Focus On Locus: Evolution Of Medicare’s Local Coverage Policy

Can the principle of equity outweigh variation in Medicare coverage policies?

by Susan Bartlett Foote

ABSTRACT: Medicare relies on a highly decentralized local-contractor structure that emerged as a political compromise in 1965. Decisions regarding Medicare’s coverage of new procedures and technologies are an important part of the program. A national coverage process exists, but Medicare’s local contractors develop most coverage policies. Although an intense debate surrounds Medicare’s local coverage process, there is little analysis to inform the discussion. To expand knowledge of local coverage policy, this paper traces its origins and evolution. I conclude that the focus on locus, framing the debate in terms of local versus national, obscures fundamental policy issues of access, equity, and quality in Medicare.

Medicare has developed two pathways to coverage for new technologies and procedures—national and local. The local process has had little systematic study, although it is now the focus of intense debate. Because of the importance of coverage policy to Medicare, it is critical to expand our understanding of the evolution of the local policy-making process, move beyond national versus local debates, and address the fundamental issues that coverage policy raises.

Background. The 1965 Medicare statute set forth broad categories of coverage, such as hospital and physician services. Congress understood that questions of coverage for specific services within the general categories would arise. Therefore, the statute provided that Medicare could not expend funds if the services were not “reasonable and necessary.”

Over the years the Centers for Medicare and Medicare Services (CMS) (known as HCFA until 2001) has developed a national policy process to prospectively evaluate new procedures or technologies to determine if they will be covered under the statute.

Medicare relies on private contractors—fiscal intermediaries (FIs, for Part A, Hospital Insurance) and carriers (for Part B, Supplementary Medical Insurance)—to process individual claims for payment. These local contractors must determine if the claim applies to a covered benefit and, if so, whether the item or service is “reasonable and necessary.” They also have acquired the authority to make prospective coverage policies that apply in their jurisdictions if there is no applicable national coverage decision. Local medical review policies (LMRPs) now constitute the vast majority of Medicare coverage decisions.

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There are now nearly fifty local contractors, which posted more than 9,000 separate coverage policies on the official LMRP Web site in 2001. These policies addressed complex innovations such as deep brain stimulation and transurethral microwave thermotherapy, as well as commonly used procedures such as toenail debridement and biofeedback therapy. Because local policies apply only in a contractor's jurisdiction, there can be many separate policies relating to a single procedure. For example, there are more than thirty-five posted policies for deep brain stimulation. Some contractors develop many policies; others have only a few. While policy variations have not been systematically studied, a few case studies have found wide variations.

The debate. There is an intense debate about the merits of the local policy process. The Medicare Payment Advisory Commission (MedPAC) recently advocated “elimination of local descriptions of policy and regulation” to reduce Medicare’s “current complexity, inconsistency, and uncertainty.” Doctors have objected to perceived variations that “do not improve quality or lower costs to the program.” Organized medicine has periodically called for national standards for coverage decisions. On the other hand, device manufacturers support the local system, arguing that “any reforms… should maintain a process for making coverage decisions locally” and that carrier consolidation would “create significant new delays in patient access.” Here I discuss the origins and evolution of the local policy process and the status of the ongoing contractor reform debate.

Evolution Of Local Coverage Policy

Background: political compromise. Several prominent researchers have described the protracted and bitter political battles leading up to the passage of Medicare in 1965. Congress needed the support of hospitals and doctors, who feared that a government health program would interfere with the practice of medicine. Congress designed a compromise that allowed private insurers to act as FIs and carriers, serving as a “buffer between the federal government and the hospitals.” The American Hospital Association (AHA), then affiliated with Blue Cross, was comfortable with an agreement that the Blues would step forward to play this buffer role.

The Medicare statute defined two different contractual structures. Under Part A, groups of hospitals, extended care facilities, and home health agencies could nominate FIs to handle hospital relations, reimbursements, utilization review, and auditing services. Under Part B, the government would contract with carriers to serve a similar function for physician services. Carriers were assigned to geographic areas, in contrast to FIs, which were selected by hospitals without specific geographic ties. After the statute was enacted, the government negotiated the FI and carrier contracts. For Part A, the overwhelming majority of hospitals nominated Blue Cross. In actual operation, the AHA selected the national Blue Cross Association (BCA) as the prime contractor for all of its member hospitals and subcontracted with the local plans to perform the services. In 1970 five national insurance companies and several regional organizations also became FIs. Part A contracts were “local,” not by congressional mandate but because of the decentralized structure of local Blues plans at the time. In contrast, commercial insurers often had agreements with hospitals across many states. However, because locally based Blue Cross plans clearly dominated the field—serving 91 percent of hospitals, 54 percent of extended care facilities, and 78 percent of home health agencies by 1970—FIs were often associated with specific localities.

