

Medicare Contracting - Medicare Administrative Contractor - Frequently Asked Questions

FAQ 1911

Question: What was the impact of Medicare Contracting Reform on the Medicare Fee-for-Service (FFS) program?

Answer: Under Medicare Contracting Reform, CMS was able to improve and modernize Medicare & FFS claims processing operations. It provided the flexibility for CMS and the Medicare contractors to work together more effectively and better adapt to changes. Medicare Contracting Reform enabled the Medicare FFS program to benefit from economies of scale and competitive performance contracting.

FAQ 1913

Question: How did Medicare Contracting Reform affect Medicare providers and Medicare beneficiaries?

Answer: As a result of Medicare Contracting Reform, both providers and beneficiaries now have a single point-of-contact for all Medicare Fee-For-Service related businesses and needs. For providers, in addition to processing claims, the MACs are able to assist providers and suppliers with obtaining information on behalf of patients about items or services received from another provider or supplier that could affect claims payment. For beneficiaries, the first point of entry for resolution of questions about Medicare coverage is 1-800-MEDICARE, which takes them through a more advanced customer service network for meeting their information needs, including complex original Medicare plan inquiries, availability of prescription drug coverage as well as finding and comparing nursing homes.

FAQ 1915

Question: How will Medicare Contracting Reform affect Medicare providers?

Answer: Through the competitive process, CMS will establish MACs that will provide improved service and performance to all providers in their jurisdictions. The MAC will serve as the single point of contact for providers and suppliers for all claims-related business. In addition to

processing claims, the MAC will be able to assist providers and suppliers with obtaining information on behalf of patients about items or services received from another provider or supplier that could affect claims payment. Medicare contracting reform also will bring some potential benefits to providers, including improved provider education and training for small providers or suppliers as well as a role in contractor evaluation via surveys. CMS will manage the MAC transitions to ensure continuity, accuracy and timeliness in claims processing and payment for providers.

FAQ 1917

Question: What were the key changes implemented with Medicare Contracting Reform?

Answer: As CMS implemented Medicare Contracting Reform, it ensured that changes were managed effectively and coordinated with other Program initiatives. CMS ensured that Medicare claims continued to be processed effectively, accurately and in a timely manner. Under Medicare Contracting Reform, contracts are now subject to the Federal Acquisition Regulation. Differences between the Title XVIII contracts (previous contracts) and the Federal Acquisition Regulation contracts (current contracts) are: Restrictions on who could receive contract award generally were limited to cost reimbursement contracts. Performance standards and criteria were published in the Federal Register. Either party could terminate. Submitted monthly expenditure reports, which did not have to be approved in advance in order to access funds. Contracts/Agreements were renewed year to year. Full and open competition is required. Several types of contracts are available. Performance standards are contained in the contract. Only Government may terminate for convenience or default. Must submit a voucher in order to get paid, and payment is made after voucher is approved. Section 509 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the maximum length of a MAC contract, inclusive of all option and renewal periods from five (5) to up to ten (10) years. Learn more about Medicare Contracting Reform on cms.gov at [Archives \(https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Archives.html\)](https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Archives.html)

FAQ 1919

Question: Will Medicare Contracting Reform affect the Medicare Advantage or the prescription drug benefit?

Answer: No

FAQ 1921

Question: Who can compete for these new contracts?

Answer: The Secretary may enter into contracts with “any eligible entity” for determining and making payments, eligible individual education and assistance, provider consultation, communication, provider education, and technical assistance. An “eligible entity” includes, but is not exclusive to current Medicare contractors (Non-insurance companies can compete for these new contracts). The Medicare Prescription Drug, Improvement and Modernization Act of 2003 sets forth the minimum conditions for eligibility to be a Medicare Administrative Contractor. These include ability to perform the functions, compliance with Federal Acquisition Regulations’ conflict of interest standards, sufficient financial assets to support performance of the functions, and any other requirements imposed by the Secretary.

FAQ 1923

Question: How do we get information on Medicare Contracting Reform?

Answer: Throughout the Medicare Contracting Reform implementation process, CMS intends to work closely with contractors, providers and beneficiaries. In March of 2004, CMS developed a website devoted to Medicare Contracting Reform at <http://www.cms.hhs.gov/MedicareContractingReform/>, which is continually updated with new information. We will communicate information and decisions as early and often as possible on our website and other forums that may be beneficial.

FAQ 2513

Question: Did the winning contractor have any subcontracts? If so, what services will the subcontractor provide?

Answer: As the J9 A/B MAC, FCSO is subcontracting with the following companies: Triple S Inc. will perform customer service, appeals, prepayment medical review and EDI support for Puerto Rico as well as provider outreach and education and onsite enrollment visits for Puerto Rico and the U.S. Virgin Islands. Figliozzi & Company will perform cost-reporting audits on a contingency basis. Holloway & Company will conduct the CMS required SAS-70 audits. Red Buffalo Services will perform IT services on a contingency basis. Subcontractors will also provide outreach support in Puerto Rico and the U.S. Virgin Islands during implementation and for 3 months post cutover and will perform provider enrollment site visits.

FAQ 14833

Question: Who are the current Medicare Administrative Contractors (MACs) for each Jurisdiction?

Answer: To find the current MACs and their contact information visit the CMS.gov website at: [Who are the MACs \(https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html\)](https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs.html)

FAQ 14837

Question: What will be the impact of Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 on Medicare Fee-for-Service (FFS) program?

Answer: The Medicare Access and CHIP Reauthorization Act (MACRA) enacted on April 16, 2015, included language in Section 509 that extends MAC contract terms from five to ten years. Also, it requires the Agency to publish performance information on each MAC, to the extent that such information does not interfere with contract procurements. CMS shares information on its strategy to implement this new legislation and includes publishing MAC performance information on the cms.gov website. To learn more visit: [MACRA Section 509 \(https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MACRA-Section-509.html\)](https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MACRA-Section-509.html)

FAQ 14841

Question: Will CMS finish the Medicare Administrative Contractor (MAC) Jurisdiction consolidation plan, combining Jurisdictions 8 and 15 to form Jurisdiction I and combining Jurisdictions 5 and 6 to form Jurisdiction G?

Answer: Originally CMS planned to implement 15 A/B MACs across the country, but later changed its strategy to consolidate these 15 Jurisdictions down to 10. In 2014, CMS postponed the final two consolidations and paused at 12 A/B MAC Jurisdictions. In 2016, after evaluating the impact of the consolidation of these remaining MAC jurisdictions, CMS concluded that further consolidation is not in the best interest of the MAC program. CMS will not be combining Jurisdiction 8 and 15 to form Jurisdiction I, nor will it combine Jurisdiction 5 and 6 to form Jurisdiction G.

FAQ 14845

Question: When will CMS finish assigning all providers to their designated geographical A/B Medicare Administrative Contractors (MACS), thereby eliminating all out-of-jurisdiction providers?

Answer: CMS has not set a timetable to move all out-of-jurisdiction providers to their designated geographical A/B MACs. Learn more about out-of-jurisdiction providers on the

CMS.gov website at: [Provider Assignment \(https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Provider-Assignment-.html\)](https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Provider-Assignment-.html)