Medicare Administrative Contractor (MAC) Jurisdictions Fact Sheet

January 2007

Overview:

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) enables the Centers for Medicare & Medicaid Services (CMS) to make significant changes to the Medicare fee-for-service program's administrative structure that will make contracting dynamic, competitive and performance-based. Through implementation of Medicare Contracting Reform, CMS will integrate the administration of Medicare Parts A and B for the fee-for-service benefit to new entities called Medicare Administrative Contractors (MACs). This operational integration will centralize information once held separately, creating a platform for advances in the delivery of comprehensive care to Medicare beneficiaries. These changes to Medicare's administration will continue to benefit Medicare's enrollee population as it increases with the retirement of the Baby Boom generation. On February 7, 2005, CMS submitted a report to Congress describing the benefits of contracting reform and its plans for implementation.

Medicare's fee-for-service plan should be comprehensive and high quality. CMS will achieve this vision with substantial improvement of the current fee for service administrative structure. The Medicare Contracting Reform provision of the Medicare Modernization Act will greatly assist CMS' efforts in this regard.

Between 2005 and 2011, the Centers for Medicare & Medicaid Services (CMS) will be conducting full and open competitions to replace the contractors that currently perform claims processing and related functions for the Medicare program with new MACs that will perform many of the same tasks, but will do so more efficiently. Central to the implementation of the contracting reform is the creation of new jurisdictions to be administered by the MACs. In this fact sheet, CMS defines the new MAC jurisdictions and explains the process that led to these decisions. Once CMS consolidates administration of Part A and Part B into integrated MACs, the following improvements to services for beneficiaries and providers can be expected:

Improved Beneficiary Services

- Most beneficiaries will have their claims processed by only one contractor, reducing the number of separate explanation of benefits statements a beneficiary will receive and need to organize.

- A/B MACs will be required to develop an integrated and consistent approach to medical coverage across its service area, which benefits both beneficiaries and providers.

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- Beneficiaries will be able to have their questions on claims answered by calling 1-800-MEDICARE, their single point of contact.

Improved Provider Services

- A simplified interface with a single MAC for Part A and Part B processing and other services will benefit providers.

- Competition will encourage MACs to deliver better service to providers.

- Requiring MACs to focus on financial management will result in more accurate claims payments and greater consistency in payment decisions.

The investment for the implementation of Medicare contracting reform will help ensure the program remains an important and secure health plan for beneficiaries, generating significant trust fund and administrative savings over time.

Establishing the MAC Jurisdictions

CMS designed the new MAC jurisdictions to balance the allocation of workloads, promote competition, account for integration of claims processing activities, and mitigate the risk to the Medicare program during the transition to the new contractors. The result is jurisdictions that reasonably balance the number of fee-for-service beneficiaries and providers. While these jurisdictions exhibit some variations in size and workload, they are more equalized than the existing fiscal intermediary and carrier workload.

Choosing MAC Contractors

CMS will ensure its MAC contracts focus on three critical areas: customer service, operational excellence, and financial management. The MACs will serve as the providers' primary point-of-contact for enrollment, training on Medicare coverage and billing requirements, and the receipt, processing, and payment of Medicare fee-for-service claims within their respective jurisdictions. These contractors will perform all core claims processing operations for both Part A and Part B. In their capacity as the face of Medicare to the providers, practitioners, and suppliers, MACs will need to maintain a staff of experts knowledgeable in all aspects of the fee-for-service program.

CMS plans to award 23 MACs through a competitive bidding process during the initial implementation phase (2005-2011). These will include 15 A/B MACs servicing the majority of all types of providers (both Part A and Part B), four specialty MACs servicing the home health and hospice providers, and four specialty MACs servicing durable medical equipment suppliers. The jurisdictions for the eight specialty MACs will reflect a realignment of the existing jurisdictions and will overlay the boundaries of the 15 A/B MAC jurisdictions.

Medicare's MAC Jurisdictions

A/B MAC Jurisdictions

Jurisdiction #	States Included in Jurisdiction
1	American Samoa, California, Guam, Hawaii, Nevada, and Northern Mariana Islands
2	Alaska, Idaho, Oregon, and Washington
3	Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming
4	Colorado, New Mexico, Oklahoma, and Texas
5	Iowa, Kansas, Missouri, and Nebraska
6	Illinois, Minnesota, and Wisconsin
7	Arkansas, Louisiana, and Mississippi
8	Indiana and Michigan
9	Florida, Puerto Rico, and U.S. Virgin Islands
10	Alabama, Georgia, and Tennessee
11	North Carolina, South Carolina, Virginia and West Virginia
12	Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania
13	Connecticut and New York
14	Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont
15	Kentucky and Ohio

Specialty MAC Jurisdictions (DME and Home Health/Hospice)

Jurisdiction	States Included in Jurisdiction
A	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
B	Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin
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
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

Medicare's MAC Procurement Schedule:

CMS began competing the workloads of the existing fiscal intermediaries, carriers and durable medical equipment regional carriers (DMERCs) with a start-up acquisition and transition cycle. This start-up cycle competed the DMERC workloads and the A/B workload for Jurisdiction 3, a first step that focused on a small discrete workload. That start-up cycle is being followed by MAC acquisition and transition Cycles One and Two. CMS anticipates each of these acquisition cycles will take approximately 9 to 12 months, from solicitation to award. The subsequent activity of transitioning the workload from the existing contractors to the new MACs will last from approximately 6 to 13 months for each MAC. Under this schedule, the full fee-for-service workload will be transitioned to MACs by October 2009.

Procurement Schedule for MACs

Cycle	Workload Being Competed	Request for Proposal Issuance Date	Award Date
Start-Up	DME MACs Jurisdiction 3	April 15, 2005 September 19, 2005	January 6, 2006 July 31, 2006
Cycle One	Jurisdictions 4, 5, 12 Jurisdictions 1, 2, 7, 13	September 29, 2006 December 15, 2006	July 2007 September 2007
Cycle Two	Jurisdictions 6, 11, 14, 15 Jurisdictions 8, 9, 10	September 2007 December 2007	July 2008 September 2008