To implement the Part B provisions, the country was divided into sixty-four geographic regions. In 1966, 140 organizations, including Blue Shield plans and commercial insurers, initially submitted carrier proposals. Forty-nine carriers were selected, of which thirty-three were Blue Shield plans and the rest commercial insurers. By 1969 one insurer dropped out, and its territory was taken over by a larger company with several existing contracts. Although the thirty-three Blue Shield
plans were assigned about half of the sixty-four geographical areas, they represented 60 percent of all Medicare enrollees. A single state constituted a geographic area for most carrier contracts, but the assignment of multiple carriers occurred in states with large populations, or when there was more than one competent applicant.14

■ The need for coverage policy. In the early years evaluation of items and services occurred when local contractors processed individual claims.15 HCFA did develop some informal guidelines establishing general criteria for claims review.16 For the most part, the national Office of Coverage Policy was rarely involved with coverage decisions, relying on contractors and local doctors to mediate disputes.17 However, as highly effective and costly innovations emerged in the 1970s, such as kidney dialysis and computed tomography (CT) scanning, all payers needed better tools for evaluation prior to payment. Medicare faced its first major technology coverage challenge over heart transplantation in the late 1970s and early 1980s. After a long and contentious battle, the HCFA central office began to expand its internal capacity to review future technologies at the national level.18

■ Informal national and local pathways. In 1981 HCFA issued a directive restating its expectation that contractors refer coverage issues of national interest to the central office.19 The agency also created a Coverage/Payment Technology Advisory Group (TAG), comprising contractors and agency staff, to discuss coverage and payment issues.20 During the 1980s HCFA issued about ten national coverage policies per year; the contractors made all other decisions case by case. The program provided some oversight of the claims review process, occasionally issuing directives on criteria and processes for evaluating claims.21 A 1984 Office of Technology Assessment (OTA) report noted that 25 percent of coverage questions submitted to HCFA in 1981 were from device manufacturers concerned about timing of coverage of their products. The OTA found that the industry’s major association stopped encouraging its members to go to the national office in the next few years, suggesting that they contact the local contractors instead. This shift occurred because the industry perceived that both the number of denials and the time for decisions had increased at the national level and that they could be more successful locally.22

These informal processes were challenged in Jameson v. Bowen in 1985.23 A Medicare beneficiary received an angioplasty, but the contractor denied the claim because the procedure was “experimental.” Jameson sued the Department of Health and Human Services (HHS). In 1987 HHS settled the case by agreeing to describe explicitly its coverage process, including how it planned to determine “whether new procedures are not covered because they have not been found to be reasonable and necessary and/or safe and effective.”24

■ Local coverage policy emerges. As a result, HCFA administrator William Roper issued a Notice of Proposed Rulemaking in 1989 to develop coverage rules and to establish applicable criteria. The proposed rule included a list of criteria necessary for Medicare coverage, including a limited cost-effectiveness requirement for certain types of technologies. Despite numerous comments and intense negotiations with all interested parties, opposition from the device industry and others led the administration to abandon the effort before the 1992 election.25 Nonetheless, HCFA continued efforts to improve the local process. A provision in the proposed rule pointed the way to local policy:

When developing utilization review policy to identify claims for services that may need review for medical necessity prior to payment, Medicare carriers and intermediaries must solicit comments...from the local medical community...on such factors as appropriate clinical indications and settings for the services under consideration.26

■ Local coverage policy matures. The new authority for local contractors arrived with little fanfare. Some contractors began issuing local policies in the early 1990s, and the first reference to the term local medical review policy appeared in the intermediary manual in 1994.27
Over time HCFA enhanced the structure and capability of contractors to develop policies, including a carrier medical director in each contract, national and regional conferences for medical directors, work groups to collaborate on technology evaluation, and Carrier Advisory Councils of physicians. The agency also imposed more requirements for LMRP development.28

**Trends In Medicare Contractor Consolidation**

- **Contractors decline in number.** Major changes also occurred in the number of contractors and in their organizational structure during this period. The initial subcontracting arrangement with the national BCA meant that many of the hospitals’ relations with Medicare were administered by their local Blues plan. But hospitals could also select default national insurers, such as Mutual of Omaha, with contracts throughout the country. Part B was explicitly tied to specific geographic areas, but the local nature of that structure has eroded because of the factors discussed below.

