the fiscal year.

- Current problems with the Data Match with MDBS include:

  - Inappropriate demand letters;
  - Inappropriate responses to employers;
  - Failure to use systems overrides and thus causing more work for GHI.

• HCFA attributes MDBS's inability to correct its operational problems to poor management and the lack of Medicare experience at the top levels.

- The carrier did not have a full-time Vice President for Medicare for the year in which its Medicare performance faltered, despite the fact that MDBS received $22 million in Medicare administrative funds, and HCFA's repeated requests that a full-time manager be named.

Comments From Blue Cross and Blue Shield of Maryland

BlueCross BlueShield of Maryland

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An independent Licensee of the Blue Cross and Blue Shield Association.

DON BEAUCHESNE
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(410) 998-5732 (FAX)

February 28, 1994

Ms. Sarah F. Jagger
Director, Health Financing and Policy Issues
United States General Accounting Office
Washington, D.C. 20548

Re: MEDICARE
Shared System Conversion Led to Disruptions in Processing Maryland Claims
Report: GAO/HRD-94-66

Dear Ms. Jagger:

Thank you for the opportunity to comment on the draft report referenced above. We understand the contents of the report and would like to add the following comments.

Blue Cross and Blue Shield of Maryland's performance prior to the conversion to the General American Part B system was good as measured by the annual performance evaluation program used by the Health Care Financing Administration (HCFA). HCFA rated our performance the best of all contractors in 1989. We had demonstrated our ability to handle large systems conversions with our move to the Arkansas Part A system and the conversion of nine other contractors to Common Working File (CWF) processing in our role as a CWF Host contractor.

In preparation for the approval to convert to a shared maintenance Part B system, we contacted HCFA in early November, 1990 about the General American system. Our original plan assumed approval in January, 1991, allowing nine months to prepare for test, and test, the new system. Final approval was received in May, 1991 with an implementation date of October 1, 1991.

Our performance has improved since our conversion to the General American system and our commitment to serving the beneficiaries and providers is strong. We continue to support HCFA's initiatives to streamline the systems that adjudicate and pay claims for Medicare beneficiaries. We

certainly endorse your recommendations that HCFA and Medicare contractors adequately plan and test each future system conversion to minimize adverse effects on beneficiaries and providers.

Thank you again for the opportunity to review this draft. Please let me know if you or your staff have any questions about these comments.

Sincerely,

Don Beauchesne
Senior Vice President
Operations

cc: William L. Jews

u:GAOltr.

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