Functional Contractors Overview

Within the Medicare Fee-for-Service (FFS) operating environment, the Medicare Administrative Contractor (MAC) is the central point of contact for providers of health care services. The establishment and monitoring of the MAC's relationships with a number of other function specific CMS contractors is critical to the integrity of the MAC contract administration. Functional contractors play an essential role.

Call Center Operations (CCO)

The CCO responds to inquiries from the Centers for Medicare & Medicaid Services' (CMS's) customer service population. The Contractor supports multi-channel operations that receive and respond to inquiries, providing information and services through various channels including telephone, mail, email, TDD/TTY, fax, and web chat. The CCO fields inquiries for CMS programs such as 1-800 Medicare, the Medicare Modernization Act (MMA), the Health Insurance Marketplace, and other relevant programs.

Virtual Data Center (VDC)

A data center serves as a platform for claims processing software systems for Medicare claims. Traditionally, the Medicare contractors either operated their own data centers or contracted out for these services. As part of CMS' contracting reform initiative, CMS reduced the number of data centers from more than one dozen separate smaller centers to two large VDCs. CMS manages these contracts. CMS migrated the entire FFS claims processing workload to the VDCs by March 2014.

Healthcare Integrated General Ledger and Account System (HIGLAS)

HIGLAS is the general ledger accounting system that replaced the former cash accounting systems used by Medicare Fiscal Intermediaries and carriers. All MACs now utilize the HIGLAS system to account for Medicare benefit payments, except for Durable Medical Equipment (DME) MACs.

Benefit Coordination and Recovery Center (BCRC)

The BCRC will perform liability insurance (including self-insurance), no-fault insurance, and workers' compensation (Non-Group Health Plan) recovery case work.
The BCRC consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The BCRC takes actions to identify the health benefits available to a Medicare beneficiary and coordinates the payment process to prevent mistaken payment of Medicare benefits. The BCRC does not process claims, nor does it handle any group health plan related mistaken payment recoveries or claims specific inquiries. The Medicare Administrative Contractors (MACs), Intermediaries and Carriers are responsible for processing claims submitted for primary or secondary payment. The BCRC does not process claims, nor does it handle any mistaken payment recoveries with respect to GHP recoveries or claims specific inquiries. Once the BCRC has completed its initial MSP development activities, it will notify the

Commercial Repayment Center (CRC) regarding a GHP MSP occurrence and will notify the BCRC regarding a liability, workers' compensation, or no-fault MSP occurrence (i.e., a Non-GHP MSP occurrence).

Zone Program Integrity Contractors (ZPICs)

The ZPICs perform functions to ensure the integrity of the Medicare Program. Most MACs will interact with one ZPIC to handle fraud and abuse issues within their jurisdictions.

Qualified Independent Contractors (QICs)

The QICs are responsible for conducting the second level of appeals of Medicare claims. The MAC is responsible for handling the first level of appeals. There are 6 QIC jurisdictions: Part A East, Part A West, Part B North, Part B South, DME Jurisdiction and one Administrative QIC.

Quality Improvement Organization (QIO)

CMS contracts with one organization in each state, as well as the District of Columbia, Puerto Rico, and the U.S. Virgin Islands to serve as that state/jurisdiction's Quality Improvement Organization (QIO) contractor. QIOs are staffed by professionals, mostly doctors and other health care professionals, who are trained to review medical care and help beneficiaries with complaints about the quality of care and to implement improvements in the quality of care available throughout the spectrum of care.

They protect beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law. QIOs protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting.

Recovery Auditor (RAs)

The RAs are responsible for reviewing paid Medicare claims to identify improper Medicare payments that may have been made to healthcare providers and that were not detected through existing program integrity efforts.