  The U.S. General Accounting Office (GAO) reported that of the fifty-eight contracts in 1999, only forty-four distinct organizations were represented because of the merger of many Blue Cross and Blue Shield (BCBS) plans.29 In 2002 the actual number of discrete organizations contracting with the CMS fell to thirty-seven (Exhibit I).30

  There are a variety of reasons for these declines. The number of primary licensees in the Blues insurance system fell from 114 in 1980 to 77 in 1990 and to 45 in 2000.31 Consolidations in the 1980s were driven primarily by a one-plan-per-state Blues strategy and the need to strengthen weak local plans. Multistate Blues plans began to compete in regional and national markets. Some plans refocused on their core insurance market functions. Exits accelerated as the financial rewards for claims processing declined.32 On the other hand, BCBS of South Carolina made a successful business processing claims for its own contracts and as a subcontractor for other insurers.33

  Another challenge was Medicare’s aggressive focus on fraud and abuse in the 1990s. Medicare contractors were considered HCFA’s front line to stop fraudulent or erroneous payments. In 1999 the GAO found that in nearly one of four claims, administration contractors were alleged to have engaged in improper and potentially fraudulent activities, such as misrepresenting their performance to appear to meet HCFA standards or to garner financial gain. Six contractors received criminal and civil settlement decrees totaling more than $235 million following these investigations.34

**EXHIBIT 1**

Consolidation In The Number Of Medicare Fiscal Intermediary (FI) And Carrier Contractors, Selected Years 1980–2002

<table>
<thead>
<tr>
<th>Year</th>
<th>FIs</th>
<th>Carriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>1990</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>1999</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>2002</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

**Multicontract networks flourish.** Departures and consolidations have led to large multicontract networks, often with no contiguous or regional coherence. Only eleven FIs and seven carriers hold single contracts (Exhibit 2). However, single-contract FIs often hold one or more contracts as carriers, and vice versa. National insurers, such as Mutual of Omaha, process claims for hospitals in forty-nine states.35

Exhibit 3 illustrates how far the program continues to move from its local orientation. In 2002 Noridian held eleven carrier contracts and two FI contracts throughout the central and western states. National Heritage had a bicoastal presence as a carrier, with contracts in California and four New England states. Consolidations continue. In 2002 Nationwide, which held the two contracts for Ohio and West Virginia, left the program, and Palmetto (part of South Carolina BCBS) acquired the contracts. Contractor consolidations have eroded the concept of local decision making.

**Politics Of Contractor Reform**

Contractors continue to play a central role in Medicare. In 2001 the program employed 21,000 people, processed a billion claims, provided services to thirty-three million people, and paid out $175 billion to providers.36

**Critiques of contractor performance.** When Congress put Medicare in the hands of the private insurance system, the federal government surrendered major management control. In 1966 administrative rule making began to address the allocation of control between the government and its contractors.37 It is not surprising that there has been a constant struggle over management and oversight, given the size and administrative needs of the program.38 As Medicare grew, policymakers often criticized contractors and the program’s

### EXHIBIT 2
**Contractors With Single-State Contracts, 2002**

<table>
<thead>
<tr>
<th>Contractor</th>
<th>State covered by carrier contract</th>
<th>State covered by FI contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS AZ</td>
<td>Multiple states</td>
<td>AZ</td>
</tr>
<tr>
<td>BCBS AR</td>
<td></td>
<td>AR</td>
</tr>
<tr>
<td>BCBS GA</td>
<td></td>
<td>GA</td>
</tr>
<tr>
<td>BCBS KS</td>
<td>Multiple states</td>
<td>KS</td>
</tr>
<tr>
<td>BCBS MT</td>
<td>MT</td>
<td>MT</td>
</tr>
<tr>
<td>BCBS NE</td>
<td></td>
<td>NE</td>
</tr>
<tr>
<td>BCBS RI</td>
<td>RI</td>
<td>RI</td>
</tr>
<tr>
<td>BCBS UT</td>
<td>UT</td>
<td></td>
</tr>
<tr>
<td>BCBS WY</td>
<td></td>
<td>WY</td>
</tr>
<tr>
<td>Chisholm Administrative Services (BCBS OK)a</td>
<td>Multiple states</td>
<td>OK</td>
</tr>
<tr>
<td>First Coast Service Options Inc. (BCBS FL)</td>
<td></td>
<td>FL</td>
</tr>
<tr>
<td>Group Health Inc.</td>
<td>NY (Queens)</td>
<td></td>
</tr>
<tr>
<td>HealthNow NY</td>
<td>NY (Upstate)</td>
<td></td>
</tr>
<tr>
<td>HGSAdministrators (Carrier/Veritus Medicare Services (FI) (Highmark Inc., formerly PA Blue Shield)b</td>
<td>Multiple states</td>
<td>PA</td>
</tr>
</tbody>
</table>

