Implementation of Medicare Administrative Contractors

Section 911 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) established the Medicare Contracting Reform (MCR). This statute requires the Department of Health and Human Services (HHS) to replace Medicare's current 48 carriers and fiscal intermediaries who process Medicare Part A and B Fee for Service (FSS) claims with Medicare Administrative Contractors (MAC). With the new MAC structure, there will be 15 contractors by jurisdiction responsible for processing Part A and B claims. Four of the A/B MAC providers will overlap responsibility for handling Home Health and Hospice claims. The final four MAC plans will be the Durable Medical Equipment contractors.

The primary reasons for instituting this change were to increase the contractor's efficiency in the receipt, processing, and payment of FFS claims. Other reasons include:

- Streamlining the coverage policies for contiguous geographic areas
- Balancing the work load of the Medicare contractors (currently, 13 of the largest contractors are responsible for processing 60% of all the FFS claims in the country)
- Creating a single source of contact (1-800- MEDICARE) for beneficiaries and providers
- Fostering competition among the MACs by rewarding them for adopting measures to increase efficiency, innovation and cost effectiveness

Medicare modified its selection process for choosing these contractors. Previously, health service providers like hospitals and nursing facilities had the ability to nominate their Medicare contractors. However, with the MAC implementation, Medicare will award contracts after a full and open competition period in accordance with the Federal Acquisition Regulation (FAR) for one base year with four one-year options. Medicare will maintain the sole ability to terminate contracts with poorly performing Medicare Administrative Contractors using performance metrics. Consequently, Medicare will conduct surveys to determine provider's satisfaction from MACs. Medicare will evaluate these contracts with MACs every 5 years based on four main areas: customer service (ensuring easy access of coverage information to beneficiaries and providers), operational excellence (enabling provision of optimal services), innovation and technology (effective coordination of Part A and B FFS Claims) and financial management (proper claims payments and uniformity in coverage reimbursement decisions).

CMS will assign providers to MACs based on the physical location where the provider furnishes services. For DME providers CMS will designate DME specialty MACs based on the beneficiary's location. A new change affects chain providers (multi-state physician groups having common control and ownership) - previously, CMS permitted them to consolidate their claims and submit to a single intermediary, which was nominated by the Qualified Chain Provider (QCP). CMS allowed this to reduce any excessive administrative costs incurred by the contractor or the chain provider. Post MAC implementation, Medicare will assign MACs to QCPs by their individual physician's locations or by the aggregation and submission of all the QCP's claims to a single MAC, having a common location with the QCP's home office. CMS will require

QCPs to show this process will be financially beneficial and cost efficient to the MAC and the provider. Additionally, the agency will evaluate providers' requests based on certain criteria- such as the size of the practice (the practice must have at least 10 participating facilities or 500 certified beds, or 5 facilities or 300 certified beds spread across 3 or more adjacent states) and central controls (uniformity in daily operations, utilization controls, personnel administration and fiscal operations among the providers). The agency prohibits the assignment of MAC jurisdiction based on the location of the provider's billing office to prevent providers from selecting billing offices in areas with less restrictive LCDs. CMS plans to monitor the workload for each MAC to ensure tasks are balanced across the geographic areas. CMS will not honor provider's request for MAC assignment or re-assignment.

CMS expects transition from the part A and B contractors to the MAC providers will take 6-13 months after their contract award dates. Under this schedule, CMS will institute full transfer to MACs by October 2010. MAC workload transition will involve a crucial step involving the consolidation of Local Coverage Determination policies (LCD) of the current contractors by adapting the "least restrictive" LCD. CMS will continue to issue the National Coverage Determination (NCD) decisions. The first cycle- Start up began with two phases in March 2005 for the procurement of the four Durable Medical Equipment MAC providers and June 2006 for the J3 A/B MAC award. The subsequent phase- cycle 1 of the MAC acquisitions started in September 2006, with awarded contracts for the following jurisdictions: J1, J2, J3, J4, J5, J7, J12 and J13. All awarded contractors (except J2 and J7 regions) have begun the process of migrating coverage policies for their regions in order to meet CMS' deadline for complete MAC program integration. CMS will award contracts for the final 7 Jurisdictions- J6, J8, J9, J10, J11, J14, J15 and all the Home Health and Hospice MAC insurers from September 2008. To facilitate a smooth transition process, MACs will notify affected physicians of new changes before they occur. These contractors will collaborate with provider's offices to resolve any possible issues with claims processing to reduce the likelihood of payment issues.

The fifteen jurisdictions for the A/B contractors are:
Jurisdiction 1 (J1) – American Samoa, California, Guam, Hawaii, Nevada, Northern Mariana Islands- Awarded to Palmetto GBA
Jurisdiction 2 (J2) - Alaska, Idaho, Oregon, Washington Awarded to National Heritage Insurance Company*
Jurisdiction 3 (J3) - Arizona, Montana, North Dakota, South Dakota, Utah, Wyoming- Awarded to Noridian Administrative Services
Jurisdiction 4 (J4) - Colorado, New Mexico, Oklahoma, Texas- Awarded to Trailblazers Health Enterprises
Jurisdiction 5 (J5) - Iowa, Kansas, Missouri, Nebraska- Awarded to Wisconsin Physician Services Health Insurance Corporation
Jurisdiction 6 (J6) - Illinois, Minnesota, Wisconsin Award date- To Be Determined
Jurisdiction 7 (J7) - Arkansas, Louisiana, Mississippi Awarded to Pinnacle Business Solutions Inc.*
Jurisdiction 8 (J8) - Indiana, Michigan Award date- To Be Determined

Jurisdiction 9 (J9) - Florida, Puerto Rico, United States Virgin Islands Award date- To Be Determined
Jurisdiction 10 (J10) - Alabama, Georgia, Tennessee Award date- To Be Determined
Jurisdiction 11 (J11) - North Carolina, South Carolina, Virginia, West Virginia Award date- To Be Determined
Jurisdiction 12 (J12) - Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania –Awarded to Highmark Medicare Services Inc.
Jurisdiction 13 (J13) - Connecticut, New York- Awarded to National Government Services
Jurisdiction 14 (J14) - Maine, Massachusetts, New Hampshire- Award date- To Be Determined
Jurisdiction 15 (J15) - Kentucky, Ohio- Award date- To Be Determined

The four jurisdictions for DME Specialty MAC carriers are:
Jurisdiction A- Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont

Jurisdiction B- Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin

Jurisdiction C- Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia

Jurisdiction D- Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming

Four of the A/B MAC contractors will absorb claim processing and administrative responsibility for Home Health and Hospice infrastructures. Using the models above for the DME Specialty MAC carriers and the A/B MAC contractors:

Jurisdiction 6 will include home health and hospice Jurisdiction D

Jurisdiction 11 will include home health and hospice Jurisdiction C

Jurisdiction 14 will include home health and hospice Jurisdiction A

Jurisdiction 15 will include home health and hospice Jurisdiction B.

* CMS awarded these contracts to these carriers, however, they was a protest against the awards filed to the Government Accountability Office (GAO), which has 100 days to respond to these requests.

The AAO-HNS will continue to monitor the MAC implementation process and provide updates to our members. It is imperative to be current on the implementation dates for your prospective MACs, as well as their new numbers, claims system processes, and changes to LCDs. If you notice unfavorable changes to your MAC's LCDs, please notify our health policy department at (703) 535 -3727 or at healthpolicy@entlink.net