**SOURCES:** Centers for Medicare and Medicaid Services, “About LMRP,” www.lmrp.net (7 April 2003); and Blue Cross and Blue Shield Association.

**NOTES:** FI is fiscal intermediary. BCBS is Blue Cross Blue Shield.

*a Organizations in parentheses are parent organizations. Many carrier and FI organizations are subsidiaries of larger organizations.

*b HGSAdministrators and Veritus Medicare Services are the carrier and FI, respectively, for Pennsylvania. Both organizations are associated with the same parent organization.
supervision of them. Carriers and intermediaries were accused of failing to be as “efficient and economical as required by law.”

The GAO has periodically analyzed contractors’ performance. In 2001 it studied operational and structural elements of contracting that frustrated participating providers. It found that physicians often do not receive complete, consistent, timely, or accurate information from contractors. It also found that HCFA’s contractor oversight was poor, with fewer than twenty-six full-time staff assigned to oversee all carrier-provider relations.

Statutory reform. Policymakers have advocated legislative changes to the statutorily mandated contracting rules for more than twenty years. In 1980 HCFA deputy administrator Earl Collier testified that the lack of competitive bidding for contracts and payment based on costs “does not contain sufficient incentives for efficient, innovative...operations.” Since 1993 the agency repeatedly proposed legislation to increase competition and provide more flexibility in how the contract relationships are structured.

Under President George W. Bush, there have been renewed efforts at contractor reform. The Medicare Regulatory and Contracting Reform Act of 2001 (H.R. 2768) was introduced in the House of Representatives 2 August 2001. An amended version, H.R. 3391, passed the House 4 December 2001 but was not considered by the Senate during the 107th Congress.

EXHIBIT 3
Contractors With Multiple-State Contracts, 2002

<table>
<thead>
<tr>
<th>Contractor</th>
<th>States covered by carrier contract</th>
<th>States covered by FI contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>AdminaStar Federal Inc.</td>
<td>IN, KY</td>
<td>IL, IN, KY, ME, MA, NH, OH, VT</td>
</tr>
<tr>
<td>BCBS AR</td>
<td>AR, LA, NM, OK, E. MO</td>
<td>AR only</td>
</tr>
<tr>
<td>BCBS KS</td>
<td>KS, NE, W. MO</td>
<td>KS only</td>
</tr>
<tr>
<td>Cahaba GBA (BCBS AL)</td>
<td>AL, GA, MS</td>
<td>AL, IA, SD</td>
</tr>
<tr>
<td>CareFirst (BCBS MD)</td>
<td></td>
<td>DC, MD</td>
</tr>
<tr>
<td>CIGNA Medicare</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empire Medicare Services (Empire BCBS)</td>
<td>NJ, NY</td>
<td>CT, DE, NY</td>
</tr>
<tr>
<td>First Coast Service Options Inc.</td>
<td>CT, FL</td>
<td>FL only</td>
</tr>
<tr>
<td>Medicare Northwest (Regency Group)</td>
<td></td>
<td>ID, OR, UT</td>
</tr>
<tr>
<td>National Heritage Insurance Company</td>
<td>CA, ME, MA, NH, VT</td>
<td></td>
</tr>
<tr>
<td>Noridian Government Services</td>
<td>AK, AZ, CO, HI, IA, NV, ND, OR, SD, WA, WY</td>
<td>MN, ND</td>
</tr>
<tr>
<td>Palmetto GBA (BCBS SC)</td>
<td>OH, SC, WV</td>
<td>NC, SC</td>
</tr>
<tr>
<td>Premera Blue Cross</td>
<td>AK, WA</td>
<td></td>
</tr>
<tr>
<td>Riverbend GBA (BCBS TN)</td>
<td>NJ, TN</td>
<td></td>
</tr>
<tr>
<td>Trailblazer Health Enterprises Inc.</td>
<td>DC, DE, MD, TX, VA</td>
<td>CO, NM, TX</td>
</tr>
<tr>
<td>TriSpan Health Services (BCBS MS)</td>
<td>LA, MS, MO</td>
<td></td>
</tr>
<tr>
<td>United Government Services (BCBS United WI)</td>
<td>CA, HI, MI, NV, VA, WV, WI</td>
<td></td>
</tr>
<tr>
<td>Wisconsin Physician Services Inc.</td>
<td>IL, MI, MN, WI</td>
<td></td>
</tr>
</tbody>
</table>

SOURCES: Centers for Medicare and Medicaid Services, “About LMRP,” www.lmrp.net (7 April 2003); and Blue Cross and Blue Shield Association.

NOTES: FI is fiscal intermediary. BCBS is Blue Cross Blue Shield. Organizations in parentheses are parent organizations. Many carrier and FI organizations are subsidiaries of larger organizations.

*Government Benefit Administrators.
key purpose was to provide Medicare with tools to manage operations more efficiently. The bill amends current law to allow competitive contracting by all qualified entities; eliminates the distinction between Parts A and B; and permits “functional contracting,” defined as the ability to split contracts into specific services such as education or claims processing.

During testimony in 2001, CMS administrator Tom Scully described ongoing administrative reform efforts under existing legislative authority that were intended to raise Medicare’s service level. In a speech to the National Health Council, Scully was reported to have said that “it’s ‘crazy’ to have 50 contractors processing Medicare claims, which leads to inconsistencies in payment and makes it difficult for CMS to make the reimbursement system more responsive to providers.” He went on to note that the administration is interested in “winnowing down to 18 to 22 reliable contractors.”

Contractor reform debates have rarely addressed the potential impact on local coverage policy making. The final House version (H.R. 3391) did include a provision that required the Institute of Medicine (IOM) to study “the capabilities and information available for local coverage determinations” and report to Congress within three years. Although the 107th Congress failed to enact reforms, contracting reform and program improvement remain an administration priority in 2003.

Whither Local? Implications For Local Coverage Policy

All of these ongoing and anticipated changes will inevitably affect the local coverage process, but to date there has been little effort to integrate coverage policy changes into the contractor-reform legislation. As we have seen, the debate is framed in terms of “local” versus “national” coverage, with MedPAC calling for elimination of local policy and AdvaMed holding firm for the local status quo.

The historical analysis presented here demonstrates, however, that “local” is an increasingly inaccurate descriptor of the contractor environment and that the term can obscure critically important issues about coverage policy design. Here I draw some conclusions about local policy from the research, and I set forth some underlying policy issues.

Is “local” a core Medicare principle?

While the original contractor structure led to more than 100 carriers and FIs, the legislative history does not reflect a deep-seated congressional intent to elevate “local” decision making to a core principle in Medicare. Decentralization emerged because of political compromise; it is simply an accident of history.

Moreover, the concept of “local” has eroded over time. As discussed above, the original “local” structure was not ever purely local, given the hospital nomination provisions in Part A in particular. As it has evolved, the “local” structure is even further removed for small geographic regions. Expanding multicontract organizations do not have a coherent geographic orientation. As they consolidate their coverage policies to reflect their corporate structure, they further diminish any link between local policies and local providers.

What values are served by regionally divided policies?

Are those values sufficiently compelling to reverse the trends toward consolidation, creating a truly local infrastructure that the market has not been able to sustain?

Can local policies be efficient and equitable?

There is no question that having 9,000 LMRPs posted on the Internet, developed by close to fifty entities, creates complexity. Case studies have shown variation among some contractor policies, but the extent of or justifications for variation are not known. Variation in coverage policies has led one CMS official to note: “It becomes problematic when a beneficiary is desirous of a service that somebody ten minutes away can get because they are covered by a different contractor.”

Variation also raises the issue of beneficiary equity, as Medicare is perceived to provide the same benefits to all Americans regardless of status or place of residence. Is the principle of equity important enough to outweigh variation in coverage policies?

Does variation detract from quality standards?

The move toward evidence-based
medicine with a focus on standards of quality is premised on best practices in medicine, not local variations in practice. Should Medicare encourage variation on coverage policy in light of trends toward quality standards?

- **Do we really need multiple evaluators?** Although the numbers are shrinking, the program still has multiple decisionmakers assessing new technologies. Why do we need so many? What qualifications and resources are necessary for assessment of new technologies? If we are moving toward evidence-based medicine, do we need multiple entities to evaluate similar or identical evidence?

- **Is “local” a proxy for decentralization?** The device industry argues that local coverage is essential for timely access to new technologies, expressing concern about the all-or-nothing national decisions made by a large federal bureaucracy. However, do these arguments rest less on ties to geography and more on having multiple points of entry into the market? If one contractor in one state makes a favorable decision, the innovator can begin to market the product as it pursues coverage decisions in other jurisdictions.

- **Should the program have a decentralized coverage process?** If so, what would be the benefits, and how many points of entry would be necessary to achieve those benefits? If decentralization serves innovators, is it the role of Medicare to promote innovation? If so, are there more-efficient alternatives?

- **Are “local” decisions inherently more timely?** Data are beginning to emerge on the time frames for national coverage decisions. Less is known about the timeliness of local decisions. As the CMS imposes more structure on the LMRP process, such as notice and reporting periods, time lines will increase. One contractor reports that the “expeditious, development timeline of a non-controversial LMRP is 6–9 months, followed by publication and effectiveness dates 45 days after publication.” For “national coverage,” the process must be repeated up to forty-eight times.

  Timeliness relates to perspective. From a manufacturer’s perspective, the first favorable local decision is timely because it allows some market access. From a beneficiary’s perspective, however, “timely” relates to whether the procedure is covered by his or her contractor, not just any contractor.

- **Is timeliness a core issue?** Does the manufacturer’s perspective outweigh the efficiency issues for the program? From the beneficiary’s perspective, does timeliness for some trump access for all? Is speed of decision making an inherent characteristic of centralized or decentralized decisions? If timeliness is a core issue, should the focus be on expediting decisions at whatever government level they are best made?

- **Is “local” a proxy for lower standards of evidence?** It is acknowledged that LMRPs must be based on “the strongest evidence available.” However, “the burden of proof for effectiveness is lower than for a national coverage decision.” Innovators prefer lower hurdles for the obvious reason that they are easier to overcome. In fact, local coverage may be more “timely” because the standards of proof are lower than at the national level.

- **What are the appropriate standards of evidence for coverage?** Should Medicare have two different standards based on locus of decisions? Why? Does a system with two standards of evidence lead to gaming?

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The contractor reform debate provides an important opportunity to reevaluate local coverage policy. It is hard to justify the current local contractor structure, given the geographic incoherence of the evolving contractor networks and the complexity of multiple local policies. Policymakers need to move beyond a focus on locus and resist framing the issue one-dimensionally as local versus national coverage policy.

The multiple policy questions raised in this paper deserve serious consideration. It is also clear that additional research is necessary to learn more about how the local process works and the characteristics of the local medical review policies; such research is now under way. If policymakers decide to retain a decentralized policy structure, however, the solution...
must rationalize the defined geographic areas. The solution must also allocate policy decisions between the decentralized and central decisionmakers based on explicit criteria for the assignment. Finally, the solution must integrate the local and national processes so that the pathway to coverage is predictable, less complex, and appropriate for the specific coverage policy questions presented.

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NOTES
1. Social Security Amendments, Sec. 1862[a][1].
14. In two cases, the region included more than one state (New Hampshire and Vermont were combined, and the District of Columbia contract included parts of Maryland and Virginia). Seven states were divided into two geographic regions (California, Illinois, Minnesota, Missouri, Ohio, Virginia, and Wisconsin). The state of New York had five carriers. Ibid., 181–182.
18. Ibid.
20. TAG was later renamed Technology Advisory Committee (TAC). TAC was alleged to have violated the Federal Advisory Committee Act.
(FACA) in 1988 and was replaced by the Medicare Coverage Advisory Committee (MCAC). See discussion in Foote, “Why Medicare Can’t Promulgate,” 718.


22. Ibid., 146, note 27.


30. This occurs because many contractors have both Part A and Part B contracts. Contractor relations can be complicated and relationships hard to disentangle. Administar has two Part B contracts and eight FI contracts and is a subsidiary of Anthem (the result of a for-profit conversion of Indiana BCBS), which is also the parent organization for Anthem Health Plans of New Hampshire and Associated Hospitals of Maine.


32. Ibid., 32.


34. Ibid., 20–21.

35. Hospitals can choose a default contractor if BC is not selected. Mutual of Omaha processes about 10 percent of Part A claims.


43. For bill summary, text, and status at the end of the 107th Congress, see the Library of Congress Web site, thomas.loc.gov.


47. H.R. 3391, sec. 12(e)(1).


52. CMS, *Medicare Program Integrity Manual* (Revision 17), chap. 1, sec. 2.3.2